Suicide Risk Assessment and Management: Acute and Tertiary Mental Health

Site Applicability

VCH:
- All Acute Mental Health and Substance Use (MHSU) services
- All Tertiary Mental Health and Substance Use (MHSU) services
- All Acute Units and Emergency Departments (ED) – for patients with a primary MHSU concern

PHC:
- All Emergency Departments – for patients with a primary MHSU concern
- St. Paul's Hospital – Acute Behavioural Stabilization Unit (ABSU)
- St. Paul's Hospital – Acute Psychiatric Units (PASU, 2N, 4NW, 8C, 9A)
- Mount St. Joseph Hospital – Geriatric Psychiatry Unit (MSJ-1S)
- St. Vincent's Langara – Alder Neuropsychiatry Unit
- Youville – Parkview Unit

Practice Level

Profession	Skill Level
RN/RPN	Basic Skill
LPN	Advanced competency: LPNs working in settings where substance use or a mental health disorder is the primary diagnosis require: • orientation consistent with LPN entry level competencies • to work in a team nursing approach when providing care for individuals in MHSU settings after successfully completing additional education ○ additional education includes structured education for LPNs (e.g. the Douglas College LPN MHSU education course)

Requirements

All patients admitted to Acute and Tertiary Mental Health services, and all patients with a primary MHSU concern admitted to a non-MHSU Acute service as listed above, are required to be screened, assessed, and managed for suicide risk. This document applies to sites serving adults (ages 19 and over).

Quick Links

Background

Suicide is a major cause of premature death. Approximately 4,500 people in Canada die by suicide every year – about 12 people every day (Government of Canada, 2022a). According to research (specifically the three-step theory of suicide), suicidal ideation results from the combination of overwhelming pain and hopelessness (May et al., 2020). It can impact anyone and involves the interaction of a wide range of risk factors, such as marital breakdown, financial hardship, deteriorating physical health, a major loss or lack of social support (Turecki et al., 2019). The combined effects of social determinants of health (such as racism, discrimination, intergenerational trauma, poverty and gender differences) affect the stressors/strengths that lead to/protect against suicide risk, as well as level of engagement and trust in health care services.

In addition, psychiatric and substance use disorders significantly increase the risk of suicide. Ninety percent of people who die by suicide have one or more psychiatric disorders, and those with substance use disorders have a 10–14 times greater risk of death by suicide compared with the general population (Esang & Ahmed, 2018). The risk of suicide increases further when psychiatric disorders are comorbid with substance use disorders (Esang & Ahmed, 2018). In acute psychiatric settings, risk of suicide is 50 times higher than the general population (Chammas et al., 2022).

Research shows that suicide cannot be reliably predicted or prevented (Paris, 2021), so it is especially important to follow the guiding principles of suicide risk management to provide the best care possible. Protective factors build resilience against risk factors and keep life worth living. Most people with suicidal ideation do not go on to attempt suicide, and the key determinant for progression from strong ideation to attempts is capability to attempt suicide (Klonsky et al., 2021). Thus, the most effective reduction of fatality from suicide is restriction of access to lethal means (Paris, 2021).

Guideline

Overview

Suicide risk management includes universal screening for possible risk, comprehensive assessment of identified risk, and interventions for reducing risk. (For process overview, see Appendix A.)

Suicide Risk Management		Documentation
Screening	***At admission:*** Identify individuals at potential risk for suicide	• C-SSRS Quick Screen or Full Screen (Cerner PowerForm) • C-SSRS Screen Version (VCH Forms)
	When there are changes in condition/care as per site-specific standards: Re-screen for suicide risk	• C-SSRS Ongoing Screen (Cerner iView) • C-SSRS Screen Version (VCH Forms)
Assessment	***When screening indicates potential risk:*** Assess risk/protective factors and nature/severity of risk	• Narrative Note (Cerner Documentation or paper chart) • MH Emergency Nursing Assessment (Cerner PowerForm) • C-SSRS Risk Assessment (VCH Forms) • Suicide Risk Alert (Cerner/PCIS)

Interventions	***Based on assessment:*** Plan for individualized interventions that promote safety	• Narrative Note or Suicide Risk Care Plan (VCH Forms or PHC FormFast 10973-PS296) • Special Care Plan Alert • Safety Plan (VCH Forms or PHC FormFast 10236-PS293)
Postvention	***If there is a suicide attempt:*** Make appropriate reports and provide postvention	• Narrative Note

Guiding Principles

Several principles are important to consider across all stages of suicide risk management (see also Provincial Suicide Risk Reduction Framework).

Guiding Principles for Suicide Risk Management	
Therapeutic Approach	• Developing a therapeutic relationship is essential to support the individual to feel safe expressing suicidal thoughts and feelings without fear of prejudice or judgment. • Shared decision-making with the individual, where appropriate, can strengthen the therapeutic alliance, increase treatment efficacy, and enable informed choices by the individual (Canadian Mental Health Association, 2023).
Engagement of Support Persons	• Whenever possible and with the individual's consent, include the individual's family, Substitute Decision Maker (SDM), and/or other support person(s). • Discuss limits of confidentiality (see Information Privacy & Confidentiality: VCH/PHC). • Ensure that support persons are involved with care, feel supported, and are informed about signs of suicide risk and appropriate interventions. • Consent for sharing information is not always required when someone is at risk, but careful consideration is needed to decide if it is appropriate to share without consent. • For more information, see Family Involvement VCH/PHC, Consent to Health Care VCH/PHC and Patient and Family Education.
Cultural Safety, Diversity, and Equity	• Clinicians should approach suicide prevention with humility and awareness of cultural influence on suicide risk. Neglecting to do so can result in the under-identification and mishandling of suicide risk (Mental Health Commission of Canada, 2021). • Culture affects the types of stressors that lead to suicide; the development of suicide risk, tolerance of psychological pain, and potential for suicidal behavior; and how suicidal thoughts and behaviors are expressed (Chu et al., 2022). • Beliefs about distress, illness, and suicide are further impacted by factors associated with age, sex and gender identity, and religion. • Identity, connection to community, and traditional healing practices are important protective factors. Involve a cultural liaison (e.g., Indigenous Wellness Liaison, Elder, etc.) where possible and support access to traditional medicines and ceremony.

	• See also Cultural Competency & Responsiveness, Indigenous Cultural Safety, and Spiritual Care & Multi-Faith Services.
Trauma-Informed Practice	• While providing care to patients and support persons with a trauma-informed approach is always important, it is especially critical when addressing suicide. • This includes awareness of the prevalence and impact of trauma, establishment of physical and emotional safety, respect for choice, and focusing on strengths. • Providing compassionate and culturally safe care reduces the risk of discrimination, racism, and re-traumatization from care (Canadian Mental Health Association, 2023). • Review and build on individual and interpersonal strengths and coping strategies • See also Trauma Informed Practice guideline or BCMHSUS Trauma Informed Practice.
Clinical Judgment	• Screening and assessment tools are intended to support clinical judgment. • When in doubt, choose the more cautious approach.
Interprofessional Team Approach	• Consult regularly with team members, leadership, and other care providers (e.g., case reviews/informal discussion/observation with the psychiatrist, most responsible provider/clinician, nurse, social worker, mental health clinician, psychologist). • Consult with/refer to other bio-psycho-social-spiritual services to increase engagement and protective factors (e.g., spiritual care, peer support, Occupational Therapist, Recreation Therapist, Registered Dietician, Indigenous Wellness Liaisons/Indigenous Patient Navigator).
Use and Limitations of Standardized Tools	• Most suicide screening and assessment tools do not account for cultural differences, which may undermine their validity when applied to diverse cultures, languages, racialized groups, and sexual minorities (Mental Health Commission of Canada, 2021). • No screening tools have been validated with Indigenous peoples (Ansloos et al., 2022); thus, it is particularly essential that standardized tools are used within a trauma-informed, culturally safe therapeutic approach when working with First Nations, Métis, and Inuit people (Canadian Mental Health Association, 2023). • While suicide risk assessment tools add valuable information to the overall suicide risk assessment process, they have not been shown to accurately or consistently predict death by suicide (Sadek, 2018). Thus, it is best to use assessment tools as sources of information to complement and corroborate findings from comprehensive, clinical interviews (Mental Health Commission of Canada, 2021) and to address individual patient needs rather than attempting to predict probability of suicide (Large, 2022).

Screening

The purpose of screening is to reduce the underestimation of suicide risk and improve identification of specific individuals at risk using an early, consistent, and systematic process (Canadian Mental Health Association, 2023). Standardization, when used together with respect and humility, can be helpful for reducing stigma and discrimination. Note that screening will not predict whether someone will go on to attempt suicide; rather, the purpose of screening is to identify potential risk.

All patients of Acute/Tertiary MHSU services and all patients seen in Acute/Emergency Departments with a primary MHSU concern should be screened for the presence of possible suicide risk **using the Columbia-Suicide Severity Rating Scale (C-SSRS) Screen** (Appendix G). This will occur:

- ***At admission*** to the unit
- ***When there is a change in the individual's condition*** (e.g. new or worsening diagnosis) or a change in their psychosocial circumstances (e.g. loss of loved one)
- ***When there is a change in care*** (e.g., during each shift for applicable sites, transfer from one service to another, before/after therapeutic leave for applicable sites).
- ***When there is new information that raises concerns*** (e.g., support person expresses concerns)
- Specific requirements for frequency of re-screening will be ***site-specific***. Frequency of re-screening may also be increased on a case-by-case basis depending on ***clinical judgment***.

See also Guiding Principles of Suicide Risk Management.

Assessment

The purpose of a comprehensive suicide risk assessment is to review risk factors, practical capability, warning signs, and protective factors (see Appendix B) **to determine nature of risk and plan for individualized interventions**. Assessments are conducted when:

- Screening identifies non-zero suicide risk (e.g., "Yes" response to any item on the C-SSRS Screen)
- Individual demonstrates behaviours or verbalizes feelings suggestive of suicidal ideation
- Concern is raised by support persons or staff member

See also Guiding Principles of Suicide Risk Management.

Comprehensive Suicide Risk Assessment	
Engagement of individual & Support Persons	• Explain the reason for assessment (e.g. routine part of assessment, risk factors identified). • Assess elopement risk if applicable. • Determine level of understanding and participation of support person(s), and assess if they can/should participate in supporting the individual and promoting interventions.
History of suicidal behaviour	• Has the individual attempted suicide before? • What were the details and circumstance of the previous attempts? • Are there similarities to the current circumstances?
Pain and hopelessness	• What are the main sources of this individual's distress? • Does this individual believe that it might be possible for their predicament to change?
Other Risk Factors	• Assess current mental health and substance use: depression, mood, anxiety, current stressors, psychosis, delusions, hallucinations, command hallucinations (e.g. someone telling them to take their own life). Assess for recent change in baseline.

	• Does the individual engage in non-suicidal self-injury?
Protective factors	• What is the individual's main reason for living? Do they have hope for the future? • Do they have cultural or religious connections? A well-developed social support network? Responsibility for children, family or pets? • Do they have connection to a sense of purpose or meaning for their life? • Do they have access to clinical care or supports? • Do they feel hopeful and connected regarding their supports? • What has helped keep the individual safe in the past? • Does the individual recognize their own strengths and effective coping strategies?
Suicidal ideation	Nature of thoughts • Are thoughts of suicide present? Do they have a desire to take their own life? • Are thoughts passive (e.g., "I would be better off dead") or active (e.g., "I want to kill myself)? • Do they perceive someone/something is directing them to kill themselves? • Are they avoidant of the topic of suicide? Intent • What is the individual's degree of suicide intent? How determined is the individual to act? Plan • Is there a specified method, place or time? • How long has the individual had these plans for suicide? • How often does the individual think about them?
Practical capability	Means • Has the individual attempted this method before? • Does the individual have access to methods/means for their plan for suicide? • Is the individual willing to remove their access to means (e.g., allow a trusted support person to lock away their firearm temporarily)? Lethality • Is the chosen method irreversible, for example, shooting or jumping off a bridge? • Does the individual have experience, expertise, and/or comfort with the planned method?
Safety of others	• Have the individual's thoughts ever included harming someone else? • Are there issues with child custody and/or financial issues? Are the children safe?

Interventions

The purpose of interventions is to increase an individual's ability to cope and decrease risk of suicide.
Appropriate interventions will:

- Respond to the nature of risk of the specific individual.
- Build on strengths/protective factors to foster self-worth, meaning/purpose, hope, and connectedness.

- Reduce risk factors, physical/psychological pain, and practical capability for suicide.

Intervention plans will be reviewed and updated regularly (e.g., once per shift) to ensure that the interventions continue to be appropriate for the individual and the current nature of risk.

See also Guiding Principles of Suicide Risk Management. For additional discussions and recommendations related to suicide interventions, contact Ethics VCH/PHC.

Suicide Risk Interventions	
Safe environment	• Check environment for potential risks and consider removing unsafe items (e.g., cords, belts, potential weapons, bags, art supplies, medical equipment, ligature points, sharps) • Offer sensory modulation or de-stimulating surroundings • Consider moving the individual to a room closer to the nursing station or using a purpose-built higher observation room (e.g., with cameras, anti-ligature door alarms, clear sightlines to the nursing station, etc) • Search of patient belongings upon return from leaves/passes may be appropriate if there are reasonable grounds to believe the patient may have harmful items that puts patients/staff at risk (see Therapeutic Leaves).
Patient monitoring	• Increase observation levels as appropriate (e.g., 1:1 care, increased screening for changes in condition/circumstance) • Review and modify therapeutic leaves/passes as needed • Assess for distressing symptoms (e.g. hallucinations, anxiety, physical/emotional pain, impulsivity) or worsening of suicidal ideation • Ensure basic needs (e.g., food, water, pain management) are respectfully met • Assess need for and effectiveness of PRN medications and other interventions used
Safety Planning	• Safety planning is required when screening indicates any non-zero level of suicide risk (i.e., the patient answers “yes” to any of the questions on the C-SSRS screen) and there is a temporary or permanent decrease in intensity of level of care (e.g., before therapeutic leave or discharge). • The purpose of a safety planning intervention is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behaviour. • Brainstorm collaboratively with the individual (and support persons where possible), and use the My Safety Plan form to guide and document safety planning. • Provide copies of the Safety Plan to the individual (and support persons with consent). • Review and update Safety Plan with the individual/support persons as needed.
Chronic Suicidality	• Suicidality can exist on a continuum between acute and chronic risk. • Some individuals experience chronic suicidality, and while their level of risk remains elevated, they may not require acute hospitalization. • Interventions that help address risk factors or underlying contributors that lead to an individual’s suicidality may be helpful.

	• Increased contact with community resources, safety plans, and planned follow-up discharge planning can also help lower the risk of a fatal suicide attempt. • A clinician's goal is to minimize risk through best practice with the knowledge that there is no specific "right way" that will totally eliminate suicide risk.
Discharge	• Begin planning for discharge well in advance • Collaborate between in-patient and community/primary services for continuity of care • Recommend additional services as appropriate (e.g., referral to counselling) • Liaise with community supports and support persons to provide MHSU follow-up. • Review safety plan with the individual and family/support persons • Reassess for changes in risk factors • Review protective factors and identify individual strengths

Documentation

Documentation in the individual's health record regarding suicide risk screening, assessment, interventions, and care planning should be done throughout the individual's admission and upon discharge, and as close as possible to the time of care or event. (See table below for tools to guide documentation.) The frequency of additional assessment and documentation is determined by the patient's condition or nature of risk. Accurate and timely documentation helps ensure communication regarding the individual's level of suicide risk and interventions among the interprofessional team. Examples of documentable content are:

- Risk factors
- Protective factors
- Mental Status Exam (MSE)
- Interventions
- Ongoing evaluation
- Safety planning

Stage for Documentation		PHC Cerner Sites	VCH Cerner Sites	Non-Cerner Sites
Screening	Initial	C-SSRS Quick Screen or Full Screen (Cerner Powerform)		C-SSRS Screen Version (VCH Forms)
	Ongoing	C-SSRS Ongoing Screen (Cerner iView)		
Assessment		Narrative Note or MH Emergency Nursing Assessment PowerForm and Suicide Risk Alert	C-SSRS Risk Assessment or Narrative Note or MH Emergency Nursing Assessment PowerForm and Suicide Risk Alert (Cerner/PCIS)	
Intervention	Intervention Plan	Suicide Risk Care Plan (PHC FormFast 10973-PS296) and Special Care Plan Alert	Suicide Risk Care Plan (VCH Forms) or Narrative Note and Special Care Plan Alert	Suicide Risk Care Plan (VCH Forms) or Narrative Note
	Safety Plan	My Safety Plan (PHC Form 10236-PS293)	My Safety Plan (VCH Forms)	

For more information, see Appendices C & D (all sites), E & F (Cerner sites), and G-H (VCH sites).

Patient and Family Education

Ensuring the individual is informed throughout the assessment and planning process builds trust, minimizes distress, and aids development of a therapeutic relationship. The goals of patient and family/support person education are to provide information on:

- Discharge and psychiatric follow-up plans
- Community resources and social supports (see Resources for Patients/Support Persons)
- Treatment of psychiatric illness (e.g., adherence to medication, psychotherapy, etc.)
- Individual coping strategies and strengths
- Health promotion, determinants of health, and relapse prevention
- Safety plan (including warning signs for suicide, what to do in a crisis, etc)

All patients/families will also be given a copy of their discharge plan (i.e., Acute When I Leave Hospital form or Tertiary discharge form) and contacted within 48 hours of discharge for MHSU Follow-Up.

Patient Safety Events

All incidents involving a suicide attempt (regardless of degree of harm) must be reported in the Patient Safety Learning System (PSLS) for VCH/PHC. All suicide incidents resulting in serious harm or death must also be communicated to the Patient Care Manager (or designate) and Director of Risk Management. (See procedure after unexpected death, including reporting to the coroner, for VCH or PHC.)

Postvention

Postvention is the provision of crisis intervention, support, and assistance for those affected by a suicide incident. The aim is to help support and heal those affected, and to reduce the risk of further suicides (Mental Health Commission of Canada, 2020). See Related Documents for more resources.

Incident Management

In order to ensure optimal care after critical incidents (e.g., fatal suicides, significant attempts, or events causing significant bodily harm):

- A debrief for all persons involved should be organized by leadership as soon as possible
- Timely and compassionate communication, including incident disclosure, should be made to families and/or relevant patient parties
- The on-call physician, clinical coordinator, and on-call manager (where applicable) must be notified of inpatient events occurring after hours
- Notification of the critical incident should be made to Client Relations and Risk Management

Related Documents

Policies & Guidelines

- Consent to Health Care Policy (VCH or PHC)
- Cultural Competency and Responsiveness
- Family Involvement Policy (VCH) or Family Presence Policy (PHC)
- Harm Reduction in Acute Care: **VCH** and **PHC**
- Indigenous Cultural Safety Policy (VCH or PHC)

- Mental Health Environment of Care Checklist (or email ncps@va.gov for the latest version)
- MHSU Follow-Up after Acute Care Discharge
- Procedure after unexpected death (VCH or PHC)
- Provincial Suicide Risk Reduction Framework for Clinical Care Settings (development in progress)
- Therapeutic Leave
- Trauma Informed Practice

VCH:
- Observation Levels for Acute Mental Health Patients: Vancouver, Richmond, or Coastal

PHC:
- Close and Constant Care: Decision Making Process
- Managing Unsettled/Challenging Behaviors: Least Restraint Approach

Other Clinical Resources

- Canadian Centre for Suicide Prevention
- Columbia-Suicide Severity Rating Scale (C-SSRS): Information and Resources
- Ethics: VCH or PHC
- Hope, Help, and Healing (Suicide Prevention Planning Toolkit for Aboriginal Communities)
- IS PATH WARM (Screening Tool for Risk Factors)
- Mental Health Act

Staff Supports

- WorkSafeBC Critical Incident Response (Tel: 1-888-922-3700)

VCH:
- TELUS Health EFAP (previously LifeWorks/Employee and Family Assistance Program)
- People Wellness campaigns and resources
- Sacred Spaces

PHC:
- PHC Employee Wellness (Tel: 604-872-4929)
- PHC Staff Mental Health and Wellness Toolkit
- The Chapel (Room 345) and Meditation/Quiet-Space (Room 372)
- Indigenous Wellness & Reconciliation (IWR@providencehealth.bc.ca or 604-682-2344 ext 63513)

Staff Online Training (Optional)

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- How to Talk to Someone About Suicide (via Learning Hub or Vimeo)
- Safety Planning
- Suicide Risk Assessment

Resources for Patients/Support Persons

- Canadian Association for Suicide Prevention
- Coping with Suicidal Thoughts (handout)
- Crisis Intervention and Suicide Prevention Centre of BC (Crisis Centre)
- Indigenous Health
- Kelty Mental Health (Child & Youth Mental Health Resource Centre)
- KUU-US Crisis Line
- S.A.F.E.R. (Suicide Attempt, Follow-up, Education, & Research)
- Spiritual Care & Multi-Faith Services

- Suicide Prevention for Older Adults and Guide for Family Members
- Vancouver Access & Assessment Centre (AAC)

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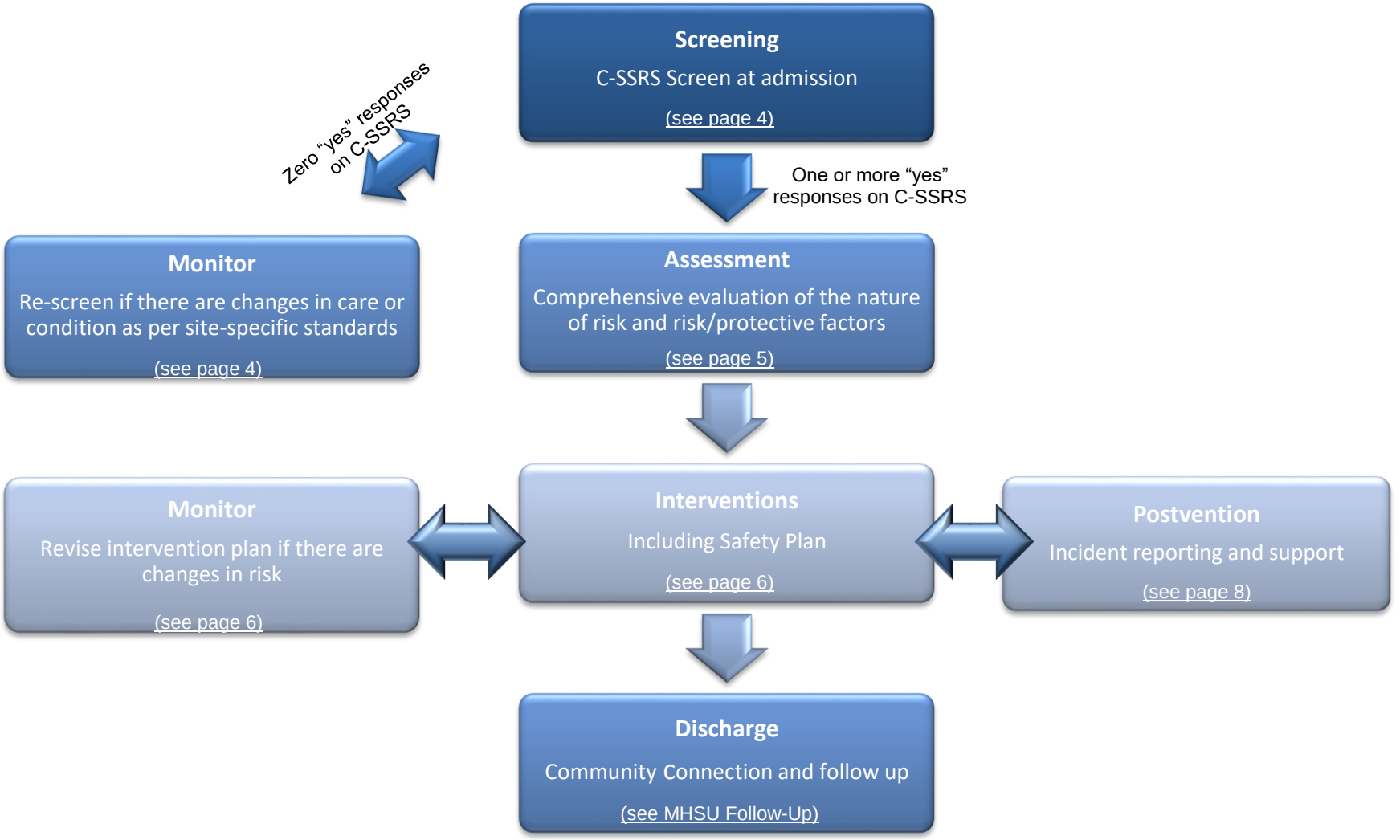
Appendices

All Sites:	Appendix A: Overview of Suicide Risk Management Process
	Appendix B: Risk Factors, Capability, Warning Signs, and Protective Factors
	Appendix C: Suicide Risk Care Plan (Optional)
	Appendix D: Safety Plan
Cerner Sites:	Appendix E: PHC/VCH Cerner Sites – Overview of Key Documentation Tools
	Appendix F: Comprehensive Suicide Assessment
VCH Sites:	Appendix G: VCH C-SSRS Screen Version
	Appendix H: VCH C-SSRS Risk Assessment (Optional)

Appendix A: Overview of Suicide Risk Management Process



Appendix B: Risk Factors, Capability, Warning Signs, and Protective Factors

Suicidal ideation develops from the combination of unbearable pain (usually psychological) and hopelessness that things can improve (May et al., 2020). Pain and hopelessness can arise from a wide variety of **risk factors** and **social determinants of health**. **Protective factors** build resilience against risk factors that escalate ideation, and understanding an individual's relationship to the protective factor can help us to understand if (and how much) it will keep life worth living despite pain and hopelessness.

A key determinant in the progression from ideation to attempt is **capability** – in other words, an individual with suicidal ideation will only make a suicide attempt if and when they have the capacity to do so. **Warnings signs** are indicators that this escalation from ideation toward attempt may be occurring. While every individual is unique, see the lists below for examples of each.

Social Determinants of Health	
Factors that impact individual and community health (positively or negatively) including suicide risk	• Historical and socioeconomic context (including systemic discrimination, racism, intergenerational trauma, poverty) • Community resources and capacity (including barriers to care or experiencing discrimination and inequity while seeking care) • Physical and social environments • Health behaviours, coping skills, and relationships (including perspectives on suicide and mental wellness)
Populations over-represented in cases of high suicide risk due to social determinants of health	• Indigenous peoples (including some First Nations and Metis communities and all Inuit communities). (See In Plain Sight for more information.) • 2SLGBTQ+ (two-spirit, lesbian, gay, bisexual, transgender, queer, and other gender/sexual minorities) • People in poverty • People who are unhoused or underhoused • People who are not involved in a relationship (e.g., widowed, divorced, separated)
Risk Factors	
Clinical	• Past or current suicidal ideation and/or suicidal intent • Past suicide attempts • Past or current substance misuse or other addiction (e.g., gambling) • Past or current major psychiatric illness, including mood (especially depression, bipolar), psychosis (e.g., schizophrenia), thought disorders, and/or anxiety (e.g., panic attacks) • Past or current non-suicidal self-harm • Personality disorder (e.g., borderline, narcissistic, antisocial) • Impulsive or violent traits by history • Family history of suicide and/or psychiatric illness • Major physical illness or chronic pain, loss of health status
Situational	• Social isolation (e.g., new or worsening estrangement, rural location) • Major or multiple losses or stressors (economic, occupational, relational)

	• Transitions in care (e.g., discharge from hospital) • Past or current abuse (physical, sexual, psychological) • Indian Residential School or Indian Hospital experiences • Past or current trauma (acute, chronic, complex) • Experience of racism (interpersonal, structural, internalized) • Pregnancy

Demographic	• Gender: Men are more likely to die by suicide, while attempts are more frequent in women
	• Older adults, particularly if there are:
	  • Generational biases regarding seeking help from professionals
	  • Multiple losses: loved ones, home, job, social role, independence, health
	  • Fears of institutionalization

Capability	
Dispositional	• Temperamental, personality, or genetic factors that may decrease aversion to self-inflicted pain, injury, and death (e.g., low pain sensitivity)
Acquired	• Exposure to life experiences associated with pain, injury, death and fear that over time increase habituation and desensitization to the natural fear of death (e.g., physical abuse, non-suicidal self-injury, suicide of a loved one, combat training, exposure to injuries/death through work)
Practical	• Concrete factors that increase an individual's knowledge of, access to, and/or expertise in lethal means (e.g., firearms, lethal toxins, prescribed medications) – this may be the most important form of capability in predicting suicide attempts. • Practical capability can be increased or decreased rapidly (e.g., researching on the internet methods to die, no longer having privacy to carry out their plans).
Warning Signs	
Examples	• Social withdrawal • Thoughts/signs of hopelessness • Increased use of substances • Saying goodbye and/or thanking people • Frequency and intensity of suicidal ideation • A clear, detailed, formulated plan • Risk taking • Researching methods, obtaining sharp objects, or hoarding medication • Talking about being a burden • Preparations for death/getting affairs or wills in order/giving away belongings • Communication of suicidal intent, suicide note
Protective Factors	
Examples	• Connectedness with close friends or family, community, employment, pets, interests or hobbies, a valued identity or role, or any sense of purpose or meaning • General health and wellbeing

- Community participation, ceremony, and cultural expression (Indigenous peoples in particular)
- Access to culturally safe, consistent, and trusted clinical care/support and positive therapeutic relationship/alliance
- Hope/goals for the future
- Effective problem-solving and coping skills
- Self-worth/self-esteem
- Spiritual/cultural/religious beliefs, faith community/religious clergy, practices, and identity
- Awareness of significant others about their suicidal thoughts
- Stable relationship and/or presence of dependent children

Appendix C: Suicide Risk Care Plan (Optional)

Available via FormFast (Form 10973 – PS296). Also coming soon to VCH Forms.

Providence Health Care
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INPATIENT MENTAL HEALTH & SUBSTANCE USE SUICIDE RISK CARE PLAN

* 1 0 9 7 3 *

Interdisciplinary Care Plan

SUICIDE NURSING CARE PLAN		
	Strategy and details (check all that apply)	**Notes**
Safe Environment	☐ Check/remove unsafe items from patient's room ☐ Patient's room moved closer to nursing station ☐ Patient in hospital pajamas ☐ Offer sensory modulation or de-stimulating surroundings ☐ Other:	
Patient Monitoring	☐ Close observation (Q15MIN) ☐ Constant care 1:1 monitoring ☐ Hold passes ☐ Regular assessment of distressing symptoms (e.g. hallucinations, anxiety, pain), level of risk and/or worsening of suicidal ideation ☐ Assess need/effectiveness of PRN medications and other interventions ☐ Other:	
Clinical Approach	☐ Use trauma-informed and culturally safe approach ☐ Establish therapeutic rapport and collaborative partnership with patient ☐ Establish interdisciplinary team approach, with regular discussions regarding patient's presentation and level of risk ☐ **Collaborate with patient to complete a Mental Health Safety Plan** *[Form 10236]* (one copy to patient, one copy for chart) ☐ Offer education/counselling to patient ☐ Liaise with support person(s) regarding patient's presentation and level of risk ☐ Other:	
Discharge	☐ Review Mental Health Safety Plan *[Form 10236]* with patient and support person(s) ☐ Collaborate with community/primary services for continuity of care ☐ Provide information about community resources and psychiatric follow-up appointment details on **When I Leave Hospital** *[Form 11369]*	

Signature: _____ Printed name: _____ Date: _____

Appendix D: Safety Plan

Available soon via Cerner (FormFast) and VCH Forms.

MY SAFETY PLAN

Date of Safety Plan/Update: _____

My family/support person(s) are: ☐ aware of my Safety Plan (where possible & with my consent) ☐ not aware of my Safety Plan

Step 1 Warning Signs that a crisis may be developing *(e.g., thoughts, images, mood, situation, behaviour)*			
1. 2. 3.			
Step 2 Internal Coping Strategies to take my mind off my problems *(e.g., relaxation technique, physical activity)*			
1. 2. 3.			
Step 3 People and Social Settings that Provide Distraction			
1. 2. 3.			
Step 4 People I Can Ask for Help			
1. Name: Contact: 2. Name: Contact: 3. Name: Contact:			
Step 5 Professionals or Services I Can Contact			
Step 6 Make my Space Safer *(e.g., remove unsafe items)* **or Go to a Safer Place**			
1. 2. 3.			
Step 7 Call or Chat with Crisis Lines			
Step 8 Receive Emergency Services			

Reviewed by: _____ Patient Name _____ Support Person (where possible with consent) _____ Staff Name

Appendix E: PHC/VCH Cerner Sites – Overview of Key Documentation Tools

For sites on Cerner, the following tools are recommended to support documentation related to suicide risk screening, assessment, care planning, and safety planning.

Stage	Recommended Cerner Tool(s)	Access	Example(s) & Cerner Instructions
Screening (Initial)	C-SSRS Quick or Full Screen	Powerform triggered as a nursing task on admission OR available via *AdHoc folder*	CST Cerner Help: CSSRS Screen
Screening (Ongoing)	Ongoing C-SSRS	MH Adult Quick View band – accessible via Interactive View (*iView)*	CST Cerner Help: Interactive View (choose *Ongoing Columbia Suicide Severity Rating*)
Assessment	Nursing Narrative Note For ED: MH Emergency Nursing Assessment	Accessible *Documentation*	Appendix F
Interventions: Suicide risk care plan	Suicide Risk Care Plan (place copy in chartlet and document care planning undertaken in Nursing Narrative notes)	VCH Forms (coming soon) PHC FormFast (Form 10973 - PS296)	Appendix C
Interventions: Safety plan	My Safety Plan (place copy in chartlet and document safety planning undertaken in Nursing Narrative notes)	VCH Forms (coming soon) PHC FormFast (Form 10236 - PS293)	Appendix D

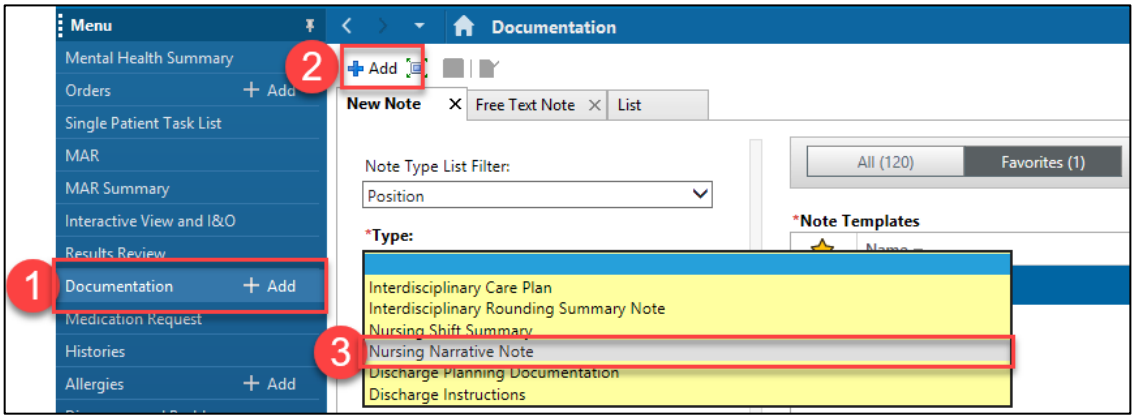
The following **alerts** are available for patients with positive suicide risk:

Alert	Recommended Cerner Tool(s)	Example(s) & Cerner Instructions
Suicide Risk Alert	Identify suicide risk by applying a Suicide Risk Process Alert (alert is visible on Care Compass)	CST Cerner Help: High Risk Alerts
Special Care Plan Alert	Identify a suicide risk care plan has been completed by applying a Special Care Plan Alert (alert is visible on Banner Bar)	CST Cerner Help: Process Alerts

Appendix F: Cerner – Comprehensive Suicide Assessment

Nursing Narrative Notes

A comprehensive suicide assessment should be documented as a Nursing Narrative Note via Documentation and **ensure the title reflects a comprehensive suicide assessment**.



Comprehensive suicide assessment completed as a Nursing Narrative Note via Documentation

Sample Documentation

Example 1

46 year old male, recently divorced experiencing second episode of major depression. Denies current suicidal ideation, but presents with notable risk factors including: past history of serious suicide attempt by overdose two years ago and reports daily of panic attacks and increased anxiety. Identified loss of marital support as a recent trigger and unable to verbalize meaningful protective factors. Nurse completed environmental safety check of room, scissors removed and stored in nursing station. Encouraged to attend group activities on unit. Patient given 2mg Ativan po PRN at 1300h for “panic attack.” Patient described PRN as “effective” and was able to participate in art therapy with recreational therapist at 1400h. Plan to discuss individual and interpersonal coping strategies for managing anxiety this afternoon. Will continue to assess and monitor for changes in mental status.

Example 2

37 year old, married female experiencing postpartum psychosis. Currently endorses active suicidal ideation, expressing "desire to jump off the Burrard street bridge." No date or time planned, but reports reflecting on plan two to three times a day. Identified pressure to breastfeed and fear of someone kidnapping her baby as major sources of distress. No documented history of self-harming behaviour or past suicide attempts. Current risk factors include: family history of schizophrenia (father and uncle), chronic low back pain, stress of caring for a 1-week old newborn (currently cared for in NICU), and paranoid delusions related to her "brother trying to steal (her) baby." She is uncertain that her situation will ever change, describing her circumstance as "hopeless." Patient denies thoughts of harming others or her baby. She states that she "loves her child more than anything and would never do anything to hurt her." Moreover, she describes her baby as her main reason for living. Additional protective factors including ties to church and strong family support network. Nursing completed an environmental safety check of patient's room (no unsafe objects found), supporting patient in using the sensory modulation room during periods of anxiety, holding unaccompanied passes, collaborating with maternity nurses to provide education related to breastfeeding and breastfeeding alternatives, and facilitating visits with baby in the NICU. Will continue to assess and monitor for changes in mental status.

Appendix G: Columbia-Suicide Severity Rating Scale (C-SSRS) Screen Version

Available via VCH Forms. For Cerner Sites, see Appendices E & F.

Vancouver CoastalHealth

PATIENT LABEL

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: *Was this within the past three months?*		

Appendix H: Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment (Optional)

Available via VCH forms.

Vancouver CoastalHealth

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

PATIENT LABEL

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)
☐	Actual suicide attempt ☐ Lifetime	☐	☐ Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	☐ Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐	☐ Mixed affective episode (e.g. Bipolar)
☐	Other preparatory acts to kill self ☐ Lifetime	☐	☐ Command hallucinations to hurt self
☐	Self-injurious behavior *without* suicidal intent	☐	☐ Highly impulsive behavior
Suicidal Ideation Check Most Severe in Past Month			☐ Substance abuse or dependence
☐	Wish to be dead		☐ Agitation or severe anxiety
☐	Suicidal thoughts		☐ Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)		☐ Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)		☐ Homicidal ideation
☐	Suicidal intent with specific plan		☐ Aggressive behavior towards others
Activating Events (Recent)			☐ Method for suicide available (gun, pills, etc.)
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		☐ Refuses or feels unable to agree to safety plan
Describe:			☐ Sexual abuse (lifetime)
			☐ Family history of suicide (lifetime)
☐	Pending incarceration or homelessness		**Protective Factors (Recent)**
☐	Current or pending isolation or feeling alone		☐ Identifies reasons for living
Treatment History			☐ Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments		☐ Supportive social network or family
☐	Hopeless or dissatisfied with treatment		☐ Fear of death or dying due to pain and suffering
☐	Non-compliant with treatment		☐ Belief that suicide is immoral; high spirituality
☐	Not receiving treatment		☐ Engaged in work or school
Other Risk Factors			**Other Protective Factors**
☐			☐
☐			☐
☐			☐
Describe any suicidal, self-injurious or aggressive behavior (include dates)			

First Released Date:	24-JAN-2020	
Posted Date:	21-DEC-2023	
Last Revised:	21-DEC-2023	
Last Reviewed:	21-DEC-2023	
Review Due by:	21-DEC-2026	
Approved By: *(committee or position)*	PHC	VCH
	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
		Regional Mental Health and Substance Use Lead, VCH