Suicide Prevention and Safe Care Guidance

v1.0 issued 16/02/2022

1 Background and Purpose of these guidelines

"Suicide is a major health issue and suicide prevention is a government priority. In the UK there are over 5000 suicide deaths per year, and nearly 500 further suicides in Ireland. Approximately three-quarters of these occur in men, in whom suicide is the second most frequent cause of death in those under 35 years of age. The most common method of suicide is hanging, followed by self-poisoning.

Approximately 90% of people dying by suicide have a psychiatric disorder, although this may not have been recognised or treated. Depression is the most common disorder, found in at least 60% of cases. This may be complicated by other mental health issues, especially alcohol misuse and personality disorders.

While most clinicians and care workers outside of psychiatric specialties will only experience a few suicides during their career, it is crucial that we are vigilant for people who may be at risk. The effects of suicide on families can be devastating.

It is important to recognise that the suicide of a client/patient can also have a profound effect on the professionals involved in their care. Following a suicide they may be helping support the people bereaved by the death, dealing with official requirements (e.g. response to the coroner and other agencies), and at the same time trying to cope with their own emotional responses."

The synopsis above is taken from Assessment of suicide risk in people with depression Centre for Suicide Research, Department of Psychiatry, University of Oxford

The purpose of these guidelines is to offer guidance for maximising suicide awareness and prevention and to highlight the provision of suicide safe care to all clients and staff in line with national best practices to promote life.

2 Who are these guidelines for?

Clients and their families, Case Managers, Case Management Assistants, Care and Support Staff, and any other professionals that may be involved in the client/patient's care.

3 Definitions

Suicide Threat: A suicide threat is a verbal or non-verbal communication that the individual intends to harm him/herself with the intention to die but has not acted on the behaviour.

Suicidal Act or Attempt: suicidal act (also referred to as suicide attempt) – a potentially self-injurious behaviour for which there is evidence that the person probably intended to kill himself or herself. A suicidal act may result in death, injuries, or no injuries.

4 Risk Factors

- A family history of mental disorder including suicide and/or self-harm.
- History of previous suicide attempts (this includes self-harm).
- Severe depression.
- Anxiety.
- Feelings of hopelessness.
- Personality disorder.
- Alcohol abuse and/or drug abuse.
- Male gender
- Physical illness (especially when this is recently diagnosed, chronic and/or painful).
- Exposure to suicidal behaviour of others, either directly or via the media.
- Recent discharge from psychiatric inpatient care.
- Access to potentially lethal means of self-harm/suicide.

"The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides."

Public Health England, September 2020

5 General Awareness and Prevention Strategies

If there is a previous history of threat or actual self-harm, it is vital to have a robust risk assessment and an action plan designating any specific named individuals to be promptly contacted, for example, psychologist, nurse, and, as necessary, law enforcement or mental health agencies.

If the person is not able to give consent, the clinician should act in the client's best interests. Where possible, this should involve consultation with family, friends or carers.

Where possible, be open and honest with clients about your concerns regarding the risk of suicide.

The assessment of clients with a history of self-harm will include the nature of the behaviour, frequency, and possible triggers. The origins and functions of self-harm for the individual and the link to mental illness should all be considered. An assessment for any Clinical Team may involve formal psychometric measures if appropriate.

The client should be actively involved in the assessment, if able, to ascertain and support their understanding of their behaviour and also support from staff that they feel would be most beneficial. In some cases, involvement from carers may be useful.

Encourage staff and family members to be aware of and report any unexplained and alarming changes in behaviour or personal habits.

Any staff member who observes or learns of behaviour believed to be an imminent threat of self-harm should report it to their line manager as soon as possible.

All suicidal indicators and or/self-harming behaviour should be recorded in detail in the clinical notes.

If the care team believes that the possibility of a serious incident of self-harm leading to suicide could be imminent, supportive observations must be considered as part of the risk management plan. During periods of observation, staff should record information relevant to the following:

- Level of co-operation with the observation process.
- Mood and verbalised thoughts and feelings – in particular, expressions of helplessness or hopelessness.
- Compliance with medication.
- Memory and orientation.
- Interpersonal engagement with staff/family.
- Level of physical activity.
- Sleep and appetite pattern.
- Any incidents of attempted self - harm or aggression.

"Self-harm describes any behaviour where someone causes harm to themselves, usually as a way to help cope with difficult or distressing thoughts and feelings. It most frequently takes the form of cutting, burning, or nonlethal overdoses. However, it can also be any behaviour that causes injury – no matter how minor, or high-risk behaviours. Basically, any behaviour that that causes harm or injury to someone as a way to deal with difficult emotions can be seen as self-harm."

Mental Health Foundation 'The Truth about Self Harm'

"Where practical, and with consent, it is recommended that clinicians inform and involve family, friends or other identified people in the patient's support network (such as the GP or Child Mental Health Service (CMHS)). This is particularly important where risk is thought to be high."

Assessment of suicide risk in people with depression Centre for Suicide Research, Department of Psychiatry, University of Oxford

6 Talking about Suicide

"Some clients may introduce the topic without prompting, while others may be too embarrassed to admit they may have been having thoughts of suicide. However, once the topic is raised, careful and sensitive questioning is essential. It should be possible to broach suicidal thoughts in the context of other questions about mood symptoms or link this into exploration of negative thoughts (e.g. "It must be difficult to feel that way – is there ever a time when it feels so difficult that you've thought

about death or even that you might be better off dead?"). Another approach is to reflect back to the patient your observations of their non-verbal communication (e.g. "You seem very down to me". "Sometimes when people are very low in mood, they have thoughts that life is not worth living: have you been troubled by thoughts like this?")."

Assessment of suicide risk in people with depression Centre for Suicide Research, Department of Psychiatry, University of Oxford

Ongoing and effective communication regarding issues and care of clients who are suicide risks, both verbally and in writing, is a key element of a good suicide prevention programme.

The majority of people who feel suicidal do not actually want to die; they just do not want to live the life they have. The distinction may seem small but is very important. It's why talking through other options at the right time is so vital.

By asking someone directly about suicide, you give them permission to tell you how they feel. People who have felt suicidal will often say what a huge relief it was to be able to talk about what they were experiencing.

Remember, once someone starts talking, they've got a better chance of discovering options that aren't suicide.

"Evidence shows asking someone if they're suicidal can protect them. They feel listened to, and hopefully less trapped. Their feelings are validated, and they know that somebody cares about them. Reaching out can save a life".

Rory O'Connor, Professor of Health Psychology at Glasgow University

Communication involves both informal sharing of information as well as more formalised opportunities, such as shift handovers, multi-disciplinary meetings, and debriefings especially following any critical incidents.

7 Intervention Strategies

Immediate notification to the police and other emergency assistance is imperative if a suicidal act is being actively threatened, or if someone is already injured or in immediate danger.

The first staff member on the scene must call for help (if possible) from another staff or family member, locate the individual, and contact emergency services on 999, immediately securing any medical treatment and/or mental health services, as necessary.

No suicidal person should be left alone, nor any confidences promised. Thus, in cases of a life-threatening situation, a person's right to confidentiality will be waived.

If required, staff members should move all other persons out of the immediate area and arrange appropriate supervision if needed. Others should not be allowed to observe the scene.

Any staff member, who is originally made aware of any threat or witnesses any attempt towards suicide or self-harm that is written, drawn, spoken, or threatened, should immediately notify the Case Manager and any authorities as required.

Staff should listen to and take seriously accounts of self-harm and respond with acceptance, understanding and respect. Disapproving, condemnatory, and punitive responses are not helpful. The client should be given regular attention and the opportunity to talk to a supportive member of staff whether an incident of self-harm occurs or not.

Staff should be aware of the potential of self-harm and should directly raise the possibility with the patient when appropriate by asking the person if they have hurt themselves.

Any threat in any form must be treated as real and dealt with immediately.

8 Post Intervention Strategies

A full incident report should be completed by the Case Manager or Care Agency in Charge within 24 hours following any attempt or threat situation. This should be shared with all relevant parties and professionals.

For services that are CQC registered any attempted suicide or attempt to self-harm is a notifiable incident under regulation 18 of the Health and Social Care Act.

The Case Manager/Agency should promptly follow up with any staff who might have witnessed the attempt. Appropriate support and/or professional help will be sought if required.

Should a staff member choose to decline immediate support they should be monitored for signs of post trauma and re-offered support as and when required.

Ongoing monitoring and regular risk assessments will be required to reduce risk of further incidents.

9 Recommended Training and Resources

Clinical Guide: Assessment of suicide risk in people with depression. Centre for Suicide Research, Department of Psychiatry, University of Oxford. https://www.dpt.nhs.uk/download/2hn1ZTaUXY

Centre for suicide research, University of Oxford Dept of Psychiatry, Medical Sciences Division: +44 (0)1865 902469 https://www.psych.ox.ac.uk/research/csr

Zero Suicide Alliance: https://www.zerosuicidealliance.com/training

National Suicide Prevention Alliance: Tel: 020 8394 8300 https://www.nspa.org.uk

The Samaritans: Freepost SAMARITANS LETTERS; Tel: 116 123; Email: jo@samaritans.org

10 References

Clinical Guide: Assessment of suicide risk in people with depression. Centre for Suicide Research, Department of Psychiatry, University of Oxford.

Gordon, H. (2002) Suicide in secure psychiatric facilities. Advances in Psychiatric Treatment. 8: pp 408-417.

Rory O'Connor, Professor of Health Psychology at Glasgow University. https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/myths-about-suicide/

Public Health England. Local Suicide Prevention Planning. A Practice Resource, September 2020.

https://www.mentalhealth.org.uk/publications/truth-about-self-harm

Prevention of Suicide and Minimisation of Self Harm. Thames Valley Forensic Mental Health Service, Oxford Health NHS Foundation Trust. Date of last review, February 2019

NHS Long term Plan, 2019.

HM Government. Preventing suicide in England: A cross government strategy to save lives. London: Department of Health; 2012.

NHS England Mental Health Taskforce. The five year forward view for mental health. NHS England; 2016.

NICE guidance - Preventing suicide in community and custodial settings (Nice Guideline 105) September 2018. NICE Standards CG16, CG133.

National Suicide Prevention Strategy (2012).