Nursing Best Practice Guideline
Shaping the Future of Nursing

Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour

RNAO

RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

NURSING BEST PRACTICE GUIDELINES PROGRAM

Greetings from **Doris Grinspun**
Executive Director
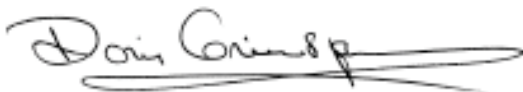**Registered Nurses' Association of Ontario**

It is with great excitement that the Registered Nurses' Association of Ontario (RNAO) presents this guideline, *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour,* to the health care community. Evidence-based practice supports the excellence in service that nurses are committed to delivering in our day-to-day practice. RNAO is delighted to provide this key resource to you.

RNAO offers its heartfelt thanks to the many individuals and institutions that are making our vision for Nursing Best Practice Guidelines (BPGs) a reality: the Government of Ontario for recognizing our ability to lead the program and providing multi-year funding; Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines (IABPG) Programs, for her expertise and leadership in advancing the production of the BPGs; each and every Team Leader involved, and for this BPG in particular – Elaine Sta. Mina – for her superb stewardship, commitment and, above all, exquisite expertise. Also thanks to Samatha Mayo, RNAO's IABPG Program Coordinator, for her intense work to see that this BPG moved from concept to reality. A special thanks to the BPG Panel – we respect and value your expertise and volunteer work. To all, we could not have done this without you!

The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the development, implementation, evaluation and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementating and evaluating the guidelines and working towards a culture of evidence-based practice.

Successful uptake of these guidelines requires a concerted effort from nurse clinicians and their health care colleagues from other disciplines, from nurse educators in academic and practice settings and from employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to practice actions.

We ask that you share this guideline with members of the interdisciplinary team as there is much to learn from one another. Together, we can ensure that the public receives the best possible care every time they come in contact with us. Let's make them the real winners in this important effort!

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Executive Director
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Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour

Disclaimer

These guidelines are not binding on nurses or the organizations that employ them. The use of these guidelines should be flexible based on individual needs and local circumstances. They neither constitute a liability nor discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the Registered Nurses' Association of Ontario (RNAO) give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

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Advisory Panel Members representing diverse perspectives were solicited for their feedback, and the Registered Nurses' Association of Ontario wish to acknowledge the following for their contribution to the development of this nursing best practice guideline:

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How to Use This Document

This nursing best practice guideline is a comprehensive document providing the resources necessary for the support of evidence-based nursing practice. The document should be reviewed and then applied to both specific needs of the organization or practice setting/environment and to meet the needs and wishes of the client. This guideline should not be applied in a "cookbook" fashion, but used as a tool to assist in decision-making for individualized client care and in ensuring that appropriate structures and supports are in place to provide the best possible care.

Nurses, other healthcare professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools, etc. It is recommended that this guideline be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. For the purpose of the document the recommendations appear to be discrete – they are intended to function as a whole.

Vignettes have been developed to illustrate the concepts described throughout the document. When reading these vignettes, nurses are encouraged to reflect on their own nursing practice; the presented "Nurse's Response" should be considered only one of many possible nursing approaches to the given scenario.

It is highly recommended that practice settings/environments adapt this guideline in formats that would be user-friendly for daily use. This guideline includes suggested formats for such local adaptation and tailoring.

Organizations wishing to use the guideline may decide to do so in a number of ways:
■ Assess current nursing and health care practices using the recommendations in the guideline.
■ Identify recommendations that will address identified needs or gaps in services.
■ Systematically develop a plan to implement the recommendations using associated tools and resources.

The Registered Nurses' Association of Ontario (RNAO) is interested in hearing how you have implemented this guideline. Please contact us to share your story. Implementation resources will be made available through the RNAO website to assist individuals and organizations to implement best practice guidelines.

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Summary of Recommendations

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1. The nurse will take seriously all statements made by the client that indicate, directly or indirectly, a wish to die by suicide, and/or all available information that indicates a risk for suicide.	III
2. The nurse works toward establishing a therapeutic relationship with clients at risk for suicidal ideation and behaviour.	IV
3. The nurse works with the client to minimize the feelings of shame, guilt and stigma that may be associated with suicidality, mental illness and addictions.	III
4. The nurse provides care in keeping with the principles of cultural safety/cultural competence.	III
5. The nurse assesses and manages factors that may impact the physical safety of both the client and the interdisciplinary team.	IV
6. a) The nurse recognizes key indicators that put an individual at risk for suicidal behaviour, even in the absence of expressed suicidality. For individuals who exhibit risk indicators, the nurse conducts and documents an assessment of suicidal ideation and plan. b) The nurse assesses for protective factors associated with suicide prevention. c) The nurse obtains collateral information from all available sources: family, friends, community supports, medical records and mental health professionals.	IV IV IV
7. The nurse mobilizes resources based upon the client's assessed level of suicide risk and associated needs.	IV
8. The nurse ensures that observation and therapeutic engagement reflects the client's changing suicide risk.	IV
9. The nurse works collaboratively with the client to understand his/her perspective and meet his/her needs.	IV
10. The nurse uses a mutual (client ◄──► nurse) problem-solving approach to facilitate the client's understanding of how they perceive his/her own problems and generate solutions.	IV
11. The nurse fosters hope with the suicidal client.	IV
12. The nurse is aware of current treatments to provide advocacy, referral, monitoring and health teaching interventions, as appropriate.	IV
13. a) The nurse identifies persons affected by suicide that may benefit from resources and supports, and refers as required. b) The nurse may initiate and participate in a debriefing process with other health care team members as per organizational protocol.	IV IV
14. The nurse seeks support through clinical supervision when working with adults at risk for suicidal ideation and behaviour to become aware of the emotional impact to the nurse and enhance clinical practice.	IV

RECOMMENDATION	TYPES OF EVIDENCE
Educational Recommendations	
15. Nurses who work with individuals at risk for suicide must have the appropriate knowledge and skills acquired through basic nursing education curriculum, ongoing professional development opportunities and orientation to new work places.	IV
16. Nursing curricula should incorporate content on mental health issues, including suicide risk reduction and prevention, in a systematic manner to promote core competencies in mental health practice.	IV
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21. Organizations allocate resources to ensure that all nurses have opportunities for clinical supervision and coaching on an ongoing basis.	IV
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24. Organizations support nurses' opportunities for professional development in mental health nursing.	IV
25. Organizations support research initiatives related to suicide and other mental health issues.	IV
26. Organizations develop a plan for the implementation of best practice guideline recommendations that include: ■ An assessment of organizational readiness and barriers to education. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Dedication of a qualified individual to provide the facilitation required for the education and implementation process. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. ■ Strategies for sustainability. ■ Allocation of adequate resources for implementation and sustainability, including organizational and administrative support.	IV

* Please refer to page 14 for details regarding the interpretation of evidence.

Interpretation of Evidence

Types of Evidence

Ia	Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study without randomization.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

Evidence to support nursing care for patients at risk for suicidal ideation and behaviour is organized with respect to the type of evidence rather than the level of evidence. The randomized control trial traditionally is considered the gold standard of evidence used to guide practice. As such, randomized control trials have become the benchmark for the establishment of a hierarchy of levels of evidence against which all other ways of knowing is of lesser value. However, multiple, alternative ways of knowing and understanding of a phenomenon are commonly, acknowledged and valued. Qualitative investigations, emic perspectives of a culture, clinical expertise, promising practices and client knowledge all contribute to the evidence of what it means to provide safe care for those who are at risk for suicidal ideation and behaviour. As such, types of evidence provide guidance for practice.

Responsibility for Guideline Development

The RNAO, with funding from the Government of Ontario, has embarked on a multi-year program of nursing best practice guideline development, pilot implementation, evaluation, dissemination and support of uptake. One of the areas of emphasis is on nursing interventions related to the assessment and management of adults at risk for suicidal ideation and behaviour. This guideline was developed by a panel of nurses and other health professionals convened by the RNAO. This work was conducted independent of any bias or influence from the Ontario Government.

Purpose and Scope

Best practice guidelines are systematically developed statements to assist practitioners' and clients' decisions about appropriate health care (Field & Lohr, 1990). This best practice guideline aims to assist nurses working in diverse practice settings provide evidence-based care to adults at risk for suicidal ideation and behaviours. Within the scope of this guideline, *adults at risk* may include any adult who may exhibit risk factors, with or without expressed suicidal intent. Nurses may interact with these clients in the community, long-term care facilities or in a hospital. A further discussion of risk factors is provided in Recommendation 6.

Although some approaches presented in this guideline may be applicable to the pediatric client, it is recognized that children and adolescents have special assessment and treatment needs related to developmental stages that are beyond the scope of this guideline.

Self-injury (sometimes referred to as self-harm or self-destructive behaviours), without the intent to die, is a broad phenomenon which may either overlap with, or be differentiated from, suicidal behaviour (Klonsky, 2007; Linehan, 1986; Santa Mina et al., 2006; Stanley et al., 2001). Frequently, it is associated with childhood trauma (Connors, 1996; Santa Mina & Gallop, 1998). Although keeping the client safe is always a priority, assessments and interventions for clients who self-injure may differ from those recommended for suicidal ideation and behaviour. As such, it is beyond the scope of this document to include the care of clients who engage in repetitive, non-suicidal self-injurious behaviours.

The potential health impact of this guideline is the reduction and prevention of risk for suicidal ideation and behaviours in adults, who receive care from RNs and RPNs, in any setting, thereby contributing to a reduction in suicide rates. The promotion of protection for the individual and families, the enhancement of reasons for living, and the delivery of successful nursing interventions will all reduce the risk for suicide.

The focus of this guideline is on best practice within the context of the individual nurse-client relationship and so will not address primary prevention interventions that may reduce the risk of suicidal ideation and behaviour. Though nurses play a major role in strengthening communities and advocating for social determinants of health, specific primary prevention strategies in this regard will not be discussed here. Moreover, despite the urgency to address the specific needs of Aboriginal youth population in Canada, the development of participatory, community-based approaches are beyond the scope of this guideline. There are, however, many educational resources and various intervention models that may offer guidance for readers who are interested in the areas not specifically addressed here. Applicability of intervention models may depend on the particular client population, health care professional expertise, or practice setting. Appendix O provides some examples of such resources and models.

The guideline will focus on individuals over the age of 17 and will address:
- recognition and assessment of risk for suicidal ideation and behaviour;
- nursing interventions towards the reduction of risk; and
- strategies to promote ongoing wellness for the client and the nurse.

The goal of this document is to provide nurses with recommendations, based on the best available evidence, related to the assessment and management of adults at risk for suicidal ideation and behaviour.

The intent is to increase nurses' comfort, confidence and competence in this practice area, in order to enhance safety for their clients and to lower the impact of suicide for society. This document is intended to provide support to the nurse in her/his care of the suicidal client.

This guideline contains recommendations for RNs and RPNs on best nursing practices in the area of assessment and management of adults at risk for suicidal ideation and behaviour. It is intended for nurses who may or may not be experts in this area of practice, who work in a variety of practice settings, across the continuum of care. It is acknowledged that individual competencies vary between nurses and across categories of nursing professionals, and are based on knowledge, skills, attitudes, critical analysis and decision-making that are enhanced over time by experience and education. It is expected that individual nurses will perform only those aspects of assessment and intervention for which they have received appropriate education and experience, and that they will seek appropriate consultation in instances where the client's care needs surpass their ability to act independently.

It is acknowledged that effective health care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and clients/families.

Development Process

In January of 2007, a multidisciplinary panel with expertise in practice, education and research from hospital, community and academic settings, was convened under the auspices of the RNAO. The panel discussed the purpose of their work, and came to consensus on the scope of this best practice guideline. Subsequently, a search of the literature for clinical practice guidelines from all health care professions and disciplines, systematic reviews, relevant research studies and other types of evidence was conducted based on the following clinical questions:

1. What are the contributing factors/predictors of suicidal ideation and behaviour?
2. What are the screening/assessment tools (measures, etc.) for suicidal ideation and behaviour?
3. What are the elements of clinical assessment for suicidal ideation and behaviour?
4. What are effective clinical interventions or postventions to prevent suicide and suicidal behaviour?
5. What are the standards of clinical practice for assessment and management of suicidal ideation and behaviour?

As part of the evidence review, the development panel conducted a critical appraisal of existing clinical guidelines related to suicide. A total of nine clinical practice guidelines on the topic of suicide were identified that met the following initial inclusion criteria:

- published in English;
- developed in 2002 or later;
- strictly on the scope of the guideline;
- evidence-based; and
- available and accessible for retrieval.

Members of the development panel reviewed these nine guidelines using the Appraisal of Guidelines for Research and Evaluation Instrument (AGREE Collaboration, 2001). This process resulted in the decision that five of these guidelines were relevant to the scope of the current guideline and would be used to inform the development of this guideline. These were:

- American Psychiatric Association (APA). (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors.* Arlington, VA: Author.
- Canadian Coalition for Seniors' Mental Health. [CCSMH] (2006). *National guidelines for seniors' mental health:The assessment of suicide risk and prevention of suicide.* [Online] Available: http://www.ccsmh.ca/en/natlGuidelines/natlGuidelinesInit.cfm
- National Collaborating Centre for Mental Health. (2004) *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* London, UK: National Institute for Clinical Excellence (NICE).
- New Zealand Guidelines Group (NZGG). (2003). *The assessment and management of people at risk of suicide.* Wellington (NZ): Author.
- U.S. Preventative Services Task Force. (2004). Screening for suicide risk: Recommendation and rationale. *Annals of Internal Medicine,*140(10), 820-821.

After reviewing the evidence in the research literature and guidelines, the panel focused its review on guidelines that were within the scope of practice of the RN and RPN. All panel members reviewed the empirical literature. Although the review of the existing guidelines demonstrated substantive evidence to guide practice for the assessment of risk factors and warning signs for suicidal ideation and behaviour, empirical evidence specific to nursing practice was limited (Cutcliffe & Stevenson, 2007). Therefore, the literature was critically appraised by all panel members for a thematic analysis of additional recommendations to guide nursing practice for clients who are at risk for suicide.

Through consensus method, the panel identified the major recommendation themes. The major recommendation themes were divided amongst panel member subgroups, according to their areas of clinical and academic expertise and interest. The subgroups linked the evidence (ranging from randomized controlled trials to grey literature) to the recommendations. The guideline recommendations were then brought back to the whole panel for consensus and approval. The document was further developed with vignettes, practice boxes and light bulb reminders to become a document that would readily support clinical practice. This process resulted in the development of practice, education, organization, policy and research recommendations. Further details regarding the search strategy and outcomes are provided in Appendix A.

Recognizing the importance of collaboration across disciplines in this practice arena, a multidisciplinary advisory panel was assembled to provide consultation to the project. Members of the advisory panel provided individual written feedback after reviewing the draft guideline and participated in a teleconference meeting to discuss their findings. Suggested revisions were considered by the development panel and, where appropriate, integrated into the guideline.

A subsequent draft was submitted to a set of external stakeholders for review and feedback. Stakeholders represented various health care professional groups, clients and families and professional associations. External stakeholders were provided with specific questions for comment, as well as the opportunity to give overall feedback and general impressions. The feedback from stakeholders was compiled and reviewed by the development panel – discussion and consensus resulted in revisions to the draft document prior to publication.

An acknowledgement of the advisory panel members and stakeholder reviewers is provided at the front of this document.

Background Context

"Every year in Canada, approximately 4,000 people die by suicide" (Canadian Association for Suicide Prevention/L'Association canadienne pour la prevention du suicide [CASP/ACPS], 2004, p. 8). Suicide remains a leading cause of death for men, women and young people. Population-adjusted rates of suicide have increased from 8.9 per 100,000 in 1950 to 13.13 in 1999 – an increase of almost 50% (CASP/ACPS, 2004). According to the Mood Disorders Society of Canada (MDSC) (2007), suicide accounts for 24% of all deaths among Canadians ages 15 to 24 years, 16% of all deaths for the age group of 25 to 44 years, and the age range with the highest number of suicides is the age group of 25 to 44 years. However, suicide rates vary dramatically across populations. A number of groups have been identified in the empirical literature as being at elevated risk for suicidal behaviour including youth, elderly, Aboriginal Peoples, gay/lesbian populations, and those who are incarcerated (White, 2003). In addition, 73% of the hospitalizations for suicide attempts are for people ages 15 to 44 years (MDSC, 2007). As an example, the rate of suicide among First Nations ages 10-44 years was 27.9 deaths per 100,000 compared to 13.2 deaths per 100,000 for non-Aboriginal people in Canada (First Nations and Inuit Health Branch, 2004). Detailed Canadian statistics regarding suicides and suicide rates are provided in Appendix C.

Suicide is a complex phenomenon that is influenced by physical (including genetic), psychological, spiritual, social, economic, historical, political, cultural and environmental factors. Many people in Canada have been affected by suicide at some point in their lives, be it family members, peers, colleagues or friends. In every family and in each community, the aftermath of a death by suicide is as painful and tragic as it is profound and far-reaching.

It is clear from qualitative investigations and clinical expertise that suicide can be prevented and the risk of suicide reduced.

Guiding Principles/Assumptions in the Assessment and Care for Adults at Risk for Suicidal Ideation and Behaviour

- "Stigma of mental illness can be defined as the negative attitude based on prejudice and misinformation that is triggered by a marker of illness – e.g. odd behaviour, or the mention of psychiatric treatment in a curriculum vitae" (Sartorius, 2007, p. 810). 'Stigma of suicide' can be defined similarly, as a negative attitude based on prejudice and misinformation that is triggered by a suicide or suicidal ideation or behaviour. Suicide, and suicidal ideation and behaviour is sometimes, but not always, linked to a mental illness. The presence of stigma is problematic because it leads to ongoing discrimination and marginalization with detrimental effects for clients, families and communities of people, including decreased self-esteem, increased isolation and vulnerability and, in the presence of a mental illness, a higher probability of relapse.

- Suicide is an abrupt ending to life and the most extreme way in which people respond to overwhelming distress. The nurse needs to understand this from the perspective of the client and approach these actions in a non-judgmental and non-blaming way.

- Nurses have a significant role in intervening when individuals express suicidal ideation and behaviour.

- The goal of intervention is to reduce the risk of suicidal ideation and behaviour, and to promote the safety of the client, staff and others. Nurses cannot stop every death by suicide. Suicide is complex, and prevention cannot rest solely in the hands of a small group of people.

- Establishment of a therapeutic relationship is fundamental to this work.

- Excellence in relational practice takes into consideration issues of difference and cultural safety.

- There are significant psychological and potentially physical impacts on the nurse when providing care for adults at risk for suicidal ideation and behaviour. The work environment must provide adequate supports for the nurse.

- In treatment planning, the nurse considers factors that support mental health and wellbeing, keeping in mind determinants of health, including social and cultural factors. It is important to support internal strengths and self-esteem, and the development of emotional coping and life skills needed for stress management.

- Safe, effective care is best achieved when nurses work in collaboration with the interdisciplinary team and client, family and community.

- Documentation is a standard of nursing practice and is an integral part of the assessment and care of clients at risk for suicidal ideation and behaviour.

- All of the following recommendations are utilized in conjunction with the requirements set forth by the College of Nurses of Ontario (i.e. practice standards) and relevant legislation (i.e. *Mental Health Act and Freedom of Information and Protection of Privacy Act, R.S.O., 1990, c. F.31).*

Assessment and Care of Adults at Risk *for* Suicidal Ideation and Behaviour: Process Overview

INTAKE ASSESSMENT

Physical
Psychosocial (i.e. support/resources)
Mental
Spiritual
Trauma – Physical, Emotional, and Sexual
Addictions
Suicide Behaviour
Risk of Self-Harm

CLIENT'S NEEDS (CLINICAL ASSESSMENT)

Safety
Self-Perception
Nutrition
Self-Care
Daily Activities
Sleep
Pain and Comfort
Information
Medication
Counselling
Coping Skills
Transportation
Finances and Housing
Role/Relationship

INTERVENTIONS

Listen – Interpersonal Communication
Take Seriously
Safety/Safety Factors
Observations
Mobilize Resources and Support
Cultural Safety
Education
Therapeutic Relationship
Supportive Therapy
Reduce Anxiety
Instill Hope
Mental Health Services
Collaborative Team
Treatment Modalities
Community/Family Services
Documentation
Monitor and Follow-up

Evaluate Client's Anticipated Outcomes

Source: Adapted with permission from Muxlow & Hamer (J. Muxlow & B. Hamer, personal communication, October 22, 2007)

Practice Recommendations

Recommendation 1

The nurse will take seriously all statements made by the client that indicate, directly or indirectly, a wish to die by suicide, and/or all available information that indicates a risk for suicide.

Type III Evidence

People who die by suicide have often expressed suicidal thoughts or displayed warning signs to families or health professionals, and so should be taken seriously (New Zealand Guidelines Group, [NZGG], 2003). Clients express suicidal ideation overtly with statements such as 'I am going to kill myself', and through indirect statements or behaviours. Indirect statements, such as 'I can't take it anymore', are significant, as a person's willingness to overtly disclose thoughts about suicide may be restricted for many reasons (i.e. cultural or religious beliefs and/or a desire for concealment in order to limit intervention by others (American Psychiatric Association [APA] ,2003). Sometimes the indirect expression is behavioural rather than verbal, such as storing medications, purchasing a gun, making a will, arranging for a funeral, settling financial affairs, giving belongings away, donating body to science, neglecting to care for self or relationships, sudden changes in religiosity – either greater or less than usual, or a deterioration in health (Holkup, 2002). Furthermore, the indicators that people give may be somatic in nature, particularly with elderly people. It is not uncommon for people who die by suicide to have been to a health care clinician weeks prior to their death for physical complaints, such as pain (Holkup, 2002). Refer to Recommendation 6 for a more detailed description of warning signs and risk factors.

"Taking seriously" means to conduct a suicide risk assessment, to document the assessment, to discuss the assessment with other members of the client's health care team and create a plan for safety and care as determined by the outcome of the assessment. If there is any uncertainty about suicidal intent and risk, the case should be discussed as soon as possible with appropriate health care providers or consultants, and the client's status should be considered a potential emergency until assessed otherwise by clinicians (NZGG, 2003). "Taking seriously" also includes being sensitive to, and aware of, the constellation of social situations such as sudden losses, and emotional states such as depression, that combine to increase the risk factors for suicide (APA, 2003; Holkup, 2002).

Self-harm intentions and behaviours without the expressed desire to die should also be taken seriously, as it is known that people who die by suicide frequently have had previous self-harm attempts. Also, people who engage in self-harm and suicidal behaviour may have different intentions on different occasions and therefore, each event is to be treated with full respect and care (APA, 2003; Royal College of Psychiatrists [RCP], 2004). People who engage in repeated episodes of self-harm behaviour may underestimate the lethality of their behaviour. Each episode of self-harm must be assessed for lethality and care needs to be taken that self-harm events are not minimized or trivialized.

Suicide can occur without warning and be impulsive in nature. Even with best efforts, suicide cannot always be prevented. However, nurses have a legal and ethical responsibility to try to prevent a suicide where possible (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm, 2004).

Practice Box
"Taking seriously"
(RNAO Development Panel, 2008)

1. All verbal and non-verbal behaviours that may convey an expression of dying are taken seriously.
2. The client is assessed for suicide risk.*
   Here are some suggestions to ask your client if s/he is suicidal:
   - "Are you thinking about ending your life?"
   - "Are you suicidal?"
   - "Do you have a plan to take your own life?"
   - "Do thoughts of death or suicide enter your mind?"
3. The assessment is documented and communicated to the appropriate members of the health care team.
4. Based upon the assessment, appropriate interventions are initiated.

Type IV Evidence

*Refer to Recommendation 6 and Appendices H-K for detailed information regarding assessment.

Vignette

Scenario: On the evening shift, the RN gives Mr. Smith, a 60-year-old retired widower with cancer, his bedtime medications. He sighs and says, "There is no point to any of this. It is not worth living like this. I should just get my affairs in order now."

Nurse's Reflection: The nurse is aware that many losses, a depressed state and a medical illness can put one at risk for suicidal ideation and behaviour. The client has a constellation of factors that combined could put him at risk for suicidal ideation and/or behaviour. Although he does not overtly state that he wants to take his life, the nurse identifies the indirect verbal cues and the non-verbal cue of deep sighing, which could indicate despair. The nurse is aware of the client's psychosocial background that also can increase his risk.

Nurse's Response: The nurse appropriately takes the client's statements seriously and conducts a suicide risk assessment. She documents her assessment and communicates her findings based upon the urgency with the appropriate team members.

Recommendation 2:

The nurse works toward establishing a therapeutic relationship with clients at risk for suicidal ideation and behaviour.

Type IV Evidence

The therapeutic relationship describes an interpersonal process that occurs between the nurse and the client(s), which is purposeful and directed at advancing the client's best interest and outcomes (Registered Nurses' Association of Ontario [RNAO], 2006c). The qualities of the therapeutic relationship include active listening, trust, respect, genuineness, empathy and responding to client concerns (RNAO, 2006c).

As it relates to the care of clients at risk for suicidal ideation and behaviour, the establishment of a therapeutic relationship is considered essential for creating a context within which the nurse can actively engage with the client to explore their needs and develop strategies to reduce suicide risk (APA, 2003; Delaney & Johnson, 2006; NZGG, 2003). Furthermore, effective interventions to creating a safe environment embrace an attitude of respect for the individual and a confirmation of their autonomy; it is about providing safety and maintaining their dignity, while assisting them in managing their behaviour (Bisconer, Green, Mallon-Czajka, & Johnson, 2006; Delaney & Johnson, 2006; Reynolds, O'Shaunessey, Walker & Pereira, 2005). As such, the therapeutic relationship may also be healing in itself, as it may foster a sense of hope while contributing to a person feeling heard, respected and connected (Billings, 2001; CCSMH, 2006; NZGG, 2003; O'Brien & Cole, 2003). Both APA (2003) and NZGG (2003) guidelines suggest that positive therapeutic relationships have protective effects for suicide.

Importantly, the nurse must acknowledge that particular circumstances may pose challenges to the establishment of a therapeutic relationship. Certain client characteristics, (e.g. if the client is highly agitated), may make engagement in a therapeutic relationship especially difficult. Interventions to promote safety, such as calling emergency services or increasing the level of observation, may be perceived by the client to be a breach of trust, and therefore represent another potential challenge. Moreover, the nurse's own feelings toward death and suicide can pose an obstacle itself; the activation of these emotions may lead to defensive responses on the part of the nurse (APA, 2003), thereby impacting one's ability to establish a therapeutic relationship. Working through these challenging situations, as well as issues of transference and counter-transference, requires collaboration, mentorship and clinical supervision, all of which support the nurse in establishing a relationship that is therapeutic for the client and developing a sense of self-awareness regarding her or his practice. Refer to Appendix D for further discussion regarding transference and counter-transference.

For more information regarding therapeutic relationships, refer to the RNAO Best Practice Guideline *Establishing Therapeutic Relationships* (Revised) (RNAO, 2006c).

Vignette

Scenario: Naomi, a 42-year-old mother of three, has been admitted to a busy emergency department because of a near fatal overdose of prescribed pain killers for chronic pain. This is the fourth admission to emergency for Naomi – all related to an overdose of medication. Naomi is deemed "difficult" post-recovery from overdose attempts. She lashes out and is generally resistant to any kind of treatment. She pulls out her IV, and is curt and abrasive in her interactions with staff. Naomi's nurse overhears a conversation in the conference room between another nurse and the emergency room physician in which they are in agreement that "enough is enough". They are discussing ways that the system might put a penalty on people who "cost the system money" and take time away from the "really sick people." They would like to see Naomi transferred to a different emergency room "on her next attempt".

Nurse's Reflection: The nurse recognizes that the staff response may be reflective of unrecognized transference and counter-transference – the client may be lashing out at the staff for a number of reasons unknown to herself, perhaps related to a sense of hopelessness, shame, guilt, and/or fear that is also embodied in her suicidal behaviour and attached to 'unresolved' past relationships and experiences. The nurse knows it is not uncommon for health care providers to experience feelings of hopelessness, fear and anger in response to clients who they feel they have been unable to help. The client's repeated suicidal attempts and lashing out behaviour triggers many emotions which, if unrecognized and consequently not addressed, may lead to poor treatment and/or outcomes.

Nurse's Response: The nurse works to build a therapeutic relationship with Naomi. While attending to her, he demonstrates calmness, patience and a willingness to listen. He is non-judgmental. The nurse attempts to understand what the client may be feeling and experiencing. He also approaches the clinical leader in the emergency room and requests that this client be discussed in the next team rounds. He prepares to discuss the issue of transference and counter-transference as related to persons who make repeated suicide attempts as a means of opening up the dialogue with his colleagues.

Recommendation 3:
The nurse works with the client to minimize the feelings of shame, guilt and stigma that may be associated with suicidality, mental illness and addiction.

Type III Evidence

Suicide continues to be stigmatized in contemporary society (Murray & Hauenstein, 2008), leading to implications for individuals at risk for suicidal ideation and behaviour. Feelings of shame, guilt and stigma have an accumulative effect on clients' mental well-being, on their families and social support system, on accessing professional help and counseling, and on their self-esteem (Barlow & Morrison, 2002; Ostman & Kiellin 2002). One study found that suicide attempts are commonly followed by shame reactions (Wiklander, Samuelsson & Asberg, 2003). Within the therapeutic relationship, expressions of respect, tolerance and an

affirmation of the client's self-worth may help to minimize these feelings (Ashmore, 2001; Wiklander et el., 2003). Wiklander and colleagues (2003) suggest that suicidal clients accept treatment better and feel less ashamed in such environments. Clients may benefit similarly when not pushed for traumatic life event details by the nurse (NZGG, 2003). Moreover, one study reported that the reduction of stigmatization proved critical in declining suicidality in US Air Force personnel (Knox et al., as cited in Sakinofsky, 2007b).

To minimize the effect of the nurse's own potentially negative reactions to the client, it is essential that nurses engage in reflective practice and obtain support to address such challenges (McMain, 2007).

Beware of your own negative attitudes, beliefs and behaviours, which may have negative impact on the client.

Vignette

Scenario: The client, a 21-year-old man, with a history of major depression and alcohol abuse, was transferred to a medical unit, from an intensive care unit, post self-inflicted wound. His weekend nurse came to see him to change his dressings. He said, "My parents are coming in today to see me. This is the first time I have seen them since I hurt myself. I am not looking forward to this visit. I know they love me and are worried. They have done a lot for me and this is a disappointment for them. No one in our family does these kinds of crazy things. We don't even talk about being depressed in our family. They told me on the phone that they do not want anyone to know about this. I am not to tell anyone, not even my friends. They say I will lose my friends and could lose my job. I am so ashamed. I made things worse and don't think I can fix any of this."

Nurses' Reflection: The nurse recognizes the stigma associated with suicide attempts for both the client's family and for the client.

Nurses' Response: The nurse listens non-judgmentally. She states that often others do not understand the depths of despair that someone can experience leading to self-destructive behaviour. It can be a challenge to comprehend. However, the mutual love between him and his parents is a strength towards building that understanding. Suicide was a response to his distress. He has new opportunities to address his problems in life. He can do that privately with a therapist. He can choose his own time and manner for sharing as much or as little as he is comfortable sharing, and with whomever he trusts. The nurse offers the additional support of speaking with the unit social worker. The patient can share with his family should he decide it is appropriate. The nurse understands that in this case, the client is probably experiencing the cumulative effects of shame, guilt, and stigma associated with suicidality.

> ## Recommendation 4:
> **The nurse provides care in keeping with the principles of cultural safety/cultural competence.**
> *Type III Evidence*

Both the client and nurse bring their own culturally derived attitudes, values and beliefs to the therapeutic relationship. As such, culture can greatly impact how issues of mental health, suicide and death are discussed and addressed in the context of this relationship. For example, culture may influence feelings of guilt and shame regarding suicide (NZGG, 2003; Proctor, 2005), the willingness to speak about death and suicide (APA, 2003), and attitudes regarding family and community roles in care provision (NZGG, 2003). Health care providers have a powerful role in the health of the client, and cultural differences between the nurse and client may exacerbate these power relations. This has implications on the client's experience of care as well as the effectiveness and safety of clinical practice.

From a critical cultural perspective, culture is complex, dynamic, political and historical – it is a relational process that shifts over time "depending on our history, our past experiences, our social, professional and gendered location, and our perceptions of how we are viewed in society" (Browne & Varcoe, 2006). Cultural safety is a concept which began in nursing education in Aotearoa, New Zealand with Māori nurses (Ramsden, 1993; 2000) in recognition of inequities in health status and health care for Māori related to continuing colonizing processes and practices. Cultural safety begins with the self-reflection of the nurse/ health care provider. The nurse needs to recognize that both the client (as individual, family and/or community) and the provider are "bearers of culture" – a 1:1 relationship is always bicultural. It requires an examination of how each individual is located within historical, social, economic and political processes that influence health care, health and well-being; an understanding that differential positions of power in health care influence health and well-being need to be addressed; and a recognition that structural inequities that impact health care, health and well-being need to be shifted (Ramsden, 1993) in keeping with the social mandate of nursing.

Cultural safety is more than recognizing and respecting "difference" – it is a relational concept that demands engagement with policies and practices that impact health care and health. The nurse demonstrates acceptance and respect for the 'culture' of the client and for the associated differences, in addition to advocating for change in response to policies and practices that may be experienced as 'unsafe' by the client. Appendices E and F provide a more detailed discussion of cultural safety. Additional information about culture is available in the RNAO Healthy Work Environments Best Practice Guideline *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* (RNAO, 2007).

Cultural safety is safe service as defined by those who receive the service (Papps, 2005).

Vignette

Scenario: A community mental health nurse in a large urban centre is asked to see Jacques. Jacques, a 22-year-old man who identifies as First Nation (FN), has entered the clinic and requested to see a physician or nurse. He shows minimal emotion (i.e. flat effect), and seems preoccupied and restless. He shares that he is experiencing suicidal thoughts.

Nurse's Reflection: The nurse understands that her own assumptions, beliefs, and values impact how she will respond to Jacques. She recognizes that many FNs have been negatively impacted by a long history of colonization and neocolonial practices – *The Indian Act*, 1876 (which continues to influence the lives of Aboriginal people, including how health services are offered and delivered), residential schooling, reserves (urban, rural and remote), current land claim negotiations, health transfer arrangements, etc. She wants to ensure that Jacques feels comfortable in the clinic. The nurse also knows that power is an important consideration in all nurse-client relationships, and that for FN people this may be particularly relevant (i.e. there may be a lack of trust with health care services). However, the nurse is aware that she must get to know Jacques and that she cannot make any assumptions about what Jacques thinks or believes.

Nurse's Response: The nurse begins her assessment with Jacques by asking what brings him to the clinic and attempts to understand what she might do to make him comfortable. She is non-judgmental. She does a complete history and includes questions about his family and community, including a question about where he is from and what he understands as the issue that brings him to the clinic. She asks him about his beliefs about health, illness and healing. She demonstrates an interest in Jacques as an individual and as a member of his family and community. The nurse is interested in those beliefs and practices that might be important to Jacques in relation to dealing with the suicidal thoughts and healing processes and practices.

> ### Recommendation 5:
> **The nurse assesses and manages factors that may impact the physical safety of both the client and the interdisciplinary team.**
>
> *Type IV Evidence*

Before intervening to enhance the client's safety, the nurse needs to ensure her/his own safety first. This may involve enlisting the help of others, such as team members, police and/or emergency services (i.e. Code White, 911), or even leaving the scene until appropriate supports are in place.

Attending to the physical safety of the client is an ongoing priority when providing nursing care and should be initiated before a thorough clinical assessment of suicide risk is completed. Interventions are highly variable depending on the practice setting, and though they may not guarantee that self-injurious actions will not occur, these interventions may minimize the physical threat of such behaviour on the client and health care team. In keeping with the therapeutic relationship, it is imperative to engage the client and family throughout the process of implementing safety measures.

The nurse should be alert to the physical setting and any item in it that may pose a threat to safety. Reduce access by removing such items from the person and the environment, be it the hospital room and/or the home, as appropriate.

Though there is no such thing as a suicide-proof unit, physical safety features are encouraged for organization-based settings that may potentially work with clients at risk for suicidal ideation and behaviour (Simon, 2004; Yeager, Saveanu, Roberts, Reissland, Mertz, Cirpilli, et al, 2005). It is also suggested that external stimuli, such as noise and commotion, may increase agitation and aggression (Joint Commission on Accreditation of Healthcare Organizations, 1998). In such cases, reducing the cause of stimuli or moving to a less stressful area may be helpful. Appendix G provides some environmental considerations to promote physical safety.

In some cases, the client may present with physical injury that requires medical attention. Life threatening injuries should be addressed immediately. The acuity of other injuries should not be underestimated and should be considered when prioritizing the client's care needs (National Collaborating Centre for Mental Health [NCCMH], 2004). Ongoing medical and physical assessment is warranted in such cases.

Maintaining the client's dignity is essential. Considerations of emotional and psychological safety should be balanced with ensuring physical safety. For example, restrictive interventions, such as seclusion or restraints, although sometimes used in inpatient settings to maintain safety, may also be very stressful for clients and hinder recovery by reinforcing perceptions of being out of control (Murray & Hauenstein, 2008). Therefore, when any safety measures are implemented, it is important to keep the client informed and engaged in the decision-making process.

Practice Box

Potentially hazardous items may include, but are not limited to
(Bennett, Daly, Kirkwood, McKain & Swope., 2006)**:**

- clothing (e.g. belts, shoelaces)
- cords
- lighters
- linens
- medications
- other equipment
- oxygen therapy devices and tubing
- plastic bags
- sharp or glass objects
- toxic substances

Type IV Evidence

Vignette

Scenario: A distressed client, Mary-Lou, calls the community nurse stating "I'm suicidal… I've cut my wrists with a steak knife. I've already called the ambulance and they're on the way." Mary-Lou is a 46-year-old client living alone in the community with a diagnosis of borderline personality disorder (see Glossary). As well, she has limited cognitive ability due to a borderline level of intelligence. She is frequently lonely and has a difficult time structuring her day in order to make it productive and seem not so long. Mary-Lou verbalizes to the nurse that she has already called the ambulance. The nurse knows that this particular client tends to use the ambulance for non-essential services. However, in this case the client has made superficial abrasions horizontally to the right forearm using a dull steak knife.

Nurse's Reflection: The nurse ensures that 911 has been called. He recognizes that his responsibility as the community nurse is to provide support and assess the severity of the suicide attempt and physical harm to the client. He recognizes his first priority is to ensure the safety of the client and therefore will attend to the physical abrasions should he arrive before the ambulance. He recognizes that his role is to provide teaching and support to the client regarding how to communicate more effectively with supportive services in the community. He recognizes the complexity of this client's situation as she may have many reasons for her cutting behaviour, including the wish to die. He recognizes the need to collaborate with the patient's clinical team as soon as possible.

Nurse's Response: After attending to the client's needs, the nurse and the client look around the apartment for items that may pose a risk after the client is released from hospital. With the client's awareness and agreement, these items are removed to prevent further attempts of suicide until such a time that the client is stable and in control of her actions. The nurse communicates with the most appropriate member of the client's care team and seeks consultation, if at all possible. Arrangements are made for the client to be assessed by the Emergency Room physician and subsequently seen by her community psychiatrist for further follow-up and possible adjustment in medications. The nurse discusses the client's support network with the client, including her connections with family, friends and community resources, and explores possible strategies for keeping herself safe. He further supports the client by facilitating the use of community services, such as counseling.

> **Recommendation 6a:**
>
> **The nurse recognizes key indicators that put an individual at risk for suicidal behaviour, even in the absence of expressed suicidality. For individuals who exhibit risk indicators, the nurse conducts and documents an assessment of suicidal ideation and plan.**
>
> *Type IV Evidence*

Even in the absence of expressed suicidality, the nurse's knowledge of risk factors may help to identify individuals with suicidal ideation and behaviour. Risk factors include those characteristics that have been studied in large populations and have been shown to be associated with an increased likelihood of suicide (NZGG, 2003). Examples include, being male, being elderly, hopelessness, previous suicide attempts, and past and current psychiatric illness (APA, 2003). Refer to Appendix H for a list of risk factors. Risk factors can be categorized as being either dynamic and modifiable or static and unmodifiable. Modifiable risk factors are those that are amendable to change. This is an important point, as the identification of modifiable risk factors should be used to direct decision-making regarding intervention and support planning (APA, 2003). Examples of modifiable risk factors include depression, anxiety, hopelessness, substance use, intoxication and access to lethal means. In contrast, static risk factors are those that cannot be changed, such as age, gender and history of suicide attempts. Although knowledge of risk factors does not permit the clinician to predict if or when a client will die by suicide (APA, 2003), the recognition of risk is a major component of promoting the safety of these clients (APA, 2003; Mann, Apter, Bertolote, Beautraise, Currier, Haas, et al., 2005). By focusing treatment on the risk and protective factors that can be strengthened or mitigated, it may be possible to decrease a patient's suicide risk (APA, 2003).

In addition to knowledge of risk factors, it is important to be aware of warning signs for suicide. Whereas risk factors are characteristics that have been shown to be associated with an increased likelihood of suicide, warning signs may be overt signs or symptoms that alert the nurse to a current risk.

Practice Box
Warning Signs

The following information may be reported or observed by the client and/or their family, friends, community supports, medical records and mental health professionals (Holkup, Centre for Suicide Prevention, 2002; 2002a; NZGG, 2003):

- Talking about suicide or death directly (e.g. "I wish I was dead.")
- Talking about suicide or death indirectly, including themes of hopelessness and worthlessness (e.g. "What's the point of going on?", "I'm tired", "Everyone would be better off without me.")
- Threatening suicide, describing methods of suicide or researching methods of suicide on the Internet.
- Formation of suicide plan.
- Increased intensity of suicidal ideation.
- Putting affairs in order (e.g. making or changing a will, giving money or possessions away, donating one's body to science, saying good bye, writing suicide notes).
- Purchasing or stockpiling medications, firearms, razors.
- Exploring balconies, bridges, rooftops.

- Engaging in risky behaviour (e.g. increased use of alcohol or substances, reckless driving).
- Self-neglect (e.g. change in appearance, including changes in weight and appetite).
- Change in personality.
- Change in mood (e.g. depression, anxiety, agitation).
- Social withdrawal and isolation, including a loss of enjoyment in activities.

Type IV Evidence

A comprehensive assessment of risk involves interviewing the client, reviewing the medical records and/or gathering information from family or significant others. Key indicators of risk may be evident in client's current presentation, history, social and living conditions, and demographic characteristics. As such, suicidal ideation and behaviour may be present even when not expressed explicitly by the individual. Moreover, the applicability of risk factors may differ based on the particular individual and cultural background. The nurse must also be aware that the number of risk factors identified through assessment does not necessarily describe the degree of risk exhibited. For example, an individual with five risk factors is not necessarily at higher risk than an individual with two risk factors. These factors are not simply present or absent, but are dynamic and vary in severity (APA, 2003). Overall, the estimation of risk and decisions regarding the frequency of reassessment is best conducted through the use of clinical judgment, in collaboration with the health care team.

If the nurse suspects a risk of suicidal ideation and behaviour, then further assessment of the suicidal ideation and plan is required.

There is no evidence to suggest that asking a person directly about the topic of suicide will increase the likelihood of suicidal ideation and behaviour (APA, 2003; NZGG, 2003). According to APA (2003), "Asking about suicide is necessary and will not lead the person to suicide" (p. 19). An assessment specific to factors related to suicide helps to uncover the purpose and meaning behind any suicidal ideation and behaviour, thereby informing the development of appropriate and meaningful interventions (Murray & Hauenstein, 2008).

Given the significant association between suicide and mental illness, a major part of suicide assessment is a comprehensive psychiatric/psychosocial assessment to gather information regarding (APA, 2003; NZGG, 2003):

- presenting problem and/or current mental status;
- history of present illness;
- past psychiatric history;
- past medical/surgical history;
- current and recent past medication;
- drug allergies;
- substance use history;
- forensic history;
- family history;
- psychosocial history; and
- nursing diagnosis.

Within the psychiatric/psychosocial assessment, a mental status exam is a systematic approach to the assessment of an individual's current mental status, specifically related to psychological, emotional, social, and neurologic functioning. Refer to Appendix I for components of a mental status assessment.

Practice Box
Example interview questions
Source: NZGG (2003). Reproduced with permission

- How has your mood been lately?
- Has anything been troubling or worrying you?
- Have you had times when you have been feeling sad or 'down'?
- Have you ever felt like life is just getting on top of you?
- Do you sometimes wish you could just make it all stop, or that you could just end it?
- Have you thought about how you might do this?
- Have you ever wished you were dead?
- Have you ever thought about taking your own life?

Type IV Evidence

To conduct a comprehensive assessment regarding suicidal ideation and plan, a clinical interview and use of valid and reliable assessment tools may be used to gather information specific to (APA, 2003; NZGG, 2003):

- presence of risk factors;
- lack or presence of protective factors (e.g. spirituality, hope, future orientation, cultural and/or spiritual factors);
- suicidal intent;
- plan;
- lethality;
- access to means;
- timeframe;
- hope; and
- previous attempts.

Interview questions that may be useful in such interviews are provided in Appendix J.

Engaging in discussions regarding suicide can be difficult for the nurse. While teamwork and clinical supervision may be means by which a nurse may acquire support through these situations, it is also important to note that nurses must have the appropriate level of skill and knowledge to conduct these clinical assessments in a therapeutic way.

STOP **Assessment tools are only to be used as part of a comprehensive assessment and should not be used in isolation** (APA, 2003; NZGG, 2003)**. Despite the wide variety, there is limited evidence to support the use of any particular tool. Moreover, existing tools have low predictive ability to determine who will or will not die by suicide** (APA, 2003)**. As such, this guideline suggests that while these tools may help to facilitate communication and information gathering in the context of an interview, the results do not replace clinical judgment in the practice setting. The use of psychological scales for diagnosis should be reserved for clinicians with specialized training. Refer to Appendix K for examples of assessment tools.**

Special Consideration: Intoxication

When the presenting client is intoxicated, it can be extremely difficult to conduct a comprehensive suicide risk assessment. In such cases, assessment should focus on immediate risk for suicide and the intoxicated client should be kept in a safe environment and reassessed when sober (NZGG, 2003). Individuals presenting with intoxication should also be assessed for immediate medical concerns related to the substance use. For example, in those known or suspected to frequently use alcohol, it is necessary to provide ongoing assessment and management of symptoms of withdrawal (i.e. potential alcohol-related seizures, Delirium Tremens), according to established protocols. Ongoing medical assessment in conjunction with assessment of suicide risk is essential to maintaining the safety of the client.

Intoxication (e.g. from alcohol, elicit drugs, polypharmacy, over the counter drugs, etc.) may increase impulsivity (NZGG, 2003), and therefore reinforces the need to keep individuals presenting with intoxication and suicidal ideation safe. According to the New Zealand guidelines (2003), intoxication may also increase the person's distress, aggressiveness and decrease problem-solving abilities. Moreover, evidence demonstrates that alcohol use/intoxication is a common prelude to a suicide attempt (APA, 2003). Ongoing assessment of suicide risk is essential.

Recommendation 6b:
The nurse assesses for protective factors associated with suicide prevention.
Type IV Evidence

The NZGG (2003) define protective factors as "aspects of a person's life that give them some reward, meaning or sense of purpose, or sense of connection with others" (p. 23). Protective factors are associated with a decreased risk for suicidal ideation and behaviour and therefore play a major part in both risk assessment and supportive care planning. Factors associated with protective effects may include internal strengths, such as the client's own coping skills and self-confidence, as well as external strengths, such as social support systems and access to mental health resources (Holkup, 2002). Moreover, a positive therapeutic relationship has also been suggested to be protective against suicidal behaviours (APA, 2003; NZGG, 2003). A list of protective factors is provided in Appendix H.

Protective factors may be assessed through clinical interviews. It has been suggested that through asking the person what has kept him/her from acting out the plan thus far, you may illuminate protective factors (Holkup, 2002).

STOP

No-Suicide Contracts

The literature suggests that no-suicide contracts are frequently employed as assessment and/or management tools by health care professionals despite the lack of empirical evidence to support their use (APA, 2003; Farrow, 2002). **No-suicide contracts do not guarantee a person's safety, thus should not be relied upon as the sole indicator as to whether a person may try to end his or her life** (Farrow, 2003; NZGG, 2003).

Although there is no standard definition, a no-suicide contract essentially refers to a verbal or written agreement between a patient and clinician that the patient will not kill themselves. Within the literature, no-suicide contracts may also be referred to as no-suicide prevention contracts, no-harm contracts, no-suicide decisions, safety agreements, contracts, suicide agreements and contracting to stay alive (APA, 2003; Farrow, 2002; Rudd, Mandrusiak & Joiner, 2006). Common components of a no-suicide contract include an explicit statement not to kill or harm oneself, details about duration of the agreement and contingency plans should the client be unable to keep the conditions (Centre for Suicide Prevention, 2002b; Rudd, et al., 2006).

If used, no-suicide contracts should be used with caution, and not used with clients who have had previous suicide attempts, are agitated, psychotic, and impulsive or intoxicated (APA, 2003; Murray & Hauenstein, 2008). Despite consensus that no-suicide contracts should only be used within the context of a therapeutic relationship, the literature suggests that nurses often utilize such tools in emergency or community crisis situations (Farrow, 2003). As a result, the no-suicide contract may provide a false sense of security and provide little more than alleviation of anxiety on the part of the health care professional.

Despite the lack of empirical evidence to support their use, the panel suggests that if used, no-suicide contracts be used with caution and only within the context of a therapeutic relationship and a more comprehensive assessment and management plan. If, and when, a decision is made to include a no-suicide contract as part of the treatment plan, it should not be done in isolation, but rather within the context of the multidisciplinary team, inclusive of the client. Although no-suicide contracts can be used as a means to empower the client by involving him or her in the development of his or her treatment plan, the client's willingness to enter into such an agreement should not be used as an absolute indicator as to whether he or she may go on to harm or kill oneself (APA, 2003). Should a client be unwilling to enter into a no-suicide contract, this may be indicative of ambivalence and his or her inability to adhere to the contract, necessitating further assessment and exploration of other management options. On the contrary, a client's willingness to include a no-suicide contract as part of their management plan does not guarantee that he or she will not go on to harm or kill oneself. In a study by Kroll (2007), of the 152 psychiatrists who used no-suicide contracts, 41% reported that they had patients who attempted or killed oneself after entering into such an agreement. Additional research is required to determine the efficacy of the no-suicide contract.

Practice Box

Examples of questions to aid in the assessment of protective factors

(RNAO Development Panel, 2008)

- You say that you have had thoughts of suicide, but have not acted on them. What has stopped you thus far?
- What in life makes you want to keep on living?
- Who are the people in your life that make you want to go on living?
- What resources do you access when feeling unsafe and/or who are the people that you go to for support?
- You have said that in the past you didn't act on these thoughts because of X. How much does that factor into your decision-making now? (NZGG, 2003)
- What aspirations do you have for life and/or what goals would you like to accomplish?
- When feeling overwhelmed, what problem solving and/or coping mechanisms do you utilize?
- In the past when you had suicidal thoughts, with whom did you share these thoughts?
- If you are a spiritual or religious person, do your beliefs act as a protective factor and if so, how?

Type IV Evidence

Vignette

Scenario: A 38-year-old woman is brought to the emergency department by paramedics because of suicidal ideation. During the nurse's suicide risk assessment, the woman states that she has been having thoughts of jumping off the 17th floor balcony of her apartment. She tells the nurse that she walked out onto the balcony this morning and looked over the edge but that something held her back. She stated that she returned inside and called 911.

Nurse's Reflection: The nurse recognizes that the patient was contemplating suicide this morning and requires a thorough suicide risk assessment. Not only must the nurse explore and document risk factors in her assessment, but he must also explore those factors that are protective against suicide. The nurse knows that protective factors are associated with a decreased risk of suicidal ideation and behaviour, and play a major part in the risk assessment and supportive care planning.

Nurse's Response: To elicit protective factors the nurse proceeds to ask the patient what it was that held her back. The patient states that she has a two-year-old son and that she worries what would happen to him, as nobody else can care for him as well as her. The patient reports that she has guilt related to leaving the full parenting responsibility to her husband. Thus far, the nurse understands that the patient's child is a protective factor. The nurse becomes interested in finding out if there is anything else that helps the patient to want to go on living and proceeds to ask, "You say that you have had thoughts of suicide, but have not acted on them. Is there anything else besides your child that has stopped you?" The patient states, "There are no guarantees". As the nurse further explores this comment with the patient, he learns that the patient worries that she may not die and be paralyzed for life.

Recommendation 6c:
The nurse obtains collateral information from all available sources: family, friends, community supports, medical records and mental health professionals.
Type IV Evidence

Collateral information is an important component of a suicide risk assessment with all adult clients, particularly in cases where the client is unknown to the nurse, is unwilling or unable to participate in suicide risk assessment. Collateral information is that which is obtained from others who know the client, such as family, significant other and other professional supports. Such information can provide important information about the client's mental state or behaviour that may indicate suicidal ideation, as well as any recent stressors that may be impacting on the client (APA, 2003; NZGG, 2003).

It is important for the nurse to consider the issue of confidentiality and understand the relevant privacy legislation (eg. the province of *Ontario's Personal Health Information Protection Act, 2004* (PHIPA)) (Cavoukian, 2004). The client's consent for obtaining collateral information must be sought prior to doing so. If the client does not want family members or significant others to be contacted and this does not compromise the safety of the client, then confidentiality must be maintained (NZGG, 2003). However, in emergency situations, it is permissible to obtain collateral information without consent in order to maintain the safety of the client or others (APA, 2003; Cavoukian, 2004; NZGG, 2003). Importantly, when interacting with family members or significant others to obtain collateral information, it must be understood that the goal of such communication is to acquire information, not to provide information. Challenges may arise in cases where potential sources of collateral information are not available or there are inconsistencies in the information received. In these situations, further investigation may be warranted to help the nurse and health care team develop an understanding of the particular clinical scenario.

Collateral information is that which is obtained from others who know the client, such as family, significant other and other professional supports.

Practice Box
Examples of questions for acquiring collateral information
Source: NZGG (2003). Reproduced with permission

- Are they their usual self?
- Have they made any comments that they would be 'better off dead'?
- Have there been any statements about 'things getting better soon'?
- Have you been worried about them? Do they seem down or depressed?
- Are they drinking more than usual?

Type IV Evidence

Vignette

Scenario: A 48-year-old man is brought to the emergency department by the police for suicidal ideation. The assigned nurse learns that the patient contacted a crisis line for assistance, which then called the police out of concern for the patient's safety. The patient, who is unknown to the hospital, reveals that he lives with his wife and that he would like to return home, as she will be worried about him. The patient states that although he was feeling suicidal earlier, he feels much better and would like to leave. Despite her efforts, the patient is unwilling to speak with the nurse any further.

Nurse's Reflection: Given the circumstances, the nurse recognizes that it will be necessary to speak with the patient's wife to inquire about the patient's mental state and any behaviour that may indicate suicidal ideation. The nurse is cognizant of the patient's request for privacy. However, she is also aware that privacy legislation permits her to obtain collateral information. The nurse knows that speaking to family, friends or health care professionals is an important component of a suicide risk assessment and can help to inform decision-making regarding disposition.

Nurse's Response: The nurse explains to the patient that it will be necessary to remain in hospital for a psychiatric assessment, part of which will include contacting his wife for information. The patient is unhappy and requests that the nurse does not contact his wife. The nurse reassures the patient that the goal of the conversation will be to obtain information not to provide information. The nurse proceeds to call the patient's wife and following introductions she asks her if she has noticed any changes in the patient's behaviour. More specifically the nurse inquires about suicidal ideation and whether or not the patient has made any comments about wanting to die. Additionally, she asks the patient's wife whether or not she has noted any behaviours that would suggest the patient has been thinking about suicide, such as hoarding pill. Although the patient denies having any thoughts of wanting to die, the nurse learns from the patient's wife that she has been very concerned about him as the patient has been increasingly withdrawn, has been drinking increasing amounts of alcohol, and has been saying comments such as, "I would be better off dead." The patient's wife reveals that the patient had a previous suicide attempt only two months ago. Based on this additional information the team decides that the patient is at high risk and requires a psychiatric evaluation and inpatient hospitalization.

Practice Box
Elements of Risk Assessment
(APA, 2003; NZGG, 2003)

1. Conduct a Psychiatric Assessment
   a) Presenting problem – from the perspective of the patient, including identified psychosocial stressors.
   b) History of present illness – duration and severity of symptoms
   c) Past psychiatric history – past psychiatric hospitalizations, dates, locations, diagnoses
   d) Past medical history – illnesses, surgeries, dates and locations of hospitalizations
   e) Current and past medications
   f) Drug allergies
   g) Substance use history – current and past use of all substances, dates and locations of treatment settings, history of withdrawal
   h) Forensic history – past and current charges, parole, probation, jail time
   i) Family history – mental illness, suicide attempts, death by suicide
   j) Psychosocial history – emotional and sexual abuse, education, occupation, relationships, informal and formal support networks
   k) Nursing diagnosis

2. Inquire about suicidal ideation and behaviour
   a) Suicidal Ideation – Ask the patient questions to illicit information about their thoughts on living and dying. Is the patient thinking about killing oneself?
   b) Plan – Inquire about a suicide plan. Has the patient chosen a method or considered options to kill oneself? If so, has the person taken steps to put the plan in place?
   c) Access to Means – Does the patient have access to the chosen method? Is the chosen plan plausible? How easy would it be for the patient to access such means or put plans in place?
   d) Intent – Does the patient intend to die? What is the intensity of the patients desire to die? Has the patient made preparations for death, such as putting affairs in order, or writing a suicide note? Has the person taken steps to minimize being discovered? Has the person sought help prior to attempting suicide?
   e) Lethality – Inquire about methods to determine lethality. Did the patient believe that the chosen method would be lethal? Would the chosen method and plan allow for intervention?
   f) Protective factors – Are there any people or circumstances that allow the patient to want to go on living? Are there any barriers that prevent the patient from taking their life?
   g) Previous attempts – Has the patient had past suicide attempts? If so, what were the precipitants, when did each attempt occur, what was the method, what was the medical severity? Were alcohol or drugs involved?

3. Obtain collateral information – seek collateral information from all available sources including family, friends, community supports, medical records and mental health professionals. Consider relevant privacy legislation when doing so.

4. Conduct a mental status exam – include appearance, behaviour, attitude, affect, mood, psychomotor activity, speech, thought content, thought process, perception, orientation, insight, judgment, cognition.

A complete risk assessment will help to identify both risk and protective factors that may contribute to an increased or decreased risk of suicide. Illuminating such factors will assist the nurse and health care team to develop interventions designed to strengthen or mitigate factors amendable to change, thus decreasing a patient's risk of suicide (APA, 2003). The extent to which all components of the risk assessment are completed may vary depending on the setting and circumstances, but in any case the patient must be kept safe and all efforts should be made to inquire about suicidal ideation and behaviour.

Recommendation 7:

The nurse mobilizes resources based upon the client's assessed level of suicide risk and associated needs.

Type IV Evidence

The goal of mobilizing resources is stabilization of the immediate risk and symptom management for the ongoing risk. Seemingly minor sequelae of self-harm may still be associated with extreme emotional distress and the client may remain at high risk and require a thorough holistic assessment in an appropriate facility. A safety plan is developed with the input of the client to self-monitor feelings of hopelessness, helplessness and dysphoria. A structured plan to diffuse suicide method, emotion regulation (reduce tension), develop basic skills of symptom management is developed. The safety plan includes attendance of the client by the nurse or other qualified personnel until a treatment plan is in place (Holkup, 2002; RCP, 2006).

Mobilizing resources frequently requires a team plan and response. This may include actions such as:
- identification of key family members, friends, members of a religious community, who can be available for on-site or telephone support (Holkup, 2002);
- improving the awareness of family and friends about emotional distress and risk of suicide;
- identification of emergency services, such as 911, emergency medical services, crisis response services, mobile response and walk-in clinics available in the nurses' area of practice (Holkup, 2002);
- accessing emergent and/or urgent mental health services (National Collaborating Centre for Mental Health, 2004);
- finding alternatives to hospitalization, for example crisis or safe beds; and
- connecting with pastoral, spiritual and other counseling services.

In some situations, access to a team or other health care and/or emergency support personnel may be limited or not feasible. In such a situation the nurse's priority is to maintain safety for the client and others. The main goal is to identify the client in a state of emotional distress and who is at risk of harming themselves, to create a safe environment and to take appropriate action determined by the severity of the distress and risk for suicide (National Collaborating Centre for Mental Health, 2004).

For further information regarding crisis intervention, please refer to the RNAO Best Practice Guideline *Crisis Intervention* (RNAO, 2006b).

Practice Box
Mobilizing Resources
(RNAO Development Panel, 2008)

- The nurse assesses the level of risk.
- The nurse identified emergent, urgent or elective resources based upon that assessed risk level.
- The nurse mobilizes appropriate resources (formal and informal).
- The nurse mobilizes appropriate resources directly if the risk is imminent.
- The nurse ensures supervised client transport by qualified personnel.
- In the event of a self-harm or suicide attempt, the mobilization of resources is for both psychological and physical assessment.

Type IV Evidence

Vignette

Scenario: The community nurse makes his routine visit to see a mental health client. Upon entering the client's room, he finds her sitting at the table with a large bottle of Tylenol, open and empty. The client states that she was denied an opportunity to do some volunteer work and so took 'just a handful'. She expresses that she is not sure whether she wants to die or to just fall sleep and forget all her troubles. She insists she will be fine and does not want any help.

Nurse's Reflection: Although the client stated that she took 'just a handful', the nurse knows that suicidal clients may conceal or minimize the extent of their attempts and they may underestimate the lethality of their behaviour. Although the client expressed she was not sure whether she wanted to die or to sleep, the nurse recognizes that this is the ambivalence that can be common in suicidal ideation and, as such, does not rule out the risk of death. The nurse also acknowledges that sudden losses or emotional disturbances can heighten risk.

Nurse's Response: The nurse mobilizes resources by using the cell phone provided by his agency and immediately dials 911 to report a suicide attempt. He stays with the client and monitors her pulse and respirations. The nurse continues talking with the client, listening as she voiced her concerns, in an empathic non-judgmental manner. He explains to her that although she does not want help at the moment, it is important that she be fully assessed by a medical doctor in this emergency situation. The ambulance attendants take her to hospital with the nurse in the back of the ambulance with the client. The client states that she wants to call her sister to let her know what has happened. The nurse recognizes the importance of the social support for the suicidal client and so ensures that she will be able to call her sister.

Vignette

Scenario: The nurse has been working with her client, Suzy, since her admission. She feels that she has a good relationship with Suzy, as well as with Suzy's parents and boyfriend who visit regularly. Suzy has a history of depression and has overdosed in the past when she was upset and feeling hopeless. She has been doing well and recently received privileges to go off the unit on her own. The nurse noticed today that Suzy was upset after a fight with her boyfriend. She asked to go off the unit for a walk to "calm down". Upon her return, the nurse decides to go to Suzy's room to talk with her. Suzy reports she has just been to the store and has purchased a bottle of Tylenol, all of which she has taken.

Nurse's Reflection: The nurse knows that Suzy has taken overdoses in the past when she has felt hopeless. She is very concerned that Suzy may have taken an overdose of Tylenol as a reaction to the fight with her boyfriend; Suzy's new coping skills are still very fragile. She does not want to leave Suzy alone, yet she needs to get help. It is dinner time and she knows one colleague is at dinner, one is at pharmacy, one is in the nursing station and the last colleague is with another patient in the opposite hallway. She does not want to alarm any of the other patients or put them in a compromising situation. The nurse realizes that she needs to quickly assess Suzy, determine the seriousness of the attempt and make the necessary treatment arrangements. The nurse knows she is unable to do everything herself; she will have to mobilize all her resources, including her colleagues, to accomplish everything in time.

Nurse's Response: Since none of the other staff members are nearby and she does not feel it is safe to leave Suzy alone or with her roommate, the nurse asks Suzy's roommate to go to the office and ask another nurse to come while she stays with Suzy. She realizes this is not a great solution, but is very concerned because Suzy is becoming difficult to arouse. She attempts to get more information from Suzy but her condition begins to deteriorate. When two co-workers arrive, she directs one to call a code and the other to bring in the vital signs monitor and crash cart. The nurse stays with Suzy and begins taking vital signs as the team arrives to provide medical care. When the physician decides that Suzy must be transferred to the ICU, the nurse directs a colleague to begin the arrangements while she documents and contacts the family. The family is very upset and worried about Suzy, so the nurse makes arrangements for them to come meet with the doctor and visit Suzy when she is stable. She asks her colleague to inform the ICU of this. Knowing that Suzy has a caseworker in the community with whom she and the family work closely, she also leaves a message for the worker regarding the events. Lastly, the nurse notifies pastoral care so they can be available for the family as they wait at ICU. With all Suzy's supports in place, the nurse informs her co-workers that she is going to ICU to complete her report and check on Suzy's condition.

> ### Recommendation 8:
> **The nurse ensures that observation and therapeutic engagement reflects the client's changing suicide risk.**
>
> *Type IV Evidence*

Observation begins immediately for anyone identified as a suicide risk. Once a comprehensive assessment is completed, the level of support and observation should be adapted as required. There is much variation in observation practices among international literature (Jones, Ward, Wellman, Hall, & Lowe., 2000; O'Brien & Cole, 2003; Reynolds et al., 2005) and guidelines (CRAG, 2002; NZGG, 2003), particularly relating to the attributes of different levels of observation and the conditions by which observation levels can be initiated or changed. Whereby the purpose of observation is to provide support to clients who lack the capacity to prevent acting on suicidal ideation, this guideline recommends that the level of monitoring reflect the client's changing level of risk, as determined by clinical judgment and collaboration with the health care team (Clinical Resource and Audit Group, 2002; NZGG, 2003).

The client's confidence in understanding and controlling self-harm behaviour is an important factor for determining the most appropriate observation level (Murray & Hauenstein, 2008). Decision-making regarding observation levels should also involve a consideration of the level of suicide risk, existing supports for monitoring, the skill level of individuals providing observation, the suitability of the environment and organizational policies (Clinical Resource and Audit Group [CRAG], 2002). In hospital or organizational settings, this may range from knowledge of the clients' whereabouts at all times, to the client being constantly in sight and within arm's reach (CRAG 2002). Observation practices in community settings or upon hospital discharge are less described in the literature, but may involve the assessment of existing social support structures and subsequent decisions regarding the involvement of community services and/or outpatient clinics, with re-hospitalization as necessary (APA, 2003; CRAG, 2002). Furthermore, observation should be set "at the least restrictive level, for the least amount of time within the least restrictive setting" (CRAG, 2002, p. 10). Examples of levels of observation are provided in Appendix L.

The therapeutic milieu, including the nurse-client interaction, is closely tied to the experience of the client under observation. In their descriptive study of psychiatric inpatients, Jones and colleagues (2000) reported that many clients felt safer, reassured and cared for, rather than intruded upon, and experienced less frustration when nurses observing them were familiar to them and talked to them rather than remaining distant and silent. Because of this influence of nurses' attitudes and behaviours on clients' experiences, the authors suggest that observation should be viewed as an opportunity to engage in therapeutic interactions with clients (Jones et al., 2000).

Although observation should be carried by individuals trained with the appropriate knowledge and skills, the role of the non-professional (e.g. family member) is one for local discussion and consideration (CRAG, 2002). Importantly, clear documentation facilitates communication within the team and the ongoing assessment of the need for observation (CRAG, 2002). The client and significant others should also be informed about the decisions made regarding observation (CRAG, 2002) and included in decision-making as appropriate.

Recommendation 9:

The nurse works collaboratively with the client to understand his/her perspective and meet his/her needs.
Type IV Evidence

Suicidal persons are significantly more likely to perceive they have needs, and many believe their needs have not been fully met (Pirkis, Burgess, Meadows & Dunt., 2001). To assist in meeting the needs of the client, the nurse should utilize effective communication techniques, such as listening and validating, so that the client is able to convey his or her story and needs from their own perspective (Gough, 2005; Murray & Hauenstein, 2008; O'Brien & Cole, 2003). Cdereke & Ojehagen (2002) assessed the needs of clients in five general areas (basic, health aspects, social needs, daily functioning and services), and found that basic needs, social needs and health care needs ranked the highest as being unmet during the first 12 months post-suicide attempt. Maslow's Hierarchy of Needs (Maslow, 1943) (Figure 1) offers a framework for the consideration of needs, where lower-level needs, such as food and shelter, must be met before higher-level needs, such as a sense of self-worth. Using a client-centred and culturally competent approach to assessment, the specific needs of the individual can be identified.

Self-Actualization Needs
(e.g. desire for self-fulfillment)

Esteem Needs
(e.g. self-respect, esteem from others)

Love Needs
(e.g. affection, sense of belonging)

Safety Needs
(e.g. stability, protection from danger)

Physiological Needs
(e.g. food, sleep)

Figure 1: Maslow's Hierarchy of Needs (Maslow, 1943)

Following the identification of needs, the nurse should be actively involved with the client to develop strategies to meet these needs. Such strategies may involve the following:

- Facilitating access to services (Eagles, Carson, Begg & Naji., 2003)
- Counseling, medication and information (Pirkis et. al., 2001)
- Active outreach
- Encouragement of active participation in social environments, as appropriate, to strengthen the client's ego and modify aversive interpersonal patterns (O'Brien & Cole, 2003)
- Using collaboration and teamwork to ensure a consistent approach to care

Collaboration is the mutual sharing and working together in order to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced (Stanhope & Lancaster, 2000).

Practice Box
Possible Strategies for Affirming a Client's Self-worth
(RNAO Development Panel, 2008)

Validation, respect and compassion go a long way to demonstrating that you recognize the person's worth. Here are some ways to share with the client that other people see their worth:

- Encourage the client to be kind and understanding with themselves. Support the use of a diary to journal their thoughts and to positively reframe any negative thoughts.
- When dialoguing with the client, acknowledge their strengths.
- Work with client to set achievable daily goals and to accomplish them.
- Help the client to visualize change. Help the client describe the desired changed behaviour.
- Help the client establish rewards for small accomplishments.
- Help the client not blame themselves when something does not go as they wanted.
- Assist the client to counteract negative thoughts with positive thoughts.

Type IV Evidence

Vignette

Scenario: Carol is a newly admitted client who was referred by the family doctor because of the potential for suicide. The nurse who first interviews her learns that Carol is a 57-year-old widow of one year. She is frail and thin looking. Eight months ago she was a victim of a burglary. Since that time she has become increasingly agitated and unable to sleep for fear of being burglarized again. When she falls asleep, she wakes up after only 30-40 minutes believing she is hearing someone outside. She has changed the locks, but does not feel safe. She comments that her husband had always kept her safe. She lives alone. Her closest friend lives about two miles away. As she does not drive and her busband had always taken her to visit, she has not seen her friend since her husband's death. There is public transport but she thinks the bus stairs, subway stairs/escalators and crowds would be too much. Carol does speak on the phone to her friend about once a day. Carol is able to walk to a corner store to get food but states, "It is no fun to cook for one". During the interview, the nurse hears Carol mumble, "I am so tired of it all". Carol is tearful and at times seems distant.

Nurse's Reflection: The nurse recognizes that discussion with the client should focus on her perspective of what is going on in her life. She utilizes different communication techniques to understand better what need(s) are not being met that have led to the crisis for this admission. Using Maslow's Hiearchy of Needs (Maslow, 1943), the nurse shapes her questions to encompass Carol's:
- basic needs (sleeping, eating, daily functioning, health care issues);
- safety needs (employment, money, feeling safe, housing, transportation, other services);
- loving/belonging needs (social including friendship, family, sexual intimacy);
- esteem needs (confidence, respect of self/others and by others, self esteem); and,
- self-actualization needs (ability to problem solve, accept facts, morality, lack of prejudice, delete, appreciate life, trust).

Nurse's Response: The nurse asks:
- What has been going on in your life?
- What has changed for you?
- You have had problems in the past, so what is different now?
- Did something recently happen, if so what? How does this affect you? How does this affect people who you consider your supports?
- What is the connection between how you are feeling and what has happened to you?
- How does what has happened affect how you feel about your future?
- What other factors are affecting how you feel?

By listening and observing, the nurse learns that Carol's basic needs of sleeping, eating and daily functioning are at risk. Other needs at jeopardy include: her safety needs which includes her feeling of safety and her transportation needs; her loving/belonging needs as she has lost her husband as well as physical contact with her closest friend; and her self-actualization needs. Carol presents in a distressed, highly anxious, depressed state which is overshadowing her ability to problem-solve, a primary component in self-actualization. Carol and the nurse work together to prioritize Carol's needs. They first focus on the basic needs and safety needs. The nurse initiates interventions that will assist Carol in having both her physical and emotional well-being met. She asks further questions to assess whether Carol is capable of assisting with her own care, or if she needs further support while in this emotionally distressed state.

> ### Recommendation 10:
>
> **The nurse uses a mutual problem-solving (client ◄──► nurse) approach to facilitate the client's understanding of how they perceive his/her own problems and generate solutions.**
>
> *Type IV Evidence*

Suicidal ideation and behaviour often represents a way of coping with situations that the individual perceives to be unbearable and can be linked to psychological and emotional pain (Berlim, Mattevi, Pavanello, Caldieraro, Fleck, Wingate, et al., 2003). As such, suicidality does not necessarily communicate a desire to die and can be influenced by interventions which provide the individual with alternative coping strategies. According to Sakinofsky (2007b), reducing suicide risk involves preventing the client from being overwhelmed by the predicament caused by an accumulation of problems.
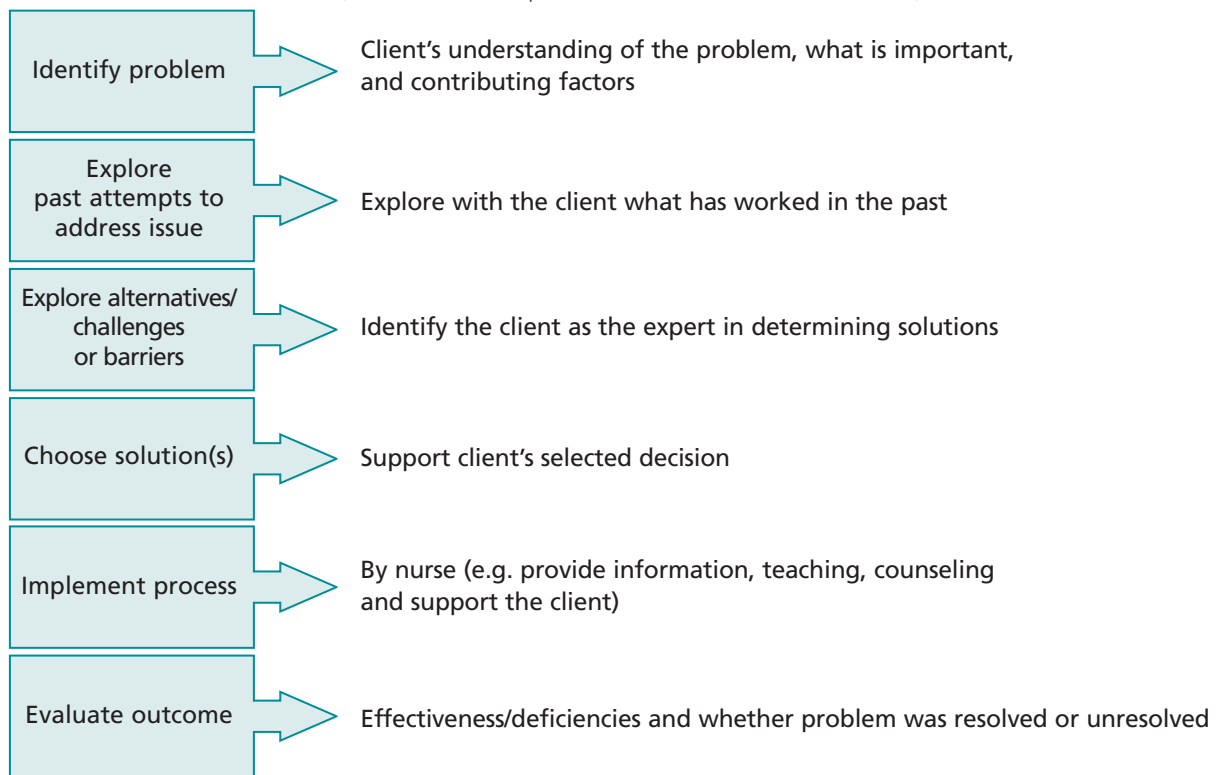
Many clients may not understand the connection between their stressors and their suicidal thoughts or behaviours (Murray & Hauenstein, 2008). By assisting individuals to recognize how they perceive their problems and generate solutions to these problems (i.e. suicide), the nurse can facilitate the client's understanding of what has led to their suicidality, and how to use a variety of options in future problem-solving (Fontaine, 2003; Murray & Hauenstein, 2008). Promoting the client's involvement in generating their own strategies not only ensures the appropriateness of such strategies, but also helps the client regain a sense of control regarding the situation. The most important process for clients and families is how to solve problems (Fontaine, 2003). When applying a problem-solving approach, it is also important to tailor this approach based on the client's readiness and where the client is on the autonomous or dependent continuum. Autonomous clients feel trapped and need arms length support; dependent clients need to feel unabandoned (Burgess, 1998).

Although it is widely used in mental health nursing practice, the body of empirical knowledge surrounding the essential attributes and effectiveness of the problem-solving approach is lacking. However, despite the gaps in the evidence base, problem-solving therapy has shown promise in reducing repeated episodes of deliberate self-harm (Hawton, Townsend, Arensman, Gunnell, Hazell, House, et al., 2006; Mustafa Soomro, 2006) and has been linked to the management of triggers to impulsivity (Fontaine, 2003). Some clients in crisis may have difficulty thinking clearly, are confused and have difficulty problem-solving. For an understanding of how to work with such clients, especially in regard to exploring client-coping and negotiating an action plan, refer to the RNAO Best Practice Guideline *Crisis Intervention* (RNAO, 2006b).

Further research focused on problem-solving therapy as a nursing intervention is warranted. Taylor (2000) stated that the ability of the nurse to provide safe, competent care depends on good clinical problem-solving skills. Problem-solving is defined as 'the generation of possible solutions to an issue of concern, and therefore needs to be an inherent part of the practice of all professionals' (Eisenhauer & Gendrop, 1990 p.80, as cited in Taylor, 2000). This process begins when a client problem is identified by a nurse and persists through to the point where a decision is made that will alleviate or solve the problem. A suggested framework for a problem solving approach is provided on the next page.

Problem Solving Approach to Solution

(Muxlow & Hamer, personal communication, October 2007)

Identify problem	Client's understanding of the problem, what is important, and contributing factors
Explore past attempts to address issue	Explore with the client what has worked in the past
Explore alternatives/ challenges or barriers	Identify the client as the expert in determining solutions
Choose solution(s)	Support client's selected decision
Implement process	By nurse (e.g. provide information, teaching, counseling and support the client)
Evaluate outcome	Effectiveness/deficiencies and whether problem was resolved or unresolved

Practice Box

Practice Strategies Using a Problem Solving Approach to Solutions

(RNAO Development Panel, 2008)

A. Identify Problem
1. Ask the client to describe what is happening. Who are the other people involved?
2. Help the client break down the problem to focus on the immediate issue (priority).
3. What are the triggers and patterns of possible self-destructive acts?
4. Assist the client to self-monitor through the use of diaries to recall and detail relationships, moods, triggers, and patterns of self-harm behaviour.

B. Explore Past Attempts to Address Issue
1. Help the client identify what has worked in the past.
2. Help the client identify supports/resources/personal strengths.

C. Explore Alternatives/Challenges to Determine Solutions
1. Identify small steps that will provide change and some control.
2. Examine the role of medications to reduce anxiety (APA, 2003).
3. Explore safe alternatives, such as breathing and relaxation (Frazier et al., 2003).

D. Choose Solutions
1. Focus on helping the client identify small steps, coping strategies, stress reduction, problem-solving and self-examination of results.

E. Implement Process
1. Identify when patient will "stop and think" and use collaboratively agreed upon action.
2. Journaling successes, emotions, and learning is helpful (Fontaine, 2003).
3. Provide time limited therapeutic sessions to assist the client in resolving current interpersonal problems (Gaynes, West, Ford, Frame, Klein & Lohr, 2004).

F. Evaluate Outcomes
1. Promote realistic self-appraisal through discussing with the client their abilities and limitations. Help the client reflect outcomes of purposeful tasks.
2. Encourage – point out small successes and reinforce the clients ability to appraise themselves (Fontaine, 2003).

Type IV Evidence

Vignette

Scenario: A psychiatric nurse on the admission unit becomes aware that Carol's family doctor is concerned about her suicidality. During the admission interview with Carol, the nurse learns that Carol is a widow who lives alone and is a victim of a burglary four months after her husband's death. Carol is agitated and is unable to sleep due the fear of being burglarized again. The nurse also learns that Carol feels unsafe and believes she hears someone outside. Carol states that her husband always kept her safe. Although Carol's closest friend lives two miles away, she does not drive and finds public transportation and crowd too much. She had always relied on her late husband to drive her to visit her friend. Carol walks to the corner store to get food and her perception is that it is no fun cooking for one and "is tired of it all".

Nurse's Reflection: During his interaction and conversation with Carol, the nurse recognizes that the problem-solving approach for solutions encompasses components of the nursing process and acknowledges that Carol is the expert in this situation. The nurse utilizes interpersonal communication skills and techniques such as listening, respect, warmth concreteness and genuineness, to engage Carol in understanding the here and now, in exploring Carol's past history, and in exploring alternatives and solutions to the problems identified by Carol.

Using the problem-solving approach, the nurse's interactions and interventions focus on:
- Carol's perception of the problem and impact on her day-to-day activities, sleep pattern, agitation, fears and tearfulness;
- Determining Carol's safety and risk for self harm related to comments "I'm tired of it all" and "it's no fun to cook for one";
- Finding out what works in the past to resolve problems;
- Identifying Carol's strengths, coping skills, support systems, resources, relationship with her closest friend;
- Exploring what would give Carol a sense of control, personal safety and reduce her level of anxiety;
- Validating and supporting Carol's choices to resolve the problem;
- Strengthening Carol's problem-solving skills by exploring ways to assist Carol in achieving her goal and managing expectations; and
- Celebrating with Carol her accomplishments/successes.

Nurse's Response: The nurse's listening skills and ability to focus on here and now is paramount in facilitating the process for Carol to identify the problem and arrive at a solution. He assists Carol in understanding the inter-connection between the loss of her husband, the burglary, her physical and emotional presenting symptoms, and the accumulative effect on her mental wellness. One important aspect of the nurse's role is exploring Carol's safety and risk for self-harm by asking specific and direct questions about suicide gesture, intent, and plan to end her life, as well as the interventions to reduce the perceived or actual stressors on her mental well-being. The nurse identifies Carol as the expert in this situation and draws on her strengths, her effective problem-solving skills from past experiences, support system apart from her closest friend and resources. In addition, he explores small steps such as relaxation and breathing techniques to give Carol a sense of control and reduce her anxiety.

The nurse's interaction with Carol includes positive feedback on Carol's choices, decision to resolve the problem, as well as an opportunity for Carol to reflect on the anticipated outcomes to regain mental wellness. The intervention also includes information and teaching to enable Carol to identify various coping strategies. The nurse also offers Carol time-limited therapeutic sessions to assist her in attaining her goal and be accessible to provide psychological support based on Carol's choice/decision. The promotion of realistic expectations is important to reaffirming Carol's strengths, abilities and strategies used in this current situation that may be helpful in coping with other situations. However, it is important to balance this by discussing unrealistic expectations and limitations. Finally, the nurse encourages Carol to celebrate small accomplishments and reinforces Carol's expertise and ability to resolve the problem.

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Recommendation 11:

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The nurse fosters hope with the suicidal client.

Type IV Evidence

It is well established that hopelessness is associated with an increased risk for suicide and suicide attempts, and increased level of suicide intent (APA, 2003). Hopelessness, characterized by feelings of inadequacy and an inability to act on one's own behalf, is a perception of having no hope that one's life situation or circumstance will change or improve (Murray & Hauenstein, 2008). When the client is experiencing hopelessness, the nurse can instill/foster a sense of hope for the future (MacLeod et al., 1997).

There is a strong relationship between hope and caring (Cutcliffe & Barker, 2002). By forming a therapeutic relationship with the client, the nurse conveys tolerance and acceptance. How a client perceives they are treated significantly impacts how the client feels about themselves.

Suicidal clients often feel an overpowering sense of hopelessness and may project that to the nurse. The nurse must be aware of her/his own feelings of hopefulness and/or hopelessness in order to be able to support the client. The nurse who is feeling hopeless about the client needs to address this through either a team meeting or through clinical supervision, in order that the nurse's feelings of hopelessness or guilt are not conveyed to the client. Refer to Appendix D for a further discussion of transference and counter-transference issues that may arise while providing care for adults at risk for suicidal ideation and behaviour.

The idea of hope is also well situated in the context of recovery. Refer to Appendix R for suggested readings regarding recovery models.

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Recommendation 12:

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The nurse is aware of current treatments in order to provide advocacy, referral, monitoring and health teaching interventions, as appropriate.

Type IV Evidence

Treatment modalities that may be used to manage clients' risk for suicidal ideation and behaviour include: psychotherapy, psychopharmacology, electroconvulsive therapy (ECT) and complementary or alternative therapies (APA, 2003; Hawton, Townsend et al., 2006; NZGG, 2003). As part of the multidisciplinary team, the nurse must have knowledge of these modalities in order to provide client-centred interventions regarding advocacy, monitoring and health teaching, as appropriate. This area offers many opportunities for referral to persons who have specialized skills (i.e. RNs, RPNs, advanced practice nurses, psychiatrists and other allied health professionals). In keeping with the client-centred and culturally safe approach, it is also important to explore the client's knowledge and meaning of various treatment options.

Psychotherapy

Most studies regarding psychotherapeutic modalities, such as Cognitive Behavioural Therapy and Dialectical Behavioural Therapy, are focused on its use in addressing psychosocial symptoms and risk factors related to specific disorders (APA, 2003), such as borderline personality disorder (Linehan, 1993) and schizophrenia (Mamo, 2007). Other guidelines and systematic reviews note the paucity of rigorous studies that directly evaluate the effectiveness of these modalities on reducing suicidality (APA, 2003; Hawton, et al.,

2006; Mann et al., 2005; Mustafa Soomro, 2006). However, despite gaps in the literature, clinical consensus continues to suggest that psychosocial interventions and specific psychotherapeutic approaches are of benefit to the suicidal client (APA, 2003).

Psychotherapy is a "treatment method for mental illness in which a mental health professional and a patient discuss problems and feelings to find solutions. Psychotherapy can help individuals change their thinking and behaviour patterns or understanding how past experience affects current behaviour" (National Institute of Mental Health Glossary, 2005).

Psychopharmacology

Medications in treatment of depression and anxiety may also play a role in caring for clients at risk for suicidal ideation and behaviour (APA, 2003; Diaconu & Turecki, 2007; Sher, Oquendo & Mann, 2001). The nurse should possess the knowledge and skills to advocate for, monitor, support and provide health teaching to the client and family related to the use of psychopharmacology as a potential treatment modality. Although medications may help to control symptoms related to suicide risk, their use does not necessarily constitute a protective factor (Baldessarini, Pompilli, Tondo, Tsapakis, Sodani, Faedda et al., 2005) and therefore, close clinical monitoring of psychopharmacology use with suicidal clients is essential. Monitoring a client who is taking medications involves knowing the individual's baseline symptoms so that these symptoms can be compared with symptoms associated with adverse drug effects (Baldessarini et al., 2005; NZGG, 2003;).

Psychopharmacology is a subspecialty of pharmacology that includes medications used to affect the brain and behaviours related to psychiatric disorders (Austin & Boyd, 2008).

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) may be used to treat clients who are acutely suicidal. Available evidence suggests that ECT reduces short-term suicidal ideation, but it is primarily indicated in very specific clinical circumstances, such as depression (APA, 2003; Sakinofsky, 2007c). Since there is no evidence for long-term or sustained reduction of suicide risk after an acute course of ECT, close monitoring and additional treatment with psychotropic mediations are usually required during subsequent weeks and months (APA, 2003).

Complementary and Alternative Modalities

Complementary and alternative modalities (CAM) are used by clients as an adjunct treatment modality to manage their suicidal behaviour related to depression, anxiety or a mental illness (Brugha, Rampes & Jenkins, 2004; Ernst, Rand & Stevinson, 1998; Linde, Ter Reit, Hondras, Vickers, Saller & Melchart., 2001; Williams, Mulrow, Chiequette, Noel, Aguilar & Cornell., 2000). These include treatment modalities, such as herbal remedies, dietary supplements, massages/reflexology, aromatherapy, acupuncture, yoga, meditation, reiki and music (Brugha, et al., 2004; Weier & Beal, 2004). It is important for the nurse to explore the client's understanding and use of CAM in order to ensure that the client's safety is maintained, particularly with the additional use of conventional psychopharmacology.

Culture-specific modalities also need to be considered. The nurse needs to be respectful of differences within, and across ethno-cultural groups that are not considered by people within those groups to be "alternative." Rather, they are integral to health and well-being and may be used alongside western medicines and approaches, alone or not at all. For example, the sweatlodge, smudging, medicinal plants and many other traditional approaches are used by First Nations (Waldram, 1997).

Practice Box

Helpful approaches with the client using complementary and alternative modalities (CAM)

(RNAO Development Panel, 2008)

1. Acknowledge that the client uses or considers using complementary and alternative treatments as a primary and/or adjunct treatment modality.
2. Be willing and prepared to work with the client, regardless of client's choices or preferences.
3. Know the range of complementary and alternative treatments used and reasons for usage.
4. Know the difference between conventional treatment and alternative treatment.
5. Utilize interpersonal communication skills and therapeutic interventions to:
   - explore the client's beliefs and views about conventional and alternative treatment;
   - ask the client about current medication including over the counter medication and alternative therapy the client has used, tried and/ or is using;
   - explore the client's knowledge of complementary and/or alternative treatments, reason for choosing CAM, and expectations of benefits known or perceived;
   - explore the client's knowledge of side effects;
   - possess knowledge to provide information on the use of concomitant drugs such as oral contraceptives, anticoagulants and antihypertensive medications;
   - observe for harmful drug interactions as necessary; and
   - document as per agency protocol.

Type IV Evidence

Vignette

Scenario: Jim, a 42-year-old married man, comes to the community health centre requesting to see the doctor. One of the nurses at the clinic inquires if Jim has an appointment. Jim replies "No! I just need to see the doctor to make these damn things in my head go away." The nurse asks Jim to please have a seat and states "I'll be back shortly." The nurse informs the team leader that there is a client wishing to see the doctor but does not have an appointment. Meanwhile, Jim starts being boisterous and disruptive in the waiting area. The team leader decides to streamline Jim's waiting time due to his boisterous behaviour and requests that the nurse gather some information from Jim.

Suddenly, Jim's boisterous behaviour abates once he realizes that he is going to be seen and not turned away. The nurse invites Jim to come into the interviewing room to answer a few questions, During her interaction with Jim, he discloses that three years ago he was in the hospital for major depression and takes pills for his depression, blood pressure and anxiety. When the nurse inquires further about his depression and the pills he takes, Jim states that sometimes he takes St. John's Wort, ginkgo and garlic oil to help him cope and stop "the bad thoughts that tells me to hurt myself".

Nurse's Reflection: Given the client's disclosure about the medication he takes, the nurse realizes that his decision to take complementary medication could interfere with the effectiveness of prescribed medication for his depression. In thinking about how to proceed, she considers what aspects related to the client's health and well-being she will focus on, what information would be helpful in providing care to the client, and how she could assist the client in utilizing new coping strategies to reduce his anxiety level.

Nurse's Response: The nurse explores with the client his reasons for taking St. John's Wort and other herbal medicine, as well as the client's perception of effectiveness. The nurse's knowledge of the use of St. John's Wort and ginkgo concurrent with antidepressants will help in monitoring the client's response to complimentary and/or alternative medicine as evident by an improvement to mood or a lessened depressive state. In addition, the nurse's knowledge will also help in the intervention phase when providing information and teaching the client to consult with the pharmacist and/or allied health professionals before using herbal therapies; the possible side effects of taking medication, including gastrointestinal upset; the use of protective clothing for sunlight; the effects on reproductive cells and contraindication for use by couples planning a family; the effects of concurrent use with antidepressants; and, exploring new coping skills.

Recommendation 13a:
The nurse identifies persons affected by suicide that may benefit from resources and supports, and refers as required.

Type IV Evidence

Recommendation 13b:
The nurse may initiate and participate in a debriefing process with other health care team members as per organizational protocol.

Type IV Evidence

Postvention deals with the traumatic after-effects for persons affected by death due to suicide. "It involves offering mental health and public health services to the bereaved survivors" and includes working with all persons affected who are in need (Shneidman 1981, as cited in Brock 2003; Wilson & Clark, 2005). "In the suicide prevention field, 'survivor' is a word used to describe someone who has lost a significant other to suicide. It does not refer to those who have made a suicide attempt and survived" (Ball & White, 2005, p.4). The primary purpose of suicide postvention is to support the emotional recovery of persons affected by a loss due to suicide while preventing contagion or imitative suicidal behaviour (Dafoe & Monk, 2005). Youth who have a history of depression or previous suicidal ideation or behaviour may be at particular risk of the contagion effect and a planned response to support friends and others can be effective in reducing psychological, physical and social difficulties in persons affected by death due to suicide (Dafoe & Monk, 2005).

In a systematic review of the literature, Sakinofsky (2007a) found unique effects for people who have lost a significant other due to suicide. Although the grief associated with this kind of loss has much in common with other forms of complicated bereavement, especially traumatic grief, feelings such as shame, self-recrimination and a perpetual search for meaning render it somewhat different – relatives and friends of

persons who have died due to suicide are vulnerable to depressive illness and post-traumatic stress disorder (PTSD) and family cohesion is sometimes challenged (Sakinofsky, 2007a). There are relatively few studies of the efficacy of interventions (postventions) following suicidal deaths and meta-analyses of programs that allow this analysis are "mixed and show paltry effect sizes" (Sakinofsky, 2007a, p.134S).

The degree to which the nurse is involved in working with bereaved persons is variable and will be based on many factors, such as the policies of the practice setting, preferences of the bereaved individuals and the level to which the nurse is competent to engage in the therapeutic relationship. Given the range of practice settings in which the bereaved may be encountered, it may be another health professional that may provide these services (i.e. victim support, general practitioners, coroner, police, religious leaders and the clergy or specialist bereavement counselors). Appendix M provides examples of potential strategies for providing postvention support.

STOP **When providing postvention support, it is important to be sensitive to the individual's readiness to discuss the death and bereavement. It is suggested that clinicians should avoid sensationalizing the death, glorifying or vilifying the suicide victim, or provide excessive details about the suicidal act** (Gould & Kramer, as cited in Brock, 2003)**. In addition, clinicians should not impose their own beliefs, including religious beliefs, onto the client.**

Many school, institutional and community postvention services after suicide now routinely include psychological, or critical incident, debriefing. This debriefing is commonly delivered as a single session in the immediate aftermath of the suicide. Its use is predicated upon the assumption that debriefing will minimize PTSD and other adverse reactions to traumatic situations. The use of this intervention has become extensive despite the fact that its benefits to participants have not been clearly established. Recent reviews of randomized controlled trials of psychological debriefing have suggested that it is not necessarily effective in reducing PTSD, psychiatric morbidity, depression, anxiety or symptoms of distress and may, in fact, increase risk of PTSD. This conclusion invites a critical review of practice in this area and, particularly, consideration of the extent to which critical incident debriefing may have harmful effects. However, there is now widespread public expectation that debriefing should be provided for all traumatic incidents, and the victims of such incidents report that they find the process helpful. Given this level of popularity it might be difficult to withdraw this service (Beautrais, 2004).

These services could be delivered by counselors and other mental health professionals, and/or by specialist consultants with expertise and experience in facilitating postvention programs after suicide deaths. Appendix N provides examples of potential debriefing strategies.

Vignette

Scenario: The police have called the team leader in a psychiatric unit of a large urban hospital to inform her that Mr. Jones, 54-years-old, died by suicide while out on a weekend pass from the hospital. Mr. Jones had been a patient on the unit three times over the past two years. Several of the staff had worked closely with him. Mrs. Jones has also called to say she will be coming the next day with her oldest son Tom, 28-years-old, to pick up Mr. Jones' belongings.

Nurse's Reflection: The team leader understands that many people may be affected by the suicide of Mr. Jones, including family, friends, staff (including clinical and non-clinical staff) and other patients on the unit, and that the efficacy of treatment to date is not well researched. Common-sense reasoning suggests that some people will benefit from support groups with people experiencing a similar loss and that other people will prefer individual, professional or other support. The team leader also understands that often there is stigma surrounding a death by suicide and that some family members will withdraw after the event. In addition, it is not uncommon for mental health professionals to experience grief, anger, guilt and fear of blame – some will even go on to experience profound loss and sadness following their initial reaction (Sakinofsky, 2007a). "An important minority of professionals will experience symptoms of PTSD and depression that will last for a considerable time" (Sakinofsky, 2007a, p. 135S).

Nurse's Response: The team leader calls an initial staff meeting immediately after being called to inform the staff members of what has transpired and to develop a strategy to support other patients on the unit and contain potentially dangerous reactions as a result of the suicide, including copycat suicidal behaviour (Sakinofsky, 2007a). In collaboration with the treatment team, the team leader decides to defer further admissions to the unit until the environment has restabilized. In addition, the team decides to evaluate current passes for those clients considered to have suicidal propensities who are thought to be unduly distressed. It is decided that a higher level of observation may be advisable for those patients who were close to the deceased. The team leader also calls a meeting of the clients on the unit to inform them of the event and address their questions and reactions (Sakinofsky, 2007a). A clinical staff person is designated to document the particulars of the event in detail. The team leader meets with the family when they arrive to provide support with a designated staff person who worked closely with the patient – they want to ensure that the family has the information and support they need at this time, including information regarding the availability of community resources. At the end of this session, they inquire whether or not it would be acceptable for staff, who wish to do so, to attend the funeral/ memorial service. The team leader checks in with staff to determine the necessity of meeting to debrief again over the next several weeks.

Recommendation 14:

The nurse seeks support through clinical supervision when working with adults at risk for suicidal ideation and behaviour to become aware of the emotional impact to the nurse and enhance clinical practice.

Type IV Evidence

Clinical supervision is a supportive, interactive process that assists nurses in enhancing their knowledge and professional abilities while offering an opportunity for reflection and support. The importance of clinical supervision for the nurse working with suicidal clients is consistent with the literature (Carlen & Bengtsson, 2007; Cutcliffe & Barker, 2002;; Linehan, 1993; NCCMH, 2004; NZGG, 2003; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm [NZCPCPG], 2004). **Working with clients who are at risk for suicidal ideation or behaviour can be stressful for the nurse; clinical supervision is one way to help the nurse reflect on her/his feelings and maintain a therapeutic relationship with the client** (Cutcliffe & Barker, 2002).

Since clinical supervision is an interpersonal process in which nurses engage with mentors or another senior clinician to explore, examine and work through various challenges in their own practice, it is also an opportunity for reflective learning and professional growth that does not involve penalties or judgment. It provides an opportunity for the nurse to reflect safely on issues of transference and counter-transference that may arise. Refer to Appendix D for further reading on transference and counter-transference.

It can also potentially mitigate the negative effects of this difficult work on the nurse's own mental, emotional, and physical health (NZGG, 2003). Given the significant personal and professional challenges that may arise out of working with suicidal clients across the continuum of care, it is suggested that clinical supervision be implemented as an ongoing part of practice.

Vignette

Scenario: The nurse has been working with Maria, a young woman who has had multiple suicide attempts. During her last hospitalization, she responded well to medication and agreed to go to counseling after discharge. Recently, Maria separated from her boyfriend, stopped taking her medication, quit counseling, and took an overdose of her mother's sleeping medication. She has returned to the same unit and is feeling quite depressed and hopeless. The nurse liked Maria, who reminded her of her sister, and felt they had a positive, productive relationship during Maria's last admission. This admission, however, when the nurse is assigned to care for Maria she is quite abrupt with Maria and does not want to listen whenever Maria begins to talk about her feelings. Her colleague notices that she is irritable and avoiding this client.

Nurse's Reflection: The nurse's colleague mentions to her that she seems upset with this patient and asks her about it. At first the nurse denies this, stating that she is "just tired". Later, when driving home she begins to think more about this and realizes that her colleague is right. She is feeling angry with this patient but isn't sure why; something is wrong and the nurse realizes that she needs some help to figure this out. The nurse remembers that the nurse clinician for their unit has been helpful to other colleagues around patient care issues, and that he offers clinical supervision to staff. She decides to speak to the nurse clinician about her difficulty responding to this client.

Nurse's Response: The nurse arranges to meet with the nurse clinician. At first she is hesitant to speak honestly, but the nurse clinician makes her feel comfortable and reminds her that he is there to help her. She begins to talk about this client, including the fact that the woman reminds her of her sister. She starts to feel angry when talking about how she is "wasting her time with this woman". The nurse clinician helps her to realize that she is angry with this woman for many reasons. First, because she tried to kill herself again after all the time and energy that was spent on her care and treatment, and second, because she reminds the nurse of her sister, who is always asking her for help but never following through. The nurse clinician supports the nurse's reaction, but also helps her see how the client may be feeling. With this understanding, the nurse begins to work more productively again with this client. She also arranges to meet with the nurse clinician in a week to continue to discuss this client.

Education Recommendations

> ## Recommendation 15:
>
> **Nurses who work with individuals at risk for suicide must have the appropriate knowledge and skills acquired through basic nursing education curriculum, ongoing professional development opportunities and orientation to new work places.**
>
> *Type IV Evidence*

Knowledge and skills should include, at a minimum:

- effective communication skills for the development of a therapeutic relationship;
- effective interviewing skills to facilitate assessment and intervention;
- awareness of warning signs, risk factors and protective factors for suicidal ideation and behaviour, and how to assess for them;
- how to implement a problem-solving approach with a solution focus;
- collaboration with the health care team and recognizing when experts should be consulted;
- access of, and collaboration with, other supportive services across the continuum of care/community;
- familiarity of relevant legislation related to care of suicidal patients (e.g. *Mental Health Act* and *Freedom of Information and Protection of Privacy Act*, R.S.O., 1990, c. F. 31);
- awareness of one's own safety and well-being; and
- usage of clinical practice guidelines to assist with standardized documentation, clear communication and guided decision-making.

> ## Recommendation 16:
>
> **Nursing curricula should incorporate content on mental health issues, including suicide risk reduction and prevention, in a systematic manner to promote core competencies in mental health practice.**
>
> *Type IV Evidence*

There is a need for post-basic, or post-RN education in mental health nursing which is inclusive of care for clients who are suicidal. Individuals at risk for suicidal ideation and behaviour require care from health care professionals who are knowledgeable about suicide risk and are comfortable and competent to address it. In order to provide the necessary support to these clients, nurses who are not specialists in this practice area require basic skills as identified in Recommendation 15. This is particularly important as nurses who are not working in traditional mental health settings may nonetheless encounter clients with these needs and may be the only point of contact for these individuals within the health care system. Studies of nursing staff in Australian emergency practice settings indicate a general lack of formal training as it relates to the assessment and management of deliberate self-harm clients (McAllister, Creedy Moyle &

Farrugia., 2002; McCann, Clark, McConnachie & Harvey., 2006). One Canadian study also showed a lack of knowledge regarding suicidal behaviours among emergency staff (Watson, 2002). To support the development of these basic skills for all nurses on entry to practice, integration of such training into undergraduate nursing curriculum is paramount. Integration of relevant curriculum into orientation programs and professional development opportunities in settings (e.g. mental health care, emergency department) where suicide risk is of particular concern can help to further sustain and improve the ability for nurses to effectively provide care to these clients.

Nurses' knowledge and skill, attitudes, religious/other values and beliefs, personal and professional experiences with suicide and age have been suggested to affect nursing practice as it relates to individuals at risk for suicide (McCann et al., 2006; Sun, Long & Boore, 2007; Valente & Saunders, 2004; Watson, 2002). However, educational interventions remain a valuable means to promoting best practice. In one emergency department, the quality of psychosocial assessments for clients presenting with deliberate self-harm showed improvement following a one-hour educational session for nurses and junior medical staff that focused on the assessment and management of deliberate self-harm (Crawford, Turnbull, & Wessley, 1998). Similarly, a workshop focused on the care of people with traumatic brain injury exhibiting suicidal behaviours was associated with statistically significant increases in knowledge and skills scores post-workshop, and many of these gains were maintained after six months (Simpson, Winstanley & Bertapelle, 2003). However, despite the benefits of such educational sessions, the evidence to support the essential components of training is less clear and it is strongly suggested that other tools such as clinical supervision, mentoring and observation be utilized to actively support novice nurses as they develop a level of comfort and competency in this practice area.

Nurses who practice in a mental health services should be trained appropriately for this specialist role, with supervision of developing assessment skills and interventions (NCCMH, 2004; NZCPCPG, 2004). The emergency room nurse also needs specific training in mental health nursing, particularly prior to taking on the triage role (NCCMH, 2004). Additional critical thinking skills specific to this practice area can be advanced through continuing education opportunities, internships and specialist certification examinations focused on psychiatric and mental health nursing and/or emergency nursing.

The Canadian Association for Suicide Prevention/ L'Association Canadienne Pour la Prevention du Suicide (CASP/ACPS) suggests that training of health care professionals and the promotion of effective clinical and professional practice are important elements of a national strategy for suicide prevention (CASP/ACPS, 2004). It is suggested that the education of health care providers about best practice in this area should address the knowledge, skill, judgment and attitudes necessary to implement the guideline recommendations. Appendix O provides a listing of educational resources to support professional development as it relates to the care of the individual at risk for suicidal ideation and behaviour.

Organization and Policy Recommendations

> ### Recommendation 17:
> **Health care organizations that admit suicidal clients must provide a safe physical environment that minimizes access to means for self-injurious behaviour.**
>
> *Type IV Evidence*

Health care organizations that admit suicidal clients must provide a physical environment that minimizes client access to methods within the physical architecture and structure of the building, whereby clients may harm themselves (JCAHO, 1998; Sullivan et al., 2005). Clients have utilized various structures of the physical health care environment, such as door hooks for clothing, windows, medications, and chemicals as methods for suicidal behaviour. Therefore, organizations need to ensure that the physical environment, architecture and hardware are such that this potential is minimized.

Suggested structural accommodations for the suicidal client to diminish environmental harm are (JCAHO, 1998; RCP, 2006; Yeager et al., 2005):

- weight-testing breakaway hardware;
- no doors that cannot be opened easily by staff and non-lockable on the inside;
- non-breakable, shatterproof glass windows partitions;
- secure areas for medications and toxic chemicals;
- the briefing of all workers, housekeepers, and transport aides regarding safety in the environment; and
- panic buttons, access to telephones with an outside line or other emergency communication systems.

> ### Recommendation 18:
> **In health care organizations that admit suicidal patients, nursing staff complements should be appropriate to the patient: nurse ratio and to staff mix (i.e RN, RPN, health care aide) to safely meet the unpredictable needs of acutely suicidal patients.**
>
> *Type IV Evidence*

Nurses should have 24-hour access to emergency personnel, preferably a psychiatrist. They require sufficient time in their workload to conduct suicide risk assessments, provide observation and monitoring, and meet the client's needs. If possible, the staff should reflect a mix of age, gender and ethnic backgrounds that reflect the local client population (RCP, 2006).

Recommendation 19:

Organizations ensure that critical incidents involving suicide are reviewed systematically to identify opportunities for learning at all levels of service delivery.

Type IV Evidence

Organizations must ensure that all health care professionals involved in providing care to adults at risk for suicidal ideation and behaviour, work in an environment that allows them to practice according to the guidelines.Many factors contribute to the client's experience with the health care system and the positive or negative health outcomes that follow. When a critical incident does occur, such as events involving suicide, an analysis of system and process issues that may have contributed to the incident can help identify opportunities for learning and potential targets for quality improvement initiatives (Dlugacz, Restifo, Scanlon, Nelson, Fried, Hirsch, et al., 2003). A framework for ethical decision-making may be helpful to guide this process. Appendix P provides an example of such a framework.

Vignette

Mr. Smith was found unresponsive, by the nursing staff on the night shift. A cardiac arrest was called. It was determined that the patient took a large overdose of medications that he had stored up in his bedside cabinet. The unit administrator and psychiatrist followed hospital protocol and initiated a critical incident debriefing with staff, and conducted a thorough audit of the chart and unit policies. Forthcoming recommendations for change were implemented with a process for evaluation.

Recommendation 20:

Organizations develop policies and structures related to peer debriefing following a critical incident, such as a death by suicide. Policies should be developed to support staff and minimize vicarious trauma.

Type IV Evidence

Commitment to supporting the nurse's role in the care of the suicidal persons requires a healthy work environment that protects the nurse's own health and ability to provide quality care to clients. Organizations must take an active role in making appropriate services available for individuals in need of counseling or support following critical incidents that may have negative impact on staff. Peer debriefing may be one method by which this need may be met. For further details regarding peer debriefing, refer to the Practice Recommendations section.

Vicarious traumatization, also known as a secondary trauma response, is a condition in which psychological after effects are experienced by those who assist victims of traumatic events (Varcarolis, 2002, p. 799).

> ### *Vignette*
>
> **Scenario:** On the night shift, a patient attempted to hang himself. The nurses found him, resuscitated him and he was transferred to the ICU. The team of three RNs, one RPN, the medical resident and the security officer were distraught at the event. Some blamed themselves for not 'knowing' he would do this. Others were angry with the patient. Another said she had never seen anything so frightening and was worried she would be 'in trouble'.
>
> **Nurse's Reflection:** The night in-charge nurse, the unit manager, the staff psychiatrist and the program director all recognized the need for peer debriefing. A policy is in place that requires a debriefing after a traumatic event such as a suicide attempt, and any staff nurse can request and initiate it.
>
> **Nurse's Response:** The Manager ensured that the staff have access to the Employee Assistance Program telephone numbers, should they require confidential support. She ensured the immediate emotional wellbeing of all staff and provided any assistance through occupational health as required. Upon assurance that all staff were comfortable to debrief, the leadership team organized a peer debriefing at a time that was convenient to all. The peer debriefing was confidential, non-judgmental and facilitated by a person who was not in a formal position of authority over the staff.

Recommendation 21:

Organizations allocate resources to ensure that all nurses have opportunities for clinical supervision and coaching on an ongoing basis.

Type IV Evidence

Even in the absence of critical events, clinical supervision and coaching on an ongoing basis may help to mitigate the potential for negative impacts to the nurse, as well as promote the refinement of clinical skills (NZGG, 2003; RNAO, 2006b). To accomplish this, organizations must allocate financial resources to cover the cost of clinical supervision and coaching, and ensure a staffing mix that includes senior nurses who can help nurses to identify their own professional strengths and weaknesses. Such a senior nurse needs to have experience, education, and the ability to facilitate objective self-evaluation. This process is enhanced if the clinical supervision is provided by a nurse with no administrative authority over the nurse (RNAO, 2006b). For further details regarding clinical supervision, refer to Recommendation 14.

> ### *Vignette*
>
> A patient was discharged yesterday from the mental health unit. The psychiatrist received a call from the police stating that the patient had jumped from a bridge and died. The team leader, who is a nurse, initiated a critical incident debriefing according to the hospital policy. The identified staff and physicians were notified and a systematic review of the client's care was conducted. The opportunities for learning were shared with the administrative and clinical staff. Potential changes in policy were identified. The review was documented.

Recommendation 22:

Organizations implement policies regarding the systematic documentation of suicide risk assessments.

Type IV Evidence

Although there is no consensus on a standard way to document suicide risk assessments, this guideline recommends that organizations develop policies to ensure that a systematic process is adopted. Effective communication of suicide risk assessments is fundamental to promoting appropriate care for the client (Sullivan, Barron, Bezman, Rivera, & Zapata-Vega., 2005). The NZGG (2003) also emphasize the importance of a structured assessment as a way to avoid having key assessment information overlooked. In one descriptive study, a policy that identifies a systematic structure for documentation was associated with increased adequacy of psychosocial assessment (Crawford et al., 1998). A consistent process for documenting assessment information may also lead to the collection of valuable data for evaluation and quality monitoring purposes (Hawton, et al., 2006; Horrocks, House & Owens, 2004).

Recommendation 23:

Organizations promote the services available within the organization and community that may support the care of adults at risk for suicidal ideation and behaviour.

Type IV Evidence

The care of individuals at risk for suicidal ideation and behaviour requires a coordinated effort by the multidisciplinary team across the continuum of care. In order to appropriately and effectively utilize all available resources, the nurse must be supported through existing linkages between services. It is recommended that organizations work both internally (i.e. with the development of a specialized assessment team), and with community partners to develop strategies for collaboration and integration across the continuum of care. Service planning groups need to include a multi-professional membership including emergency consultants, psychiatric specialists, social work, representatives of user groups and local community agencies. If possible, representatives should be of diverse backgrounds (RCP, 2004).

Recommendation 24:

Organizations support nurses' opportunities for professional development in mental health nursing.

Type IV Evidence

Health care organizations and academic institutions must work collaboratively to ensure that nurses are equipped with the core competencies to care for individuals with mental health needs, including those who are at risk for suicidal ideation and behaviour (Barling & Brown, 2001).

> ### Recommendation 25:
> **Organizations support research initiatives related to suicide and other mental health issues.**
> *Type IV Evidence*

Nursing research related to suicide risk reduction and prevention must be supported in order to have better understanding of effective approaches for care, and therefore to strengthen the evidence base available on which to guide decision-making both at clinical and administrative levels.

> ### Recommendation 26:
> **Organizations develop a plan for the implementation of best practice guideline recommendations that include:**
> - An assessment of organizational readiness and barriers to education.
> - Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
> - Ongoing opportunities for discussion and education to reinforce the importance of best practices.
> - Dedication of a qualified individual to provide the facilitation required for the education and implementation process.
> - Opportunities for reflection on personal and organizational experience in implementing guidelines.
> - Strategies for sustainability.
> - Allocation of adequate resources for implementation and sustainability, including organizational and administrative support.
> *Type IV Evidence*

A critical initial step in the implementation of guidelines must be the formal adoption and evaluation of the guidelines. Organizations need to consider how to formally incorporate the recommendations to be adopted into their policy and procedure structure (Graham, Harrison. Brouwers, Davies & Dunn, 2002). An example of such a formal adoption would be the integration of the guideline into existing policies and procedures. This initial step paves the way for general acceptance and integration of the guideline into such systems as the quality management process.

A commitment to monitoring the impact of the implementation of the *Assessment and Care of Adults at Risk of Suicidal Ideation and Behaviour* best practice guideline is a key step that must not be omitted if there is to be an evaluation of the impact of the efforts associated with implementation. It is suggested that each recommendation to be adopted be described in measurable terms and that the health care team be involved in the evaluation and quality monitoring processes. A suggested list of evaluation indicators is provided on page 66.

New initiatives, such as the implementation of a best practice guideline, require strong leadership from nurses who are able to transform the evidence-based recommendations into useful tools that will assist in directing practice. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines* (2002) based on available evidence, theoretical perspectives and consensus. The *Toolkit* is recommended for guiding the implementation of the RNAO best practice guideline *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*. Appendix Q provides a description of the toolkit.

Research Gaps and Future Implications

The development panel, in reviewing the evidence for the development of this guideline, has identified several gaps in the research literature related to nursing assessment and intervention as it relates to suicidal ideation and behaviour.

Organizations and nurses should participate in research that assists in better understanding the provision of care for suicidal ideation and behaviour and issues in various health care settings.

Recommendations for areas of research include:
- Role and contribution of nurses in suicide risk reduction and prevention;
- Standardized formats and tools for nursing assessment: Identification of culturally appropriate formats and tools for nursing assessment;
- Nursing interventions for suicide risk reduction and prevention, including postvention, and measurement of their effectiveness and efficacy: Identification of culturally appropriate interventions and measurements of their effectiveness and efficacy;
- Impact of nurses' ongoing professional development and clinical supervision on suicide risk reduction and prevention; and
- Strategies for knowledge translation related to mental health and suicide risk reduction and prevention.

The above list, although in no way exhaustive, is an attempt to identify and prioritize the research gaps in this area. Some of the recommendations in this guideline are based on evidence gained from qualitative or quantitative research, while others are based on consensus or expert opinion. Further substantive research is required in some areas to validate the expert opinion and impact knowledge that will lead to improved practice and outcomes related to the assessment and care of adults at risk for suicidal ideation and behaviour.

Evaluation/Monitoring of Guideline

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation and its impact will be monitored and evaluated. The following table, based on a framework outlined in the RNAO *Toolkit: Implementation of Clinical Practice Guidelines* (2002), illustrates some specific indicators for monitoring and evaluation of the guideline *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour.*

	Structure	Process	Outcome
System	To evaluate the supports available in the organization that allow for nurses to participate in the care of adults at risk for suicidal ideation and behaviour.	To evaluate changes in practice that lead towards improved care of adults at risk for suicidal ideation and behaviour.	To evaluate the impact of implementing the recommendations.
Organization	■ Review of best practice guideline recommendations by organizational committee(s) responsible for policies/ procedures.	■ Modifications to policies/ procedures consistent with the recommendations of the best practice guideline.	■ Policies and procedures related to best practice strategies consistent with this guideline.
Nurse	■ Availability of educational opportunities for nurses related to care of adults at risk for suicidal ideation and behaviour within the organization's workplace orientation program, and ongoing professional development opportunities.	■ Percentage of nurses attending and completing educational sessions regarding care for adults at risk for suicidal ideation and behaviour.	■ Nurses display increased knowledge and ability to perform or supervise care of adults at risk for suicidal ideation and behaviour.
	■ Evaluation structures are in place to monitor effectiveness of education programs for nurses.	■ Nurses self-assessed knowledge of: • Risk and protective factors • Valid assessment tools • Local resources and services to support client outcomes • Intervention strategies to reduce the risk of suicidal ideation and behaviour ■ Nurses self-assessed confidence in: • Obtaining collateral information • The development of a treatment plan with interventions based on the needs of the client	■ Structured documentation in client's health record reflective of nursing assessment/ intervention related to the care of adults at risk for suicidal ideation and behaviour. ■ Nurses report being actively involved in obtaining collateral information. ■ Nurses demonstrate an understanding of confidentiality, privacy legislation and how to acquire information. ■ Documented assessment includes communication with family, friends, community supports or mental health professionals.

	Structure	Process	Outcome
Client			■ Decrease in deliberate self-harm and suicide attempt frequencies.
Financial Costs	■ Provision of adequate financial and human resources for guideline implementation.	■ Cost for education, other interventions and on the job supports. ■ New assessment/ documentation systems ■ Support systems ■ Development of new programs	■ Optimal investment of resources related to care of adults at risk for suicidal ideation and behaviour.

Implementation Strategies

The RNAO and the guideline development panel have compiled a list of implementation strategies to assist health care organizations or health care disciplines that are interested in implementing this guideline. A summary of these strategies follows:

- Have at least one dedicated person such as an advanced practice nurse or a clinical resource nurse who will provide support, clinical expertise and leadership. The individual should have strong interpersonal, facilitation and project management skills.
- Conduct an organizational needs-assessment to identify the current knowledge base and further educational requirements.
- Initial needs assessment may include an analysis approach, survey and questionnaire, group format approaches (e.g. focus groups) and critical incidents.
- Establish a steering committee comprised of key stakeholders and interdisciplinary members committed to lead the change initiative. Identify short- and long-term goals. Keep a work plan to track activities, responsibilities and timelines.
- Create a vision to help direct the change effort and develop strategies for achieving and sustaining the vision.
- Program design should include:
  - target population
  - goals and objectives
  - outcome measures
  - required resources (human resources, facilities, equipment)
  - evaluation activities
- Design educational sessions and ongoing support for implementation. The education sessions may consist of presentations, facilitator's guide, handouts and case studies. Binders, posters and pocket cards may be used as ongoing reminders of the training. Plan education sessions that are interactive, include problem solving, address issues of immediate concern and offer opportunities to practice new skills (Davies & Edwards, 2004).
- Provide organizational support such as having the structures in place to facilitate the implementation (e.g. hiring replacement staff so participants will not be distracted by concerns about work and having an organizational philosophy that reflects the value of best practices through policies and procedures). Develop new assessment and documentation tools (Davies & Edwards, 2004).
- Identify and support designated best practice champions on each unit to promote and support implementation. Celebrate milestones and achievements, acknowledging work well done (Davies & Edwards, 2004).
- Organizations implementing this guideline should adopt a range of self-learning, group learning, mentorship and reinforcement strategies that will, over time, build the knowledge and confidence of nurses in implementing this guideline.
- Teamwork, collaborative assessment and treatment planning with the client and family and interdisciplinary team are beneficial in implementing guidelines successfully. Referral should be made as necessary to services or resources in the community or within the organization.

In addition to the strategies mentioned above, the RNAO has developed resources that are available on the website. A toolkit for implementing guidelines can be helpful if used appropriately. A brief description about this toolkit can be found in Appendix Q. A full version of the document in pdf format is also available at the RNAO website, www.rnao.org/bestpractices.

Process for Update/Review of Guideline

The RNAO proposes to update this best practice guideline as follows:

1. Each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area every three years following the last set of revisions.

2. During the three-year period between development and revision, RNAO program staff will regularly monitor for new systematic reviews, randomized controlled trials and other relevant literature in the field.

3. Based on the results of the monitor, program staff may recommend an earlier revision period. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guidelines earlier than the three-year milestone.

4. Three months prior to the three-year review milestone, the program staff will commence the planning of the review process by:
    a. inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
    b. compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
    c. compiling new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research and other relevant literature.
    d. developing a detailed work plan with target dates and deliverables.

The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Search Strategy for Existing Evidence

The search strategy utilized during the development of this guideline focused on two key areas. One was the identification of clinical practice guidelines published on the topic of assessment and management of suicide risk and the second was to identify systematic reviews, and primary studies published in this area from 2001 to 2007.

STEP 1 – Database Search

A database search for existing evidence related to the assessment and management of suicidal ideation and behaviour was conducted by a university health sciences library. An initial search of the MEDLINE, Embase, CINAHL, PsycInfo and Cochrane Library databases for guidelines, primary studies and systematic reviews published from 2001 to 2007 was conducted using the search terms "suicidal ideation", "suicidal behaviour", "deliberate self-harm", "self-injury", "self-destructive behaviour", "parasuicide", "risk and resilience", "Reasons for Living", "hopelessness", and "anomie". As directed by the consensus panel, supplemental literature searches were conducted where needed.

This search was structured to answer the following questions:
- What are the contributing factors/predictors of suicidal ideation and behaviour?
- What are the screening/assessment tools (measures, etc) for suicidal ideation and behaviour?
- What are the attributes of clinical assessment for suicidal ideation and behaviour?
- What are effective clinical interventions or post-ventions to prevent suicide and suicidal behaviour?
- What are the standards of clinical practice for assessment and management of suicidal ideation and behaviour? Primary studies and reviews were included for further evaluation if they were relevant to the scope of the guideline and addressed assessment strategies or interventions consistent with the scope of nursing practice. Studies were excluded if not published in English.

STEP 2 – Structured Website Search

One individual searched an established list of websites for content related to the topic area in October 2006. This list of sites, reviewed and updated in March 2006, was compiled based on existing knowledge of evidence-based practice websites, known guideline developers, and recommendations from the literature. Presence or absence of guidelines was noted for each site searched as well as date searched. The websites at times did not house guidelines, but directed to another website or source for guideline retrieval. Guidelines were either downloaded if full versions were available or were ordered by phone/email.

- Agency for Healthcare Research and Quality: http://www.ahrq.gov
- Alberta Medical Association – Clinical Practice Guidelines: http://www.albertadoctors.org
- Bandolier Journal: http://www.jr2.ox.ac.uk/bandolier
- BC Office of Health Technology Assessment: www.chspr.ubc.ca
- British Columbia Council on Clinical Practice Guidelines: http://www.hlth.gov.bc.ca/msp/protoguides/index.html
- Canadian Coordinating Office for Health Technology Assessment: http://www.ccohta.ca
- Canadian Institute of Health Information: http://www.cihi.ca
- Centers for Disease Control and Prevention: http://www.cdc.gov
- Centre for Evidence-Based Mental Health: http://cebmh.com
- Clinical Evidence: www.clinicalevidence.org

- Clinical Resource Efficiency Support Team (CREST): http://www.crestni.org.uk
- CMA Infobase: Clinical Practice Guidelines: http://mdm.ca/cpgsnew/cpgs/index.asp
- Cochrane Library: Abstracts of Cochrane Reviews: http://www.thecochranelibrary.com
- Database of Abstracts of Reviews of Effectiveness (DARE): http://www.york.ac.uk/inst/crd/crddatabases.htm
- Evidence-based On-Call: http://www.eboncall.org
- Evidence Based Nursing: http://evidencebasednursing.com
- Guidelines Advisory Committee: http://gacguidelines.ca
- Guidelines International Network: http://www.g-i-n.net
- Institute for Clinical Systems Improvement: http://www.icsi.org/index.asp
- Joanna Briggs Institute: http://www.joannabriggs.edu.au
- Medic8.com: http://www.medic8.com/ClinicalGuidelines.htm
- National Guideline Clearinghouse: http://www.guidelines.gov
- National Library for Health: http://www.nelh.nhs.uk/
- New Zealand Guidelines Group: http://www.nzgg.org.nz
- PEDro: The Physiotherapy Evidence Database: http://www.pedro.fhs.usyd.edu.au/index.html
- Sarah Cole Hirsh Institute – Online Journal of Issues in Nursing: http://www.nursingworld.org/ojin/hirsh/hirshtoc,htm
- Scottish Intercollegiate Guidelines Network: http://www.sign.ac.uk
- TRIP Database: http://www.tripdatabase.com
- University of California, San Francisco: http://medicine.ucsf.edu/resources/guidelines/index.html

STEP 3 – Search Engine Web Search

In addition, a website search for existing practice guidelines related to suicide was conducted via the search engine "Google", using key search terms. One individual conducted this search, noting the results of the search, the websites reviewed, date and a summary of the results. The search results were further reviewed by a second individual who identified guidelines and literature not previously retrieved.

STEP 4 – Hand Search/Panel Contributions

Panel members were asked to review personal archives to identify guidelines not previously found through the above search strategy. Furthermore, the panel contributed the following additional websites that were searched using the same strategy as documented in Step 2:

- American Association of Suicidology: http://www.suicidology.org/
- American Foundation for Suicide Prevention: http://www.afsp.org/
- American Psychiatric Nurses Association: http://www.apna.org/
- American Psychological Association: http://www.apa.org/
- Canadian Association for Suicide Prevention: http://www.suicideprevention.ca/
- Canadian Institutes of Health Research: http://www.cihr-irsc.gc.ca/
- Centre for Suicide Prevention: http://www.suicideinfo.ca/
- Health Canada: http://www.hc-sc.gc.ca/
- International Academy of Suicide Research: http://www.depts.ttu.edu/psy/iasronline//
- International Association for Suicide Prevention: http://www.med.uio.no/iasp/
- National Institute of Mental Health: http://www.nimh.nih.gov/
- Royal College of Psychiatrists: http://www.rcpsych.ac.uk/
- Suicide Prevention Action Network: http://www.spanusa.org/
- Suicide Prevention Resource Center: http://www.sprc.org/
- World Health Organization: http://www.who.int/en/

SEARCH RESULTS

The search strategy described above resulted in the retrieval of 1342 abstracts on the topic of suicide. These abstracts were then screened by a research assistant in order to identify duplications and assess for inclusion/exclusion criteria.

■ 498 articles that reported specific risk factors for suicide were retrieved and reviewed to validate established lists of risk factors presented in guidelines determined to be of quality following the AGREE review as described below.

■ 92 abstracts relevant to the remaining clinical questions were identified for article retrieval, quality appraisal and data extraction.

In addition, nine clinical practice guidelines were identified that met the screening criteria and were critically appraised using the *Appraisal of Guidelines for Research and Evaluation Instrument* (AGREE Collaboration, 2001).

■ American Psychiatric Association (APA). (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors.* Arlington, VA: Author.

■ Canadian Coalition for Seniors' Mental Health. (2006). *National guidelines for seniors' mental health : the assessment of suicide risk and prevention of suicide.* [Online] Available: http://www.ccsmh.ca/en/natlGuidelines/natlGuidelinesInit.cfm

■ Holkup, P. A. (2002) *Evidence based protocol. Elderly suicide: Secondary prevention.* Iowa City, IA: University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

■ National Collaborating Centre for Mental Health. (2004) *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* London, UK: National Institute for Clinical Excellence (NICE).

■ New Zealand Guidelines Group (NZGG). (2003). *The assessment and management of people at risk of suicide.* Wellington (NZ): Author.

■ Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm. (2004). Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. *Australian and New Zealand Journal of Psychiatry, 38(11-12),* 868-84.

■ Royal College of Psychiatrists (RCP). (2004). *Assessment following self-harm in adults.* London, UK: Author.

■ Royal College of Psychiatrists (RCP). (2006). Better services for people who self-harm: Quality standards for healthcare professionals [Online]. Available: http://www.rcpsych.ac.uk/auditselfharm.htm

■ U.S. Preventative Services Task Force (USPSTF). (2004). Screening for suicide risk: recommendation and rationale. *Annals of Internal Medicine,140(10),* 820-821.

Appendix B: Glossary of Terms

Behaviour Therapy: Interventions that reinforce or promote desirable behaviours or alter undesirable ones (Austin & Boyd, 2008).

Borderline Personality Disorder: A personality disorder in which there is a pattern of difficulty in maintaining stable interpersonal relationships, self-image, and affects and marked impulsivity. This generally begins by early adulthood and is present in a variety of contexts (APA, 2000; Austin & Boyd, 2008).

Client: A client is the recipient of nursing care, with whom the nurse engages in a therapeutic relationship (College of Nurses of Ontario, 2005). "Client" may be an individual, family and/or community. For the purposes of this guideline, the term "Client" is inclusive of the term "Patient".

Clinical Practice Guidelines or Best Practice Guidelines: Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990).

Clinical Supervision: Clinical supervision is a reflective process that allows nurses to explore and examine the part they play in the events within the therapeutic relationship as well as the quality of their practice. It is an opportunity for personal and professional growth and support that does not involve penalties or judgment (Kelly, Long & McKenna, 2001).

Cognitive Behavioural Therapy (CBT): A discrete, time-limited, structured psychological intervention, derived from the cognitive behavioural model of affective disorders in which the client:
- works collaboratively with a therapist to identify the types and effects of thoughts, beliefs and interpretations on current symptoms, feelings states and/or problem areas;
- develops skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms/problems; and
- learns a repertoire of coping skills appropriate to the target thoughts, beliefs and/or problem areas (NCCMH, 2004).

Collaboration: The mutual sharing and working together to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced (Stanhope & Lancaster, 2000).

Collateral information: Information that is obtained from others who know the client, such as family, significant other and other professional supports.

Competence: The degree to which the client is able to understand and appreciate the information given during the consent process, the client's cognitive ability to process information at a specific time; the client's ability to gather and interpret information and make reasonable judgments based on that information to participate fully as a partner in treatment (Austin & Boyd, 2008).

Confidentiality: An ethical duty of nondisclosure; the client has the right to disclose personal information without fear of it being revealed to others (Murray & Hauenstein, 2008).

Consensus: A process for making policy decisions, not a scientific method for creating new knowledge. Consensus development makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black, Murphy, Lamping, McKee, Sanderson, Askham, et al., 1999).

Cultural Awareness: Cultural awareness is the first step in understanding that there are differences (cultural and other) between people. Many people respond to this awareness by taking courses designed to sensitize them to these differences (e.g. ritual and ceremonial practices as ascribed to particular groups of people rather than to the emotional, social and political context in which people exist) (Nursing Council of New Zealand, 2002, p.8).

Cultural Competence: Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients (individuals, families, groups or populations). Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served and being sensitive to these while caring for the client. (Canadian Nurses' Association, 2004).

Cultural Safety: Cultural safety begins with the nurse. It requires that the nurse consciously recognize that she/he is a bearer of culture, and sees others through her/his own 'cultural' lens. When in a relationship with another person, both the culture of the nurse/ health care provider and the client (individual, family and/or community) influence that relationship and the practice of the nurse/ practitioner. Cultural safety pushes beyond cultural awareness and cultural sensitivity to an understanding of health and health care within its broadest context – to both understand and address the historical, political and socio-cultural factors that shape them. In addition, structural inequities and power imbalances are recognized and their role in shaping health care and health are understood and challenged. Cultural safety is both a process and an outcome – it requires excellence in relational practice – there is a respect for the culture of the client that is reflected in practice. 'Culturally' safe services and care are defined as such by the client.

Cultural Sensitivity: Cultural sensitivity alerts us to the legitimacy of difference and prompts the process of self-exploration, with an understanding that we are all bearers of culture, which includes our life experiences and realities that impact on others (Nursing Council of New Zealand, 1996).

Debriefing: Staff require skilled and dedicated support following a patient suicide to minimize its detrimental effects on personal, professional and team functioning (Linke, Wojciak & Day, 2002). In debriefing, staff are assisted to come to understanding the feelings, thoughts, physical sensations, behaviours and relational patterns that mark a response to trauma. In a survey done by Linke and colleagues (2002), staff found that peer support, reviews, dedicated staff meetings and support from senior colleagues were of most value.

Deliberate Self-Harm: Willful self-inflicting of painful, destructive, or injurious acts without intent to die (APA, 2003).

Dialectical Behavioural Therapy: An important biosocial approach to treatment that combines numerous cognitive and behaviour therapy strategies. It requires clients to understand their disorder by actively participating in formulating treatment goals by collecting data about their own behaviour, identifying treatment targets in individual therapy, and working with the therapists in changing these target behaviours (Austin & Boyd, 2008).

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research are the most accurate evidence. As research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience, while privileging the former over the latter (Canadian Health Services Research Foundation, 2006).

Family: Being unique and whomever the person describes as family. Family members can include, but are not limited to parents, children, siblings, neighbours and significant people in the community (RNAO, 2006d).

Impulsivity: Acting without considering the consequences of the act or alternative actions (Austin & Boyd, 2008).

Observation: Ongoing assessment of the client's mental and health status to identify and subvert any potential problems (Austin & Boyd, 2008).

Organization and Policy Recommendations: Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are ideally evidence-based.

Problem-Solving: The generation of possible solutions to an issue of concerns and therefore needs to be an inherent part of the practice of professionals. The process begins when a client problem is identified by the nurse and persists through to the point where a decision is made that will alleviate or solve the problem (Eisenhaeur & Gendrop, 1990 in Taylor 2004).

Promising Practices: Refers to those practices/ programs that while they may not yet be shown to be efficacious through empirical studies, they seem to be associated with good results – often reported by clinicians and/or clients as beneficial to clients.

Protective factors: Factors associated with a decreased risk for a particular disorder or problem.

Psychopharmacology: Subspecialty of pharmacology that includes medications used to affect the brain and behaviours related to psychiatric disorders (Austin & Boyd, 2008).

Psychotherapy: "A treatment method for mental illness in which a mental health professional and a patient discuss problems and feelings to find solutions. Psychotherapy can help individuals change their thinking and behaviour patterns or understanding how past experience affects current behaviour" (National Institute of Mental Health Glossary, 2005).

Randomized Controlled Trials: Clinical trials that involve at least one test treatment and one control treatment, concurrent enrollment and follow-up of the test- and control-treated groups, and in which the treatments to be administered are selected by a random process.

Restraint: The use of any manual, physical, or mechanical device or material, which when attached to the client's body (usually to the arms and legs), restrict the client's movements (Austin & Boyd, 2008).

Risk factors: Characteristics that do not cause the disorder or problem and are not symptoms of the illness, but rather are factors that have been shown to influence the likelihood of developing the problem (Austin & Boyd, 2008).

Seclusion: Solitary confinement in a full protective environment for the purpose of safety or behaviour management (Austin & Boyd, 2008).

Self-harm intent: the purpose(s) or meaning(s) associated with direct self-actions, which lie outside the realm of social acceptability and hurt or harm the body (Connors, 1996).

Socio-cultural Determinants of Health: The economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole (Raphael, 2004). A national collaboration of health and social policy experts suggested that the social determinants of health particularly relevant to Canadians include: early age, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, unemployment and job insecurity (Raphael, 2004).

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Suicide: Self-inflicted death with the evidence (either explicit or implicit) that the person intended to die (APA, 2003).

Suicidal Ideation: Thoughts a person has regarding killing him/ herself (Varcarolis, 2002).

Suicidal Intent: Subjective expectation and desire for a self-destructive act to end in death (APA, 2003).

Suicidal Behaviour: Self-inflicted actions, with a nonfatal outcome, accompanied by explicit or implicit evidence that the person intended to die (APA, 2003).

Survivor of Suicide: Someone who has been impacted by a loss of a loved one or a significant other who died by suicide. The term "survivor" is applied to the experience of losing someone who died by suicide because it accurately reflects the difficulties that face people who have lost someone to suicide. Suicide can shatter relationships with loved ones, as well as best friends, colleagues at work, health professionals working with the suicidal person and/or other gatekeepers who are frequently responding to suicide. Statistically survivors of suicide are at greater risk themselves, though there is no research as to how much of this is "it runs in the family" and how much is the direct impact of the earlier suicide (Kim Watson, personal communication, November 20, 2007).

Systematic Review: An application of a rigorous scientific approach to the preparation of a review article (National Health and Medical Research Council, 1998). Systematic reviews establish where the effects of health care are consistent and research results can be applied across populations, settings and differences in treatment (e.g. dose); and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions (Alderson, Green & Higgins, 2004).

Therapeutic Engagement: Empathically receiving and validating the client's feelings and building a sense of trust (Good & Beitman, 2006).

Therapeutic Relationship: The therapeutic relationship is grounded in an interpersonal process that occurs between the nurse and the client(s). Therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client (RNAO, 2006c).

Transference/Counter-transference:

Transference: The client's unconscious process of displacing feelings for significant people in the client's past unto the nurse in the present relationship. These feelings may be negative or positive and may be highly emotional. If it is unrecognized or unaddressed, transference may decrease the likelihood of effective care and/or outcomes because it may elicit feelings in the nurse that act as a barrier to understanding the client. When it occurs, the feelings expressed by the client need to be explored (Fontaine, 2003; Hogan & Smith, 2003).

Counter-transference: The nurse's emotional reaction to a client based on feelings for significant people in the nurse's past (Fontaine, 2003; Hogan & Smith, 2003). Counter-transference may be conscious or unconscious and the feelings may be negative or positive. It is essential to be aware of counter-transference because it can interfere with understanding what is happening in the relationship with the client and act as a barrier to providing safe and effective care. Discussing feelings with colleagues may assist the nurse to bring counter-transference into conscious awareness.

Warning Signs: Overt signs or symptoms that alert the nurse to a current risk.

Appendix C: Canadian Suicides and Suicide Rate, by Sex and Age Group

Source: Table: "Suicides and suicide rate, by sex and by age group", adapted from Statistics Canada website http://www40.statcan.ca/l01/cst01/hlth66a.htm (Retrieved November 20, 2007).Published with permission.

Suicides, and suicide rate, by sex and by age group						
	1996	1997	1981	1991	1996	1997
	Number of suicides		Suicide rate per 100,000 population			
All ages	3,941	3,681	14.0	13.3	13.2	12.3
Males	3,093	2,914	21.3	21.6	20.8	19.6
Females	848	767	6.8	5.3	5.6	5.1
1-14 years	41	51	0.7	0.6	0.7	0.9
Males	32	39	1.0	0.7	1.1	1.4
Females	9	12	0.4	0.4	0.3	0.4
15-19 years	231	261	12.7	13.8	11.5	12.9
Males	190	207	21.2	23.0	18.5	19.9
Females	41	54	3.8	4.0	4.2	5.5
20-24 years	350	293	19.6	18.2	17.2	14.5
Males	300	257	33.2	31.7	29.0	24.9
Females	50	36	5.9	4.1	5.0	3.6
25-44 years	1,770	1,549	17.4	18.1	17.9	15.8
Males	1,390	1,228	26.2	28.8	24.7	25.0
Females	380	321	8.6	7.6	8.6	6.6
45-64 years	1,060	1,075	20.1	16.2	16.6	16.5
Males	786	826	28.6	25.7	24.7	25.5
Females	274	249	11.9	6.9	8.6	7.6
65 years and over	489	452	18.3	14.2	13.4	12.4
Males	395	357	30.4	26.3	25.6	23.0
Females	94	95	9.2	5.6	4.5	4.5
Not stated	–	–	x	x	x	x
Males	–	–	x	x	x	x
Females	–	–	x	x	x	x

x   suppressed to meet the confidentiality requirements of the *Statistics Act*

–   nil or zero

Source: Statistics Canada, Health Statistics Division.

Last modified: 2005-02-17.

Appendix D: Transference and Counter-transference

'Transference is a normal phenomenon that may surface and inhibit effectiveness in any phase of one-to-one relationship work and, in any setting, including non-psychiatric settings" (Ren Kneisl, Skodol Wilson & Trigoboff, 2004, p. 667). It results from unresolved past experiences that most often have occurred in childhood. The client "transfers" unresolved feelings, attitudes and wishes into present significant relationships in an effort to resolve them – thus, the client misunderstands the present in response to unresolved problems of the past but is unaware of the nature of the response (Ren et al., 2004). According to Ren Kneisl et al. (2004), transference is a form of *resistance* whereby the client unknowingly resists knowledge of childhood conflicts and experiences. Instead, these are transferred into the present relationship, including the nurse-client relationship (Ren et al., 2004). For example, transference might be operating when the client repeatedly assigns meanings to the nurse-client relationship that are attached to one or more of the client's past relationships. Ren Kneisl et al. (2004) recommend that the nurse/ therapist explore the meanings of words, gestures, events and situations in the present one-to-one relationship to determine how these reflect the past relationships – separating the client's current feelings, thoughts and behaviours from those attached to the past can free the client to work through the past and explore "creative, self-actualizing aspects of personal identity as they evolve in the current relationship" (Ren et al., 2004, p. 667). Therefore, in psychodynamic-oriented treatments, the relationship between the client and therapist is used as a focus for interpretation and change in working with the client – this may or may not mean dealing with the client's past relationships (Ren et al., 2004).

Transference may be positive or negative. Positive transference usually reflects satisfying past relationships with significant others and means the client is able to progress. Negative transference usually is reflected in negative reactions such as hostility, loathing and anger that often generate discomfort in both the nurse and the client (Ren et al., 2004).

Counter-transference involves the nurse's reactions to the client – the nurse may develop powerful feelings and attitudes in response to the client's transference or personality. In the case of counter-transference the nurse may repeatedly assign meaning to the nurse-client relationship that actually belongs to the nurse's past relationships (Ren et al., 2004). Counter-transference is considered to be an inevitable product of the nurse-client relationship, i.e. it is considered a 'normal' phenomenon in therapeutic relationships that reflects the nurse's attachment with a past relationship (Ren et al., 2004, p. 667).

The following may signal counter-transference (Ren et al., 2004):
- Irrational friendliness toward or irrational concern about the client
- Reacting with annoyance or irrational hostility toward the client
- Feeling uneasy during or after meeting with the client
- Dreaming about the client
- Preoccupation with the client during leisure time

Supervision or consultation may prevent degeneration of the one-to-one relationship. By discussing the nurse's feelings, attitudes and behaviours with a colleague, the nurse may be assisted to develop "therapeutic, goal-directed responses" (Ren et al, 2004). Counter-transference is not shared with the client because it may be destructive. In rare cases when counter-transference cannot be addressed, it may be necessary for the nurse to refer a client to another nurse.

Appendix E: Cultural Safety

Source: Smye & Browne (2002). Published with permission from author.

Ramsden (1993), a Māori nurse-leader in New Zealand, developed the concept of "cultural safety" within a nursing education context in response to colonizing processes in Aotearoa/New Zealand. These processes historically disregarded the illness and health belief systems of the Māori, and instead, privileged those of the dominant 'white' culture in the construction of the health care system.

In nursing and other health care literature, culture tends to be presented as comprising the beliefs, practices and values of particular ethnic groups (Culley, 1996). Although descriptions of cultural characteristics and practices can be useful to health care practitioners and researchers, they can also reinforce stereotypes and simplistic views of particular ethnocultural groups as outsiders, as different and as 'other.' These culturalist discourses also view issues of access, compliance, and poor health status as stemming from cultural characteristics that conflict with mainstream, routine health care practices. Cultural safety is not about "cultural practices," rather, it involves the recognition of the social, economic, and political position of certain groups within society, such as the Māori people in New Zealand or First Nations people in Canada, and the consequent impact on their health.

Cultural safety is derived from the idea of "safety" as a nursing standard that must be met, most likely by an ethical standard (Polashek, 1998). Attention is focused on health service delivery, and on broader system issues such as "general nursing policies, the nursing settings in which care is provided, and the broader health care structures of which nursing is a part" (Polashek, 1998, p. 454). Cultural safety is concerned with fostering an understanding of the relationship between minority status and health status as a way of changing nurses' attitudes from those which continue to support current dominant practices and systems of health care to those which are more supportive of the health of minority groups (Polashek, 1998). By acknowledging the inequities in health care delivery (for example, arguing that Māori people in New Zealand or First Nations people in Canada receive less than adequate service), cultural safety draws attention to the issues embedded within the social and political context of health care delivery. Cultural safety, therefore, aims to counter tendencies in health care that create cultural risk (or "unsafety") – situations that arise when people from one ethnocultural group believe they are "demeaned, diminished or disempowered by the actions and the delivery systems of people from another culture" (Wood and Schwass, 1993, p. 2). Cultural safety reminds us that it is incumbent upon all of us in health care to reflect upon the ways in which our policies, research and practices may recreate the traumas inflicted upon people through colonial and neocolonial processes. It reminds us that health discourses have been shaped in relation to political, social, cultural and economic structures, and in relation to each other, and to the way that certain knowledge is privileged in this particular historical period (Foucault, 1973).

Therefore, cultural safety is not something we look at, but rather something to look through, as an interpretive lens which itself needs to be reflected on and interrogated. It prompts us to ask a series of questions to uncover the ways in which current health policies, research and practices may be perpetuating neocolonial approaches to health care.

Appendix F: Cultural Safety – A Clinical Scenario

> ## Mary
>
> - Mary is a 45-year-old Oneida woman living in her husband's community in Northern Ontario (remote). She is the mother of two children – 25-year-old Brenda, who is married, and 22-year-old William, who is attending University in Montreal.
>
> - Mary is waiting in the local clinic with her family for transport to a hospital 600 km from her home because of a change in her mental well being over the past several weeks. She has a history of psychotic illness in the past and currently is exhibiting symptoms of psychosis – she is agitated, seemingly very depressed, confused and incoherent and is experiencing auditory hallucinations.

Engage relationally

Begin with self-reflection – who are you, the nurse? What are your beliefs, attitudes, assumptions as they relate to mental illness and recovery, First Nations people etc.?

What will you do first?

Get to know Mary and her family to see how they understand what is happening, for example:

- What does leaving home mean to Mary and her family? Consider that while most people would be anxious about leaving home, some First Nations people would find leaving and heading to a large urban institution particularly difficult because of historical trauma (e.g. residential schooling, hospitalization in TB sanitoriums) and present-day racism and discrimination.
- Find out if there are any special considerations. For example, who needs to know? Are there particular community members who need to be here at this time? Are there important wellness and healing practices that need to be considered? Are there any aspects of the illness that need to be understood differently?

What information do you need or want?

- Are there any special needs or desires that need to be met?
- If Mary needs to stay in hospital for a period of time, who will stay with her and how might this be supported (consider resources)?
- What are the kinds of things Mary and her family thinking right now?
- What do they know? What don't they know? What would they like to know?
- Do Mary and her family feel that they have a choice and the power to exercise choice?
- Are there language considerations (i.e. do you need a translator)?

Appendix G: Environmental Considerations for Promoting Safety

"Placement in a secure facility with architectural barriers to suicide is expected for all persons at imminent risk of suicide." (Yeager et al., 2005, p. 122).

A safe environment is key for the client evidencing suicidal behaviour and/or ideation in the emergency department or on an inpatient unit. It is challenging to deal with all the safety risks that exist in within a hospital, as well as those brought in by clients and visitors. Staff should scan and/or evaluate the physical (built) environment and focus on what may pose an opportunity for harm. Safety begins with compiling a list of safety features within the inpatient facility. Following this, facilities should consider implementing risk-reduction strategies.

"Creep" factors:

Over time, activities, processes, procedures and even unit improvements can introduce a dangerous item to the client care environment (e.g. changes to the security department or building additions can increase the length of time for security to respond to a Code White). Creep factors also include what the clients, visitors or staff may bring on the units. Polices regarding storage of clients' belongings and access to non-patient areas (e.g. staff room, equipment room) may help to address these factors and should be developed with involvement of all staff members (e.g. allied health professionals, housekeeping, patient care aides, security, etc.)
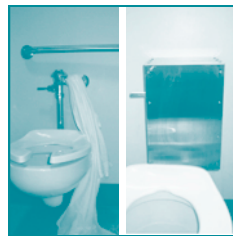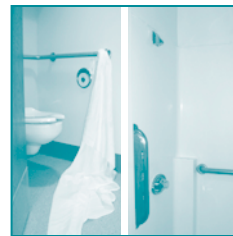
Hanging Risks:

A knotted sheet can serve as a hanging risk when combined with solid core hospital doors on inpatient psychiatric units.

The combination of a sheet and solid core door will support the entire body weight off the ground.
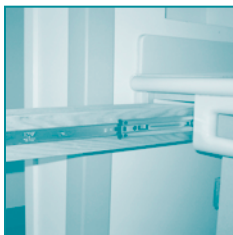
Plumbing fixtures pose risk but can be enclosed to minimize risk

Grab bars standard for ADA (Americans with Disabilities Act) pose a hanging risk from a sitting position. These can be "plated" to minimize risk.

Potential Weapons:

Cabinets can be taken apart to make weapons.

Heavy panels such as those from heating devices can be used to break windows or as a weapons against staff.

Some beds have removable headboards, which can be used as weapon against staff.

Even safety devices can pose a safety risk. Check all items, even those believed to be safe. In this example, safety hooks can cause a puncture wound.

Common linen hamper can be broken down into several potential weapons.

Crush Risks:

Although manual beds have the advantage of not requiring cords, they may also present a crush risk.

Be certain handles have been placed in a manner to minimize patient use to cause injury via crush points.

Bed frames should be check to assure safety stops are in place to minimize crush risk to patients.

Barricades:

Bed is anchored and locked to the floor to prevent barricade situation. This is thought to be a safety feature.

The same bed as in image on left hand side, combined with a nightstand and chair in the room can be used to create a barricade situation.

Other Considerations:

- Use plastic silverware and paper plates
- Ensure art work is securely attached to walls and not framed with glass (or use safety glass)
- Watch for tools or equipment left unattended (e.g. stethoscopes, brooms, etc.)
- Identify what the response time is for security to respond to psychiatric emergencies in the emergency department or psychiatry. Timed drills may be helpful.
- Safety rounds should be done regularly, at least weekly. Include "fresh" eyes (e.g. new staff or non-unit staff) when able.

Source: Yeager et al. (2005). *Figures published with permission*

Appendix H: Risk Factors and Protective Factors for Suicide

Source: Murray & Hauenstein (2008). Adapted with permission.

*Adaptations in italics

Risk Factors:

Demographic or Social Factors

- Being an older adult
- Being male
- Poverty
- Being Aboriginal, especially youth ages 14-24 (Chandler & Lalonde, in press)
- *White race* (APA, 2003)
- *Gay, lesbian or bisexual orientation – association. with attempts* (APA, 2003)
- Being single (widow, divorced, separated, single)
- Social isolation, including new or worsening estrangement, and rural location
- Economic or occupational stress, loss, or humiliation
- New incarceration
- History of gambling
- Easy access to firearms

Clinical Factors

- Past and current major psychiatric illness, including bipolar, schizophrenia and major depressive disorder (especially depression)
- Personality disorder (borderline, narcissistic, antisocial)
- Impulsive or violent traits by history
- Current medical illness
- Family history of suicide
- Previous suicide attempts or other self-injurious or impulsive acts
- Current anger, agitation, or constricted preoccupation
- Current abuse of alcohol or drugs (including solvents)
- Easy access to lethal toxins (including prescribed medication)
- Formulated plan, preparations for death or suicide note
- Low ambivalence about dying versus. living
- *Childhood trauma (sexual abuse, physical abuse)* (APA, 2003)
- *Suicidal ideas (current or previous)*
- *Suicidal intent* (APA, 2003)
- *Hopelessness* (APA, 2003)
- *Severe or unremitting anxiety* (APA, 2003)
- *Panic attacks* (APA, 2003)
- *Impulsiveness* (APA, 2003)
- *Aggression* (APA, 2003)

Precipitants

Recent stressors (especially losses of emotional, social, physical, or financial security)

Protective Factors:

- Intact social supports
- Active religious affiliation or faith (may also be a risk factor if shame/guilt about behaviour is involved)
- Marriage and presence of dependent children
- Ongoing supportive relationship with a caregiver
- *Positive therapeutic relationship* (APA, 2003)
- Absence of depression or substance abuse
- Access to medical and mental health resources
- Impulse control
- Proven problem-solving and coping skills
- *Pregnancy* (APA, 2003)
- *Life satisfaction* (APA, 2003)
- *Relief about not completing suicide* (NZGG, 2003)
- *Sense of 'unfinished business'* (NZGG, 2003)
- *Good self-esteem, self-confidence* (NZGG, 2003)
- *Awareness of significant others about their suicidal thoughts* (NZGG, 2003)
- *Sense of belonging* (Sargent, Williams, Hagerty, Lynch-Sauer & Hoyle., 2002)

Presence of risk and protective factors should be noted in the patient's chart as part of the risk assessment.

Note from RNAO Development Panel: Although the above list has been identified statistically as risk factors, readers must be aware that risk factors are not absolute and carry no weighted value, though they may be cumulative. The assessment of risk should always take place within the context of a comprehensive exam.

Appendix I: Components of a Mental Status Assessment

Source: RNAO (2006b). Adapted with permission.

The following elements may be included in a mental status assessment:

APPEARANCE

- **Age** *(chronological age and whether person looks this age)*
- **Sex, Race**
- **Body build** *(thin, obese, athletic, medium)*
- **Position** *(lying, sitting, standing, kneeling)*
- **Posture** *(rigid, slumped, slouched, comfortable, threatening)*
- **Eye contact** *(eyes closed, good contact, avoids contact, stares)*
- **Dress** *(what individual is wearing, cleanliness, condition of clothes, neatness, appropriateness of garments)*
- **Grooming** *(malodorous, unkempt, dirty, unshaven, overly meticulous, hairstyle, disheveled, makeup)*
- **Manner** *(cooperative, guarded, pleasant, suspicious, glib, angry, seductive, ingratiating, evasive, friendly, hostile)*
- **Attentiveness to examiner** *(disinterested, bored, internally preoccupied, distractible, attentive)*
- **Distinguishing features** *(scars, tattoos, bandages, bloodstains, missing teeth, tobacco-stained fingers)*
- **Prominent physical irregularity** *(missing limb, jaundice, profuse sweating, goiter, wheezing, coughing)*
- **Emotional facial expression** *(crying, calm, perplexed, stressed, tense, screaming, tremulous, furrowed brow)*
- **Alertness** *(alert, drowsy, stupor, confused)*

MOTOR/BEHAVIOUR

- **Retardation** *(slowed movements)*
- **Agitation** *(unable to sit still, wringing hands, rocking, picking at skin or clothing, pacing, excessive movement, compulsive)*
- **Unusual movements** *(tremor, lip smacking, tongue thrust, mannerisms, grimaces, tics)*
- **Gait** *(shuffling, broad-based, limping, stumbling, hesitation)*
- **Catatonia** *(stupor, excitement)*

SPEECH

- **Rate** *(slowed, long pauses before answering questions, hesitant, rapid, pressured)*
- **Rhythm** *(monotonous, stuttering)*
- **Volume** *(loud, soft, whispered)*
- **Amount** *(monosyllabic, hyper-talkative, mute)*
- **Articulation** *(clear, mumbled, slurred)*
- **Spontaneity**

MOOD/AFFECT

- **Stability** *(stable, fixed, labile)*
- **Range** *(constricted, full)*

- **Appropriateness** *(to content of speech and circumstance)*
- **Intensity** *(flat, blunted, exaggerated)*
- **Affect** *(depressed, sad, happy, euphoric, irritable, anxious, neutral, fearful, angry, pleasant)*
- **Mood** *(reported by patient/client)*

THOUGHT CONTENT
- **Suicidal or homicidal ideations** *(intent, plan, access to means, time-frame)*
- **Depressive cognition** *(guilt, worthlessness, hopelessness)*
- **Obsessions** *(persistent, unwanted, recurring thought)*
- **Ruminations**
- **Phobias** *(strong, persistent, fear of object or situation)*
- **Ideas of reference**
- **Paranoid ideation**
- **Magical ideation**
- **Delusions** *(false belief kept despite no supportive evidence)*
- **Overvalued ideas**
- **Thought broadcasting, insertion or withdrawal**
- **Other major themes discussed by patient/client**

THOUGHT PROCESS
- **Coherence** *(coherent, incoherent)*
- **Logic** *(logical, illogical)*
- **Stream** *(goal-directed, circumstantial, tangential [diverges suddenly from a train of thought], looseness of associations, flight of ideas, rambling, word salad)*
- **Perseveration** *(pathological repetition of a sentence or word)*
- **Neologism** *(use of new expressions, phrases, words)*
- **Blocking** *(sudden cessation of flow of thinking and speech related to strong emotions)*
- **Attention** *(distractibility, concentration)*

PERCEPTION
- **Hallucinations** *(auditory [including command, running commentary], visual, olfactory [smelling], gustatory [taste], tactile)*
- **Illusions** *(misinterpretation of actual external stimuli)*
- **Depersonalization**
- **Déjà vu, Jamais vu**

COGNITION
- **Orientation** *(time, person, place)*
- **Memory** *(short-term, long-term)*
- **Intellect**
- **Abstract thought**
- **Capacity to read and write**
- **Level of consciousness**

INSIGHT/JUDGEMENT
- **Awareness of illness** *(insight)*
- **Ability to make a decision wisely considering pros and cons for a course of action**

Appendix J: Interview Questions for the Assessment of Suicidal Ideation and Plan

Here are some suggested questions (APA 2003; NZGG, 2003) that an RN or RPN might use to ask about a person's suicidal thoughts, plans and behaviours. Remember, these are suggested ways to assess a person's thoughts and feelings about suicide. Always be attentive and assess both verbal and non-verbal communication or 'cues' from the person. Not all questions may need to be asked. Although this list of questions is presented in a linear fashion, they are intended to be utilized within an assessment, as a process within a conversation or discussion that flows in the context of the nurse-patient relationship. These questions can be asked within effective communication skills that include reflective listening.

A general question about the person's thoughts and feelings about living is frequently a recommended start to this discussion:

- *Sometimes people feel that life is not worth living. Can you tell me how you feel about your own life?*
- *What are some of the aspects of your life that make it worth living?*
- *What are some of the aspects of your life that may make you feel or think that your life is not worth living?*
- *Do you find yourself wishing for a permanent escape from life?*
- *How would that happen for you? What might you do to achieve that?*

It is important to continue with additional questions that are actually about self-harm, suicide and death. Even if the responses to the previous questions tend to affirm the person's value for his/her own life, those responses may not be consistent or congruent with other assessment information you have for this person, so assess for suicidal ideation and behaviour more specifically.

- *Do you think about your own death or about dying?*
- *Have you ever thought of harming yourself or trying to take your own life?*
- *Do you think or feel this way presently?*

If the person expresses thoughts of self-harm, and /or suicide, or even if he/ she seems ambivalent (e.g. says "I don't know," or "I don't remember" or "maybe, I am not sure" or "sometimes, but not right this moment"), continue with these questions as ambivalence between wanting to live and die is very common in suicidal ideation and behaviour and does not necessarily equate to no thoughts or behaviours. Be attentive to the person's cues, as not all questions may need to be asked.

- *When did you begin to experience these thoughts and feelings?*
- *What happened before you had them?*
- *Were there events in your life that preceded this such as a sudden loss or feelings of depression?*
- *How frequently have you had these thoughts and feelings?*
- *Do these thoughts intrude into your thinking and activities?*
- *How strong are they?*
- *Can you describe them?*
- *Can you stop yourself from having them by distracting yourself with an activity or other more positive thoughts?*

- *Have you ever acted upon these thoughts?*
- *Do your thoughts command you to act upon them?*
- *If you have not acted upon them, how close do you feel you came to acting?*
- *What stopped you from acting on them?*
- *Have you ever started to act on your self-harm or suicidal thoughts, yet stopped before actually doing it? For example, did you hold a bottle of pills in your hand to take them all but stopped, or go out on a ledge to jump but then stopped?*
- *Do you think you might act on these thoughts of self-harm or suicide in the future?*
- *What might help you from acting on them?*
- *If you did take your own life, what do you imagine would happen after you die to those people who are important to you?*
- *Do you have a plan to harm yourself or take your own life? If so, describe your plan.*
- *Do you have those methods available to you to take your life, such as over the counter pills, prescription pills, knives or proximity to a balcony, bridge or subway?*
- *Have you prepared for your death by writing a note, making a will, practicing the plan, putting your affairs such as your finances in order, or ensuring privacy such that you would unlikely be discovered?*
- *Have you told anyone that you are thinking about taking your life or are planning to do this?*

If a person has attempted suicide or engaged in self-harm behaviour(s), ask additional questions to assess circumstances surrounding the event(s).

- *What happened in your previous attempts to self-harm or take your life? What led up to it? Were you using alcohol or other substances? What method did you use? Sometimes people have many reasons for harming themselves in addition to wanting to die. What might have been some of your reasons for self-harm or suicide? How severe were your injuries?*
- *What were your thoughts just before you harmed yourself?*
- *What did you anticipate would be the outcome of your self-harm or suicide attempt? Did you think you would die? What did you think would be the response of others to your self-harm or suicide?*
- *Were other people present when you did this?*
- *How did you get help afterward? Did you look for it by yourself or did someone else help you?*
- *Did you anticipate that you might be discovered? If not, were you found accidentally?*
- *How did you feel after your attempt? Did you feel relief or regret at being alive?*
- *Did you receive treatment after your attempt? Did you get medical and/ or psychiatric, emergency help? Were you assessed in an emergency department? Were you cared for in an inpatient/outpatient department?*
- *How do you think and feel about your life now? Have things changed for you? Do you see your life in the same way or differently?*
- *Are there other times in the past when you've tried to harm (or kill) yourself? (If so you can re-ask many of these same questions to assess for similar or varying circumstances and presentations).*

For individuals with repeated suicidal thoughts or attempts.

- *How many times have you tried to harm yourself, or tried to take your life?*
- *When was the most recent time?*
- *What were your thoughts and feelings at the time that you were most serious about suicide?*
- *When was your most serious attempt at harming or taking your life?*
- *What happened just before you did this, and what happened after?*

Assess reasons for living or protective factors for this person.

- *How do you feel about your own future?*
- *What would help you to feel or think more positively, optimistically or hopefully about your future?*
- *What would make it more (or less) likely that you would try to take your own life?*
- *What happens in your life to make you wish to die or to escape from life?*
- *What happens in your life to help you to want to live?*
- *If you began to have thoughts of harming or killing yourself again, what would you do to prevent them?*

For individuals with psychosis, ask specifically about hallucinations and delusions.

- *Can you describe the voices you hear?*
- *Can you tell if they are male or female?*
- *Can you stop the voices?*
- *How many different voices do you hear?*
- *Do you hear these voices from within your own mind, or do they seem to come from somewhere outside of you?*
- *Do you know who these voices are? Do you recognize them?*
- *What do the voices say to you? Do they say anything positive, or do they say negative or hurtful things to you? Do they threaten you or anyone else?*
- *How do you cope with the voices? Do you do anything about them?*
- *Do they command you to do anything? If so what kinds of things do they ask you to do?*
- *Have you ever done what the voices ask you to do? What led you to obey the voices? If you tried to resist them, what made it hard to do?*
- *Have there been times when the voices told you to hurt or kill yourself? How frequently has this happened? What happened?*

Consider assessing the patient's potential to harm others in addition to him/ herself.

- *Are you having any thoughts of harming other people?*
- *Are there other people you would want to die with you?*
- *Are there others who you think would be unable to go on without you?*

Appendix K: Examples of Suicide Risk Assessment Tools

There are a wide variety of tools available that may be helpful in the assessment of suicide risk. Tools may vary based on the target patient population, the length of assessment and the applicability to different clinical or research settings. All tools have limitations and should be used in conjunction with clinical judgment. The following are provided as examples only and do not constitute an exhaustive list. The reader is strongly encouraged to refer to original sources for further information regarding instruction for appropriate use.

Example 1: The SAD PERSONS Scale for Assessing the Risk for Suicide

Source: Patterson et al. (1983). Published with permission.

The **SAD PERSONS** Scale for Assessing the Risk for Suicide

Sex
Age
Depression

Previous Attempt
Ethanol Abuse
Rational Thinking Loss
Social Supports Lacking
Organized plan
No spouse
Sickness

One point is scored for each item deemed present.
The total score thus ranges from 0 (very little risk) to 10 (very high risk).

Example 2: Nurses' Global Assessment of Suicide Risk (NGASR)

Source: Cutcliffe & Barker (2004). Published with permission.

Nurses' Global Assessment of Suicide Risk (NGASR)

Predictor Variable	Value
Presence/Influence of hopelessness	3
Recent stressful life event (e.g. job loss, financial worries, pending court action)	1
Evidence of persecutory voices/beliefs	1
Evidence of depression/loss of interest or loss of pleasure	3
Evidence of withdrawal	1
Warning of suicidal intent	1
Evidence of a plan to commit suicide	3
Family history of serious psychiatric problems or suicide	1
Recent bereavement or relationship breakdown	3
History of psychosis	1
Widow/Widower	1
Prior suicide attempt	3
History of socio-economic deprivation	1
History of alcohol and/or alcohol misuse	1
Presence of terminal illness	1
Total	
Levels of risk and corresponding suggested levels of engagement:* **Score of five or less:** Low level or risk estimated. Suggested level of engagement – Level Four **Score between six and eight:** Intermediate level of risk. Suggested level of engagement – Level Three **Score between nine and 11:** High level of risk. Suggested level of engagement – Level Two **Score of 12 or more:** Very high level of risk. Suggested level of engagement – Level One	

*Note:

Levels of Engagement (Barker & Buchanan-Barker, 2005)

Level Four: Engagement on a structured daily basis

Level Three: Formal engagement at least three times per day – morning, afternoon and evening

Level Two: Regular support (e.g. approximately every 15 minutes, varying between 10 and 20 minutes) from the nursing team throughout the day or night

Level One: Constant access to a nurse, or other professional for support

Example 3: Examples of Measures Used in Clinical and/or Research Settings

Beck Depression Inventory
Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561-571.

Beck Hopelessness Scale
Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology, 42,* 861-865.

Beck Scale for Suicide Ideation
Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The Scale for Suicide Ideation. *Journal of Consulting and Clinical Psychology, 47, 343-352.*

Hamilton Depression Inventory
Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry, 23,* 56-62.

Reasons for Living Inventory
Linehan, M., Goodstein, J., Nielsen, S., & Chiles, J. (1983). Reasons for staying alive when you are thinking of killing yourself: the Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology, 51,* 276-286.

Appendix L: Examples of Observation Levels

Four Levels of Observation	
Level I	*General Observation:* The location of all patients should be known to staff at all times, but not all patients need to be kept within sight.
Level II	*Intermittent Observation:* The patient's location must be checked every 15 minutes. This level is appropriate when patients are potentially, but not immediately at risk.
Level III	*Within Eyesight:* This is required when the patient could, at any time, make an attempt to harm themselves or others. Then patient should be kept within sight at all times, by day and by night.
Level IV	*Within Arm's Length:* Patient's at the highest levels of risk of harming themselves or others may need to be nursed in close proximity at all times, including when the patient goes into the toilet/bathroom.

Source: Reynolds, T., et al. (2005). Published with permission.

Observation in Inpatient Units	
There are three special levels of observation over and above the basic level required for all psychiatric inpatients.	
Within reach	This is for the person at extremely high risk of suicide who is expressing active suicidal intent. He/She may have recently carried out an act of deliberate self-harm, have unpredictable psychotic states and/or be impulsive and aggressive. This requires observation within reach of the person for safety purposes. On some occasions, more than one nurse may be required.
Same room and in sight	This is for the person at high risk of suicide who is expressing active suicidal intent but where there is less concern about impulsive self-destructive behaviour. This person may have recently carried out an act of deliberate self-harm or have unpredictable psychotic states. This requires constant visual observation on a 1:1 basis, with the nurse in the same room and in sight of the person.
Frequent observation (specify maximum interval in range of 10-20 minutes)	This is for the person who is considered to be at a significantly increased suicide risk compared with the average psychiatric inpatient, or where the extent of risk is uncertain. It is recommended that the timing of observations be varied to ensure the person cannot predict the exact time of the next observation.
If a person is assessed as requiring one of the above levels of observation, details must be carefully and systematically documented. People who commit suicide while engaged in mental health services are likely to have had their level of care reduced before they commit suicide (i.e. to have been judged as being at decreased risk).	

Source: NZGG, (2003). Published with permission.

Appendix M: Postvention Interventions

Source: Beautrais (2004). Published with permission.

The following interventions have been suggested as potentially beneficial to providing supportive care in postvention:

- Information about the manner, timing and circumstances of the death.
- An opportunity to view the body.
- Emotional support at a viewing of the body.
- Information about official procedures and investigations, including an explanation of postmortem and inquest procedures. Written information pertaining to these issues.
- A copy of, or the original suicide note or message shared as appropriate.
- Help and assistance with informing family and others of the death and the circumstances of the death.
- Assistance with interpretation of the postmortem report.
- A package of written information covering: grief and coping strategies for grief; suicide; available resources; a reading list; contact information for local bereavement, and bereaved by suicide, support groups; and, related matters.
- Written information about how to support children bereaved by suicide.
- Advice about responding to media inquiries and requests for information about the death.
- Referral to a general practitioner for information, support, assessment and, perhaps, medication.
- Information about inquests, including the purpose, context and protocols associated with the process, and social and emotional support during the inquest.
- Opportunities to talk about their experience of a suicide death with others who have been bereaved in this way, in the context of a bereaved by suicide support group, if available
- Access to professional individual or group counselling, therapy or psychotherapy as needed, without cost being a barrier.
- Support from religious leaders and clergy.
- Access, in a non-stigmatizing way, to factual information about suicide and mental illnesses with which suicide may be associated.
- Information about how to respond in social environments to questions about the suicide death in their family.
- Information about how to cope with grief and about how others bereaved by suicide have coped during the years following a family suicide.
- Access to information about the impact of suicide on family functioning, how other families have coped after suicide, and strategies for enhancing family communication and functioning after suicide.
- Advice about how, and what to tell children about the suicide death of a close family member, and how to protect them from risk of suicidal behaviour.
- Links with bereavement services.
- Follow-up contact, several times during the first year to reiterate offers of support and assistance, and to provide information.

Appendix N: Staff Debriefing Strategies

Source: Beautrais (2004). Published with permission.

In the organization that does offer debriefing for staff involved in the care of a client who has completed suicide, the nurse can ensure any or all of the following are provided:

- Use should be made of existing traumatic incident response plans.
- Consideration should be given to bringing in an external consultant with expertise and experience in leading a response to suicide deaths.
- Staff should be provided with information about the specific suicide death, and about suicide, generally.
- Staff should be provided with the opportunity to talk, in a supportive environment, about how the suicide has affected them, and to have their needs for support assessed.
- Relevant community resources/agencies should be identified and information provided to staff/workers and other bereaved individuals about how to access these services.
- Existing risk management procedures should be implemented to minimize risk of suicidal behaviour amongst staff, patients and others.
- Effective assessment procedures should be used to identify those at risk of severe grief responses and at risk of suicidal behaviour.
- Collegial support groups could be provided within institutional settings, including mental health settings, to provide support from staff with experience of suicide deaths.
- A meeting between staff and the bereaved family should be offered, and a facilitator provided.
- A review of the circumstances of the suicide should be conducted, if appropriate.
- Individual staff should be provided with access to professional supervision.
- At the end of the intervention all staff involved should be debriefed, and the traumatic incident response plan revised as needed.

Appendix O: Educational Resources

The following educational resources have been compiled by the development panel as a resource for nurses and their clients in learning more about suicidal ideation and behaviour. It is not intended to be an inclusive listing.

Relevant Peer-reviewed Journals:

Archives of Suicide Research – Taylor & Francis
Canadian Journal of Psychiatry – Canadian Psychiatric Association
Crisis: The Journal of Crisis Intervention and Suicide Prevention – Elsevier Science
International Journal of Mental Health Nursing – Blackwell Publishing
Journal of Psychiatric and Mental Health Nursing – Blackwell Publishing
Suicide and Life-threatening Behaviour – Guilford Publications, Inc.
Visions: BC's Mental Health and Addictions Journal – BC Partners for Mental Health and Addictions Information

Textbook Chapters:

Murray, B. L. & Hauenstein, E. J. (2008). Chapter 37 – Self Harm and Suicidal Behaviour: Children, Adolescents, and Adults. In W. Austin & M. A. Boyd (Eds.), *Psychiatric nursing for Canadian practice* (p. 898-922). Philadelphia: Lippincott Williams & Wilkins.

Myslik, B. (2005). Chapter 24 – Suicide. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (p. 317-324). Toronto: Pearson Education Canada Inc.

Other Publications:

Chandler, M. J., & Lalonde, C. E. (in press). Cultural continuity as a moderator of suicide risk among Canada's First Nations Kirmayer, L. & Valaskakis, G. (Eds.), *The mental health of Canadian Aboriginal peoples: Transformations, identity, and community*. University of British Columbia Press.

Government of British Columbia. (2007). *Working with the client who is suicidal: A tool for adult mental health and addiction services and related documents*. [Online]. Available: http://www.health.gov.bc.ca/mhd/suicide.html

Government of Canada. (2006). The human face of mental health and mental illness in Canada. [Online]. Available: http://www.phac-aspc.gc.ca/publicat/human-humain06/

Health Canada. (2002). *Suicide. A report on mental illness in Canada*. [Online]. Available: http://www.phac-aspc.gc.ca/publicat/miic-mmac/

Masecar, D. (2007). *What is working, what is hopeful... Supporting community-based suicide prevention strategies within indigenous communities (and any other community that is interested)*. Ottawa: First Nations and Inuit Health Branch, Health Canada.

Royal Commission on Aboriginal Peoples. (1995). *Choosing life: Special report on suicide among Aboriginal people*. Ottawa: Communication Group Publishing.

Examples of Suicide Intervention Models:

ASIST: www.livingworks.net

Assessment and Planning Tool Kit for Suicide Prevention in First Nations Communities: http://www.naho.ca/firstnations/english/documents/NAHO_Suicide_Eng.pdf

Mental Health First Aid: http://www.mhfa.com.au/

Website Resources:

American Association of Suicidology: http://www.suicidology.org/

American Foundation for Suicide Prevention: http://www.afsp.org/

American Psychiatric Nurses Association: http://www.apna.org/

American Psychological Association: http://www.apa.org/

BC Partners for Mental Health and Addictions Information: http://www.heretohelp.bc.ca

Canadian Association for Suicide Prevention: http://www.suicideprevention.ca/

Centre for Suicide Prevention: http://www.suicideinfo.ca/

Health Canada: http://www.hc-sc.gc.ca/

International Academy of Suicide Research: http://www.depts.ttu.edu/psy/iasronline//

International Association for Suicide Prevention: http://www.med.uio.no/iasp/

Mental Health Evaluation and Community Consultation Unit (Mheccu), University of British Columbia: http://www.mheccu.ubc.ca

National Institute of Mental Health: http://www.nimh.nih.gov/

Rethink: http://www.rethink.org/

Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samhsa.gov/

Suicide Prevention Action Network: http://www.spanusa.org/

Suicide Prevention Education Awareness Knowledge (SPEAK): http://www.speak-out.ca/

Suicide Prevention Resource Center: http://www.sprc.org/

World Health Organization: http://www.who.int

Appendix P: Framework for Ethical Decision-making

Source: McDonald (2001). Published with permission.

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Framework for Ethical Decision-Making: Version 6.0
Ethics Shareware (Jan. '01)
by **Michael McDonald**[1]
With additions by Paddy Rodney and Rosalie Starzomski[2]

</div>

1. Collect information and identify the problem.

1.1. Be alert; be sensitive to morally charged situations.

Look behind the technical requirements of your job to see the moral dimensions. Use your ethical resources to determine relevant moral standards [see Part 3]. Use your moral intuition.

1.2. Identify what you know, and don't know.

While you gather information, be open to alternative interpretations of events. So within bounds of patient and institutional confidentiality, make sure that you have the perspectives of patients and families as well as health care providers and administrators. While accuracy and thoroughness are important, there can be a trade-off between gathering more information and letting morally significant options disappear. So decisions may have to be made before the full story is known.

1.3. State the case briefly with as many of the relevant facts and circumstances as you can gather within the decision time available.

- What decisions have to be made?
- Who are the decision-makers? Remember that there may be more than one decision-maker and that their interactions can be important.
- Be alert to actual or potential conflict of interest situations. A conflict of interest is "a situation in which a person, such as a public official, an employee or a professional, has a private or personal interest sufficient to appear to a reasonable person to influence the objective exercise of his or her official duties. " These include financial and financial conflicts of interest (e.g. favouritism to a friend or relative). In some situations, it is sufficient to make known to all parties that you are in a conflict of interest situation. In other cases, it is essential to step out of a decision-making role.[3]

1.4. Consider the context of decision-making.

- Ask yourself why this decision is being made in this context at this time?
- Are there better contexts for making this decision?
- Are the right decision-makers included?

Consider the following questions:

Clinical Issues
- What is the patient's medical history/ diagnosis/ prognosis?
- Is the problem acute? chronic? critical? emergent? reversible?
- What are the goals of treatment?
- What are the probabilities of success?
- What are the plans in case of therapeutic failure?
- In sum, how can the patient be benefited by medical, nursing, or other care and harm avoided?

Preferences
- What has the patient expressed about preferences for treatment?
- Has the patient been informed of benefits and risks; understood, and given consent?
- Is the patient mentally capable and legally competent? What is evidence of incapacity?
- Has the patient expressed prior preferences, (e.g. Advanced Directives)?
- If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards?
- Is the patient unwilling or unable to cooperate with treatment? If so, why?
- In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

Quality of Life/Death
- What are the prospects, with or without treatment, for a return to the patient's normal life?
- Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
- What physical, mental and social deficits is the patient likely to experience if treatment succeeds?
- Is the patient's present or future condition such that continued life might be judged undesirable by him/her?
- Are there any plans and rationale to forego treatment?
- What are the plans for comfort and palliative care?

Contextual Features
- What chapter is this in the patient's life?
- Are there family/cultural issues that might influence treatment decisions?
- Are there provider (e.g. physicians and nurses) issues that might influence treatment decisions?
- Are there religious, cultural factors?
- Is there any justification to breach confidentiality?
- Are there problems of allocation of resources?
- What are the legal implications of treatment decisions?
- Is there an influence of clinical research or teaching involved?

2. Specify feasible alternatives.

State the live options at each stage of decision-making for each decision-maker. You then should ask what the likely consequences are of various decisions. Here, you should remember to take into account good or bad consequences not just for yourself, your profession, organisation or patients, but for all affected persons. Be honest about your own stake in particular outcomes and encourage others to do the same.

3. Use your ethical resources to identify morally significant factors in each alternative.

3.1. Principles

These are principles that are widely accepted in one form or another in the common moralities of many communities and organizations.

Autonomy: Would we be exploiting others, treating them paternalistically or otherwise affecting them without their free and informed consent? Have promises been made?

Non-maleficence: Will this harm patients, caregivers or members of the general public?

Beneficence: Is this an occasion to do good to others? Remember that we can do good by preventing or removing harms.

Justice: Are we treating others fairly? Do we have fair procedures? Are we producing just outcomes? Are we respecting morally significant rights and entitlements?

Fidelity: Are we being faithful to institutional and professional roles? Are we living up to the trust relationships that we have with others.

3.2. Moral models

Sometimes you will get moral insight from modelling your behaviour on a person of great moral integrity.

3.3. Use ethically informed sources

Policies and other source materials, professional norms such as institutional policies, legal precedents and wisdom from your religious or cultural traditions.

3.4. Context

Contextual features of the case that seem important such as the past history of relationships with various parties.

3.5. Personal judgements

Your judgements, your associates and trusted friends or advisors can be invaluable. Of course, in talking a tough decision over with others you have to respect client and employer confidentiality. Discussion with others is particularly important when other decision-makers are involved, such as, your employer, co-workers, clients or partners. Your professional or health care association may provide confidential advice. Experienced co-workers can be helpful. Many forward-looking health care institutions or employers have ethics committees or ombudsmen to provide advice. Discussion with a good friend or advisor can also help you by listening and offering their good advice.

3.6 Organized procedures for ethical consultation

Consider a formal case conference(s), an ethics committee, or an ethics consultant.

4. Propose and test possible resolutions.

4.1. Find the best consequences overall

Propose a resolution or select the best alternative(s), all things considered.

4.2. Perform a sensitivity analysis

Consider your choice critically: which factors would have to change to get you to alter your decision? These factors are ethically pivotal.

4.2. Consider the impact on the ethical performance of others

Think about the effect of each choice upon the choices of other responsible parties. Are you making it easier or harder for them to do the right thing? Are you setting a good example?

4.3. Would a good person do this?

Ask yourself what would a virtuous person – one with integrity and experience – do in these circumstances?

4.4. What if everyone in these circumstances did this?

Formulate your choice as a general maxim for all similar cases.

4.5. Will this maintain trust relationships with others?

If others are in my care or otherwise dependent on me, it is important that I continue to deserve their trust.

4.6. Does it still seem right?

Are you and the other decision-makers still comfortable with your choice(s)? If you do not have consensus, revisit the process. Remember that you are not aiming at "the" perfect choice, but a reasonably good choice under the circumstances.

5. Make your choice.

5.1. Live with it

5.2. Learn from it

This means accepting responsibility for your choice. It also means accepting the possibility that you might be wrong or that you will make a less than optimal decision. The object is to make a good choice with the information available, not to make a perfect choice. Learn from your failures and successes.

Postscript: This framework is to be used as a guide, rather than a "recipe". Ethical decision-making is a process, best done in a caring and compassionate environment. It will take time, and may require more than one meeting with patient, family and team members.

Feel free to share this framework with others. If you reprint or distribute it, please let the author know. Comments are welcomed. All substantive comments and requests to the author at: mcdonald@ethics.ubc.ca

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[2] School of Nursing, University of Victoria
[3] See "Ethics and Conflict of Interest" by Michael McDonald at
http://www.ethics.ubc.ca/people/mcdonald/conflict.htm

Appendix Q: Description of the Toolkit

Best practice guidelines can only be successfully implemented if there is: adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. In this light, RNAO, through a panel of nurses, researchers and administrators has developed the *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The *Toolkit* is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. Specifically, the *Toolkit* addresses the following key steps in implementing a guideline:

Chapter 1: Selecting your clinical practice guideline.
Chapter 2: Identifying, analyzing and engaging your stakeholders.
Chapter 3: Assessing your environmental readiness.
Chapter 4: Deciding on your implementation strategies.
Chapter 5: Evaluating your success.
Chapter 6: What about your resources?

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The Toolkit is one key resource for managing this process. The Toolkit can be downloaded at www.rnao.org/bestpractices.

Appendix R: Additional Readings Suggested by Stakeholder Reviewers

Suicide Nomenclature

Silverman, M. M., Berman, A. L., Sandal, N. D., O'Carroll, P. W., & Joiner, T. E. (2007). Rebuilding the Tower of Babel: A revised nomenclature for the study of suicide and suicidal behaviours. Part 1: Background, rationale, and methodology. *Suicide and Life-Threatening Behavior, 37(3),* 248-263.

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Raingruber, B. (2002). Client and provider perspectives regarding the stigma of and nonstigmatizing interventions for depression. *Archives of Psychiatric Nursing, 17,* 201-207.

Recovery

Barker, P. (2001). The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 8,* 233-240.

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Centre for Suicide Prevention. (2006). Fostering Hope in the Suicidal Client. SEIC Alert # 63, October 2006. [Online]. Available: http://www.suicideinfo.ca/csp/assets/alert63.pdf

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Barriers to the Problem-solving Approach

Marzuk, P. M., Hartwell, N., Leon, A. C., & Portera, L. (2005). Executive functioning in depressed patients with suicidal ideation. *Acta Psychiatrica Scandinavica, 112,* 294-301.

Williams, J. M. G., Barnhofer, T., Crane, C., & Beck, T. (2005). Problem solving deteriorates following mood challenge in formerly depressed patients with a history of suicidal ideation. *Journal of Abnormal Psychology, 114(3),* 421-431.

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Nursing Best Practice Guideline

*Assessment and Care of Adults at Risk
for Suicidal Ideation and Behaviour*

*This program is funded
by the Government of Ontario*

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NURSING BEST PRACTICE GUIDELINES PROGRAM