## SECTION 10: SUICIDE AND SELF-HARM PREVENTION

This section provides guidance for **[insert organisation name]** in responding to client observation, allegation and disclosures indicating potential self-harm and/or suicide risk.

**[Insert organisation name]** is committed to good practice in the prevention of suicide and self-harm through the development, implementation and review of procedures based on current evidence.

### 10.1 Suicide and self-harm prevention principles

* All indications of suicide, suicidal behaviour and self-harming are taken seriously and acted upon in a timely and professional manner.
* All workers receive training and supervision appropriate to their role in responding to clients at risk of self-harm and suicide.
* When responding to issues relating to suicide and self-harming behaviour, the physical and emotional safety of the client, their family and workers are considered at all times.
* All staff members have a role in detecting acute suicide risk, identifying background risk factors and ensuring appropriate assessments and interventions are undertaken.
* Where appropriate, the service liaises with and shares information with other professionals to respond to client suicidality and self-harming behaviour.

### 10.2 Suicide warning signs

All staff are aware of the different warning signs for suicide, as they indicate an elevated risk for potential suicidal behaviour.

**Direct Signs[[1]](#footnote-1):**

* Suicidal communication: Someone threatening to hurt or kill themselves or talking of wanting to do so. This could include ominous utterances, such as speaking of going away, or of others being better off without them.
* Seeking access to a method: Someone looking for ways to kill themselves by seeking access to pills, rope or other means.
* Making preparations: Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

**Indirect signs**:

Indirect signs are related to significant recent life events which may include:

* Break up with a partner/relationship/significant relationship problems
* Experience(s) of trauma
* Impending legal event or child custody issues
* Past history of suicide attempt/family history of suicide or suicide attempt/recent suicide of friend
* Loss of loved one.

**🖌Note\***

Other indirect signs could include:

* Financial crisis, job loss or other major employment setback
* Withdrawal or intoxication
* Chronic pain/illness
* Recent discharge from treatment service
* Relapse.

Also, some organisations use mnemonics to identify indirect signs. For example “**IS PATH WARM**?”

**I** = Ideation

**S** = Substance abuse

**P** = Purposelessness (loss of purpose/reason for living)

**A** = Anxiety (worry, agitation, sleep disturbance)

**T** = Trapped (feeling of being unable to escape situation)

**H** = Hopelessness

**W** = Withdrawal (from others)

**A** = Anger (rage, aggression)

**R** = Recklessness

**M** = Mood changes

\*Please delete note before finalising this policy

### 10.3 Confidentiality and duty of care

**[Insert organisation name]** has a duty of care to do everything reasonably practicable to prevent client’s self-harm, suicide attempts or suicide. Staff have a duty of care to clients and take appropriate steps to ensure clients do not come to foreseeable harm by the action or inaction of staff.

Staff members understand that confidentiality is not absolute and must be balanced against duty of care where harm to the client or others is suspected. The organisation has a legal and professional responsibility to disclose information, where not reporting might otherwise cause harm to a client or another person.

Clients are clearly informed about the limits of confidentiality in documentation provided to them at intake.

Disclosure of confidential information remains nevertheless restricted to only those services or external clinicians directly assisting the client – with any information disclosed restricted only to that which is necessary for services to be rendered. Clients are informed of any disclosure of confidential information.

Where immediate danger to a child or young person is evident, the police and/or the Child Protection Helpline (phone **132 111**) is contacted immediately. For more details, refer to the Child Protection Reporting section of this policy and the Service and Program Operations Policy.

### 10.4 Suicide Prevention assessment and screening

All clients are assessed for suicidal behaviour and those presenting with suicidal behaviour are assessed to determine the level and immediacy of suicide and/or self-harm risk.

Assessment is not a one-off event and occurs throughout treatment. Staff understand that discussing suicide with clients is vital and will not increase the risk of suicidal behaviour. Rather, sensitive questioning by a member of staff can often be a relief for clients who have been harbouring thoughts of self-harm, and an opportunity for them to receive the help and support required.

Objective and subjective evidence is used to determine a client’s risk of suicide and/or self-harm. A comprehensive assessment draws on all available information, including: interviews with the client; observation; medical, psychiatric and personal history; feedback from other staff; and information from family and carers.

Intoxication can prevent a valid immediate assessment; however, the presence of suicidal thoughts in clients who are intoxicated puts the client at high risk and this is dealt with accordingly.

**[Insert organisation name]** implement the following suicide prevention procedures:

#### 10.4.1 Suicide screening tool

**[Insert name of suicide screening tool]** is an essential part of the assessment process. The tool provides a risk rating to guide staff responses. This tool should be implemented and assessed at any significant transition points within treatment (e.g., intake, review, discharge), in addition to any time where client crisis is clearly visible or suspected.

The screening tool aims to:

* Ascertain the client’s level of suicidal risk;
* Determine what intervention and management strategies are necessary; and
* Develop a safety plan to reduce risk.

#### 10.4.2 Management and intervention procedures

Following the use of **[insert name of suicide screening tool]**, staff members assess the suicide risk level and inform the intervention required.

Intervention procedures based on the risk level include:

**Low risk**

* **[Insert intervention activity]**
* **[Insert intervention activity].**

**Moderate risk**

* **[Insert intervention activity]**
* **[Insert intervention activity].**

**High risk**

* **[Insert intervention activity]**
* **[Insert intervention activity].**

**🖌Note\***

Organisations are encouraged to identify a suicide prevention screener that is appropriate for their services and client’s needs; however, a suicide risk screener template and possible interventions based on the risk level are provided as part of this policy.

\*Please delete note before finalising this policy.

#### 10.4.3 Keep safe strategies

As part of the **[insert organisation name]** intake process all clients are provided with a Keep Safe Strategies Handout which is a list of helpful strategies that they might employ when confronted with suicidal thoughts.

Staff members are instructed to:

* Inform and clearly explain that the strategies are provided to help them through difficult times that may arise during treatment or after treatment.
* Discuss these strategies with clients and encourage them to consider and add other options.
* Encourage clients to keep the list in a safe, convenient location for ease of use and provide extra copies where necessary and throughout the service.
* Encourage the use of these strategies at all times and provide clients with extra copies if necessary.

#### 10.4.4 Client safety plans

Safety plans are developed following the implementation of a suicide assessment and screening process, and when there needs to be a crisis response or contingency strategy, staff members develop a Safety Plan. Safety Plans are developed in two instances:

* **During treatment:** safety plans are developed between the staff member and client with suicidal ideation and lists a range of different tailored strategies the client can use to address suicidal thoughts, including those intervention activities identified as part of the suicide screening tool. Each plan contains specific strategies based on the client’s need and risk involved. This document is attached to the Client Treatment Plan and Review Form and saved on the client file.
* On exit **[The following is primarily for residential services although may be applicable to outpatient services. Delete if necessary]:** the Client Exit Summary Form includes a safety planning section and is used when a client exits the organisation’s service or program. This section provides support and strategies for clients following discharge, as it can be a difficult transition without the structure and support of the organisation.

#### 10.4.5 Client commitment to treatment

When a client expresses suicidal ideation, commitment to treatment is agreed with the client on the Commitment to Treatment Form in order to encourage participation in the therapeutic process and all that it entails.

The Commitment to Treatment Form may include:

* Session attendance and participation
* Goal setting
* Homework
* Medication compliance
* Implementation of a safety plan
* **[Insert other inclusion]**
* **[Insert other inclusion].**

This is a collaborative process made in consultation with the client and is reviewed every **[insert frequency]** after the date of commitment.

**🖌Note\***

Recent evidence indicates that the traditional practice of using written or verbal contracts where the client pledges not to harm themselves may not be effective and may in fact potentially cause harm. As a result, a commitment to treatment pledge from the client is suggested as an alternative. For more information on this research, refer to the Suicide Assessment Kit (SAK). Deady, M., Ross, J. & Darke, S. (2011) Sydney, National Drug and Alcohol Research Centre (NDARC).

\*Please delete note before finalising this policy

#### 10.4.6 Consultation

All suicide prevention assessments and screening processes are discussed with a colleague or senior staff member in the next **[insert timeframe, example 24 hours]** where suicidal risk has been identified as low or moderate. In the case of a high suicide risk immediate consultation occurs, or as soon as possible. All high suicide risk level cases are considered critical incidents and are managed as per the Work Health and Safety Policy.

If direct supervisors or managers are not available, staff members are to contact **[insert senior staff and/or management role and name]** on **[insert contact number and email]** to support staff members when a case review or discussion is needed.

All staff recognise the limits of their competencies and actively seek clinical supervision, or where necessary, facilitate links to further levels of care.

#### 10.4.7 Suicide prevention referral process

If risk of suicide or self-harm is assessed as being moderate or above, an immediate referral is made to a specialist mental health service for priority assessment and intervention. The client is accompanied to the mental health service and/or hospital by a staff member, or arrangements are made for the assessment to take place at **[insert organisation name]**, or other safe arrangements are made for the client to attend the specialist mental health service.

The organisation maintains a referral directory and has established referral protocols with external services as per Section 5 of this policy.

**🖌Note\***

In organisations with exclusion criteria in place for clients with self-harm and suicide risk, please ensure to add the following statement:

“The organisation is committed to ensuring that all clients whose assessment indicates a moderate or high level of suicide risk are referred and/or transferred to another service provider so that risk to the client is appropriately managed by an organisation equipped to support their needs.”

\*Please delete note before finalising this policy

### 10.5 Monitoring, discharge and re-entry

* **[For outpatient services]**

At **[insert organisation name]** clients who have been assessed as being at risk of suicide and/or self-harm but who have not attended their scheduled appointments are actively followed up by a staff member.

* **[For residential services]**

When clients complete their program or exit the organisation voluntarily or involuntarily, they and their family members and support network are provided with contact details for crisis support, re-assessment/re-entry procedures and other treatment options. Any foreseeable barriers to assessment and re-entry to the appropriate level of care are anticipated, discussed and circumvented.

When clients exit the program, staff consider issues such as whether it is appropriate to return all medications that a client arrived with, as it may be safer for the client if the amount of medication returned to them is limited to two or three days’ use. All decisions are agreed with the client and the staff direct supervisor or senior manager on site, and are recorded on the Client Treatment Plan and Review Form and Client Exit Summary Form.

### 10.6 Professional development, supervision and support

**[Insert organisation name]** recognises that suicide risk assessment and interventions are core skills for staff with direct client contact, thus knowledge and practice are reviewed and updated regularly. All current and new staff are familiar with this policy and receive mandatory training in the recommended procedures held as required, or every **[insert time frame, e.g. 24 months].**

It is recognised that supporting clients who are at risk of suicide is challenging and emotionally draining and as a result the organisation is committed to providing supportive networks and resources for staff. Staff are encouraged to remain aware of their own emotional reactions and seek support from their supervisor and colleagues as required.

Following an emergency incident involving a client who is suicidal or self-harming, staff are offered access to immediate debriefing support.

For more information please see the Clinical Supervision Policy and Work Health and Safety Policy.

**🖌Note\***

For more information on specific practice guidelines on dealing with suicidal clients, please see the Suicide Assessment Kit (SAK) reference by Deady, Ross & Darke (2011). Also see the NADA website <http://www.nada.org.au/nada-focus-areas/mentalhealth/suicide-prevention/> for other useful resources.

\*Please delete note before finalising this policy.

### 10.7 Fatal incident

**[Insert organisation name]** recognises that a client’s suicide will impact on other clients, staff, students, volunteers, the client’s family and friends, and the wider community.

Co-ordinated responses are implemented with the aim of supporting those bereaved by suicide and preventing further suicide events. Expert advice about appropriate and safe intervention responses is provided by relevant organisations and specialist consultants.

Where appropriate, staff, students, volunteers and clients are provided with written information and resources about suicide bereavement..

#### 10.7.1 Initial actions for staff

Following the death of a client from suicide, staff members are encouraged to follow the Fatal Incident Procedures outlined in the Work Health and Safety Policy.

#### 10.7.2 Initial actions for clients

Following the death of a client from suicide, the **[insert position(s)]** provide current clients with relevant information about the death. Information is given to individuals or small groups of clients, rather than large assemblies. The emphasis is on developing understanding without condemning or glorifying the suicidal event or client.

The **[insert position(s)]** is to arrange professional group debriefing sessions for clients where relevant. Participation in these sessions is voluntary. Clients are also provided with opportunities for individual debriefing and support as required.

The organisation recognises that some staff members may not feel comfortable or have the capacity to discuss a client’s suicide with other clients. This decision is respected, and alternative sources of support are arranged for clients.

Following the death of a client from suicide, the organisation identifies clients who may be at increased risk of suicide and/or self-harm, and assists them to access appropriate support.

For more information on client support after an incident, please refer to the Work Health and Safety Policy.

### 10.8. Documentation and record-keeping

All client documents and records are appropriately managed as per the Client File Management Section of the Service and Program Operations Policy.

The organisation ensures that:

* All details of risk assessment, management plans and observations are clearly documented in the appropriate forms in the client file.
* Consideration is given to the potential need for record-sharing and potential Freedom of Information claims.

Relevant sources of corroborative history and outcomes from contact with each source are documented.

* Responses to clinical interventions are noted.
* If the decision is made to manage the client in the community sector, as opposed to hospitalisation, the rationale and reasons for the decision are documented clearly.

If family, other care providers and health professionals contact a staff member in regard to a person at risk, all concerns are documented.

1. * [Substance Abuse and Mental Health Services Administration (US)](http://www.samhsa.gov/); 2009, Treatment Improvement Protocol (TIP) Series, No. 50. Center for Substance Abuse Treatment. Accessed <http://www.ncbi.nlm.nih.gov/books/NBK64025/> on 3 December 2014

   [↑](#footnote-ref-1)