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Recognising & Managing Suicide Risk: a practice guideline for Trust practitioners

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Practice Guideline

Principles

The fundamental principles in the management of the suicidal person are:

- to do everything to ensure that they physically survive the episode of hopelessness and despair they are presently suffering, which will involve developing a plan of care that incorporates goals that will instil a sense of hope in the individual, as well as facilitating their sense of feeling supported;
- to maximise the safety of their environment;
- to promote the prevention of suicide through collaborative team working, involving all the interpersonal and community resources that one can involve (Shneidman 1993).

These principles are most likely to be achieved if (NPSA 2006):

- practitioners 'develop a trusting therapeutic relationship... ' in which service-users who feel suicidal or wish to self-harm can talk openly about how they feel and develop strategies together with staff about how to manage self-harm feelings and behaviours';
- an individual assessment of suicide risk is undertaken, particularly with those who admitted, have attempted suicide, have self-harmed in the past, and/or are currently expressing suicidal feelings.

It is important to note that 'non-suicidal self-harm, although not likely to be fatal, signals distress on the part of the service-user, accounts for a very large proportion of patient safety incidents and is of serious concern' (NPSA 2006).

Scope of the Issue

It is important to first be clear about the type of risk presented and the scope of the potential issue:

- self-harm is 'intentional self-injury or poisoning, irrespective of the current purpose of the act' (NICE 2004: 7);
- about 4% of the population self-harms and self-harm is one of the top five causes of acute medical admission for adults (Wilhelm et al 2000);
- it has been estimated that approximately 10% of those who engage in deliberate self-harm (DSH) will go on to commit suicide (Hawton 1997);
- approximately 4% of all suicides are psychiatric in-patients (Appleby 2000), a third of which occur in the first week of admission & another third during the period of discharge planning;
- it is therefore important to assess the person's current risk status by conducting an assessment with them, wherever possible, and recording this using the Trust's agreed risk assessment proforma.

Supporting *Positive Risk Management*

Viewed as an essential part of a carefully constructed plan that is developed through a collaborative approach, positive risk management 'means being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk' (DH 2007: 8-10).

This should be explicit in the decision-making process and will include:

- working with the service-user to identify what is likely to work;
- considering the views of carers / others when deciding a plan of action;
- weighing up the potential benefits and harms of possible actions;
- being willing to take a decision that involves an element of risk where the potential benefits outweigh the risk;
- communicating the potential risks and benefits, and the rationale for decisions to all involved;
- and, developing plans and actions that support the positive potentials of the service-user whilst minimising the risks.

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Assessing Risk

In deciding the person's presenting level of risk, it is considered most effective to use a structured professional and collaborative approach that involves the practitioner making a judgement about risk on the basis of: an assessment of clearly defined factors derived from research; clinical experience and knowledge of the service-user; and, the service-user's own view of their experience (DH 2007: 18-20).

Risk Factors

'A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur' (DH 2007: 13-14).

Different types of risk factors have been described:

- *Static:* unchangeable factors—such as having a history of risk (of child abuse or a suicide attempt), and though history of risk is arguably one of the best indicators of current and future behaviour, it is important to remember that there is always a first time
- *Dynamic:* factors which can change over time—such as the misuse of alcohol or the experience of symptoms (such as command hallucinations), and these may be aspects of the person, their environment or social context
- *Stable or Chronic:* these are dynamic factors that are quite stable and change only slowly
- *Acute:* factors or triggers that change rapidly, and so their influence on the level of risk may be short lived

As an aide memoire, a series of the well-known risk factors for suicide are summarised on the following page.

Remember: whether or not the level of risk is considered medium or high will depend upon:

- the number of risk factors currently evident;
- the history of risk behaviour;
- the recency, severity, frequency and pattern of previous risk behaviour;
- the individual's ideation and level of preoccupation;
- the individual's level of planning and statement of intent – *which should never be ignored.*

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Risk Factors for Suicide (DH 2007 & Other Sources)

Demographic	Clinical History
Male	Mental illness: depression with severe hopelessness; bipolar disorder; schizophrenia; severe anxiety
Younger or older age group	Personality Disorder: Borderline PD
Low socio-economic status	Physical illness, especially chronic or terminal conditions and/or those associated with pain and functional impairment
Unmarried > separated > widowed	
Unemployed or retired	Recent contact with mental health services
High risk occupational group (e.g. doctors, veterinary surgeons, farmers, nurses)	Recent discharge from an in-patient setting
White (3x more likely)	Persistent or poorly controlled symptoms
Background History	**Psychological / Psychosocial Factors**
Previous history of serious suicide attempt (especially if in the last year, by a more violent or lethal means and if leaving a suicide note)	Severe hopelessness
	Impulsiveness
Deliberate self-harm, especially if with high suicidal intent	Life event—for example: bereavement; loss; major stress; accommodation / housing problems
Childhood adversity e.g. sexual abuse	Low self-esteem
Family history of suicide	Relationship instability
Family history of mental illness	Lack of social support (isolation)
Alcoholism in the family	Alcohol / drug misuse
Current Context	
Suicidal ideation	Availability of means
Suicide plans, especially if making active preparations / final arrangements	Lethality of means

Asking Direct Questions

It is important to always ask direct questions when assessing the person's current risk status (Morgan 1998) - *for example:*

for actual self-harm / suicide

- Have you harmed yourself at any time?
- Describe what happened when you tried to harm yourself now / in the past?
- Did you make a plan to harm yourself? Can you describe your plan?
- Did you make any attempt to avoid being discovered? If so, how?
- What were your reasons for the attempt?
- What did you expect to be the outcome of your attempt?
- How do you feel about what you did now?
- Do you have a history of using alcohol or drugs?

for thoughts of self-harm:

- Have you ever had thoughts of self-harm?
- Can you describe these thoughts?
- Do you have these thoughts now?
- When was the last time you had these thoughts?
- How long have you been thinking in this way and how do these thoughts occur?
- Prior to this, have you ever expressed these thoughts to anybody? If so, who?
- What was happening in your life when these thoughts started?
- Are you thinking of a particular plan?
- What is preventing / has prevented you from acting on these thoughts?
- What would you do if these thoughts reoccurred?
- How do you feel now?

Just as it is important to ask direct questions to identify risks and precipitating factors, remember to ask about protective factors and coping strategies.

Using Structured Assessment Tools

It is worthwhile to consider the use of specialised structured assessment rating tools as an *adjunct* to practice assessment. Contributing one part of the overall view of risk, tools should only ever be used as *part* of the structured risk assessment approach with a service-user (DH 2007: 30).

Using structured risk assessment rating tools is recognised as good practice, assisting the practitioner to systematically evaluate and determine the seriousness of risk. Examples include the Beck Hopelessness Scale (Beck

1974) and Beck Scale for Suicide Ideation (Beck et al 1988). Though many of these tools are subject to copyright, some are freely available within the public domain. Using tools can help in providing a baseline against which any subsequent event can be measured and, when repeated, may provide information about the longitudinal course of the person's illness, and help in monitoring the effectiveness of care interventions (Kelleher 2007).

Assessment tools should be completed with the service user, wherever possible. For some tools, the service-user is asked to rate the worst they have been during the rating period, and if this is very different from how they feel now, this will need to be noted in the care plan. The findings from the assessment tool should be shared with the service-user and carer, following which a joint care plan should be devised that addresses all positively rated items (risks) on the tool.

Good Practice Guidelines (based on: Duffy & Ryan 2005)
Always ask about suicidal risk, thoughts and behaviour, and clearly document the response.
Be sure to record the service-user's thoughts and behaviours in the service-user's practice records.
Undertake risk assessment as a multi-disciplinary activity, wherever possible.
Whenever a decision needs to be made, always seek a brief but formal consultation with the service-user, and remember to clearly document the decision and the rationale for such.
Communicate with all those who are likely to be involved in the service-user's care, including the family and carers.
Make sure that all concerned are aware of how to access services in the event of a crisis or emergency situation.
Work closely with the service-user to empower them to ensure their own prevention of risk behaviour, building self-worth, inspiring hope and reducing their sense of helplessness by giving back the reins of control and by teaching stress reducing ways of managing emotions.
Remember: in the eyes of a Court, if it is not written down then it did not happen.

Managing Suicide Risk

If through your assessment you become aware that the service-user may be at risk of self-harm or of taking their own life, always refer them to the Consultant Psychiatrist / SHO for a further assessment of suicide risk. If the service-user does indeed present a significant risk of self-harm / suicide, a specific plan of care aimed at managing the risk must be developed and agreed—preferably in close collaboration with them and their main carers. Those who present a significant risk should receive care under the Care Programme Approach (CPA) (DH 2008).

When planning care, consider the following:

1. undertaking ongoing assessment through direct face to face contact
2. communicating the nature & degree of risk to all involved parties
3. providing information to carers on how to best help the person to engage with their plan of care and treatment and how to contact a team-member at all times (NIMHE 2003)
4. mobilising supportive resources e.g. support network, day-care services, telephone helplines
5. ensuring safe prescribing – *for example:* prescribing less toxic medications; giving medications that have fewer side-effects; dispensing in smaller supplies (no more than 7 days); involving a carer in supervising or safe-keeping the medication; ensuring that letters to the GP include specific and explicit advice on appropriate prescribing quantities
6. focusing upon alternative coping strategies, which will involve building on the service-user's strengths and coping resources
7. exploring & reinforcing the advantages of positive actions—for example: viewing self-harm / suicidal thoughts as symptoms; promoting hope; exploring and reinforcing reasons for living; generating alternative and positive solutions to problems / difficulties; weighing up the pros and cons of different actions; the use of distraction techniques; activity-planning; time-out strategies
8. supporting the service-user's application of problem-solving strategies
9. planning and supporting positive 'therapeutic' risk-taking, within agreed set limits
10. making arrangements for increasing the frequency of contact with the care coordinator / other sources of support and help
11. in preparation for discharge from an acute in-patient unit, the service-user's discharge care-plan (CPA care plan) must specify: the arrangements for promoting engagement and concordance with ongoing care and treatment; the arrangements for follow-up care by a team-

member within the first 48-hours after discharge; actions aimed at monitoring and managing risk during the first three months after discharge (NIMHE 2003)

and where necessary, limiting the opportunities for self-harm / suicide by: referring to the CRHT team and / or admission to the acute in-patient unit to ensure safety, and for assessment and treatment (*for those who are admitted to an acute in-patient unit or accepted for home treatment by the CRHT team, the service-user's care coordinator must remain in contact with the service-user and the supporting team in keeping up-to-date with ongoing care requirements, and facilitating close liaison with all involved services*)

The care plan will need to address the following issues, where present (Hatton & Valente 1977):

- isolation / withdrawal,
- impaired functioning,
- access to resources and support from others,
- coping strategies,
- satisfaction with previous psychiatric help,
- instability of lifestyle,
- previous suicide attempts,
- disorientation / disorganisation,
- hostility,
- and, any evident degree of planning.

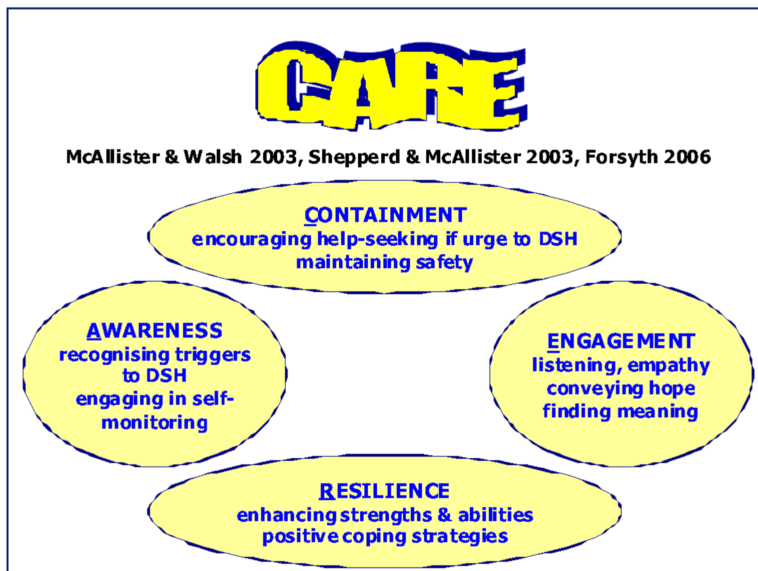
The care-plan must be written using an agreed care-planning proforma and should be signed by and copied to the service-user and to all involved parties.

Using a Framework

It may be helpful to use a framework through the continuum of wellness and illness to guide assessment and intervention, alongside other techniques, skills, theories and frameworks for providing care and facilitating recovery.

The dynamic CARE framework is an example of a relevant and practical tool for developing a plan of care for the person who deliberately self-harms (McAllister & Walsh 2003, Shepperd & McAllister 2003, Forsyth 2006), which is briefly summarised in Fig. 1.

Fig. 1: The Dynamic CARE Framework for Care Planning



Care Review

Timely and regular reviews of the service-user's care-plan must be undertaken by the individual practitioner and multi-disciplinary team. Reviewing the care plan will depend on the risk that was initially identified and on interventions planned with the service user, as the situation may change significantly over a short period of time. The risk assessment must be regularly updated.

The review process should focus on the effectiveness of the intervention, and be held within an agreed timeframe that has been negotiated with the service user.

It is important to maintain an awareness of misleading improvement and malignant alienation, as a consequence of the service-user's removal from stressful circumstances or the presentation of challenging / difficult behaviours. It is also important to recognise the risks associated with increasing motivation that is often a feature of initial improvement – this may mean that the service-user is now motivated to carry through their plan for

self-harm / suicide and therefore requires careful and detailed ongoing assessment.

Suicides and serious suicide attempts must be reviewed by a multi-disciplinary review panel that includes the staff involved in the service-user's care, with the aims of maximising the safety and well-being of patients, promoting learning and service development. Staff, service-users and carers must be given prompt and open information and offered access to effective support (NIMHE 2003).

Training

All staff who work with people at risk of self-harm / suicide are required to attend core training in the recognition, assessment and management of risk at least once in every three years (NIMHE 2003).

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