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desk guide

square

An education resource for primary health care, specialist and community settings

Most people who die by suicide have sought help in the weeks before death. Therefore the nature and quality of response offered by primary health care professionals is crucial.

Even a simple interaction like listening can be significant.

Everyone can make a difference.

suicide **qu**estions **a**nswers **re**sources

This **desk guide** aims to help you to respond appropriately to people who present at risk of suicide.

It is part of **square**, an integrated suicide prevention resource and fundamental building block for mental health promotion and the prevention of mental health problems. It should be used with the rest of the resources, not alone or as a substitute for an informed professional response. Its main focus is on adults, although much of it is also relevant to young people.

Suicide prevention is a whole of community responsibility and the best interventions are collaborative, involving:

- GPs and allied health workers
- family members
- friends
- neighbours
- community workers
- mental health specialists.

Note: Your own service or agency may have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this guide.

desk guide
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assessment and management of suicide risk chart

The following diagram represents some general principles and options for assessing and managing suicide risk. Some of the care and referral pathways will need to be adapted for individual clients.

- Engage with person's feelings and experiences
- Ask questions about suicidal thoughts or plans
- Be non-judgemental and respectful.

Assess risk level and initiate a **management plan**

If **LOW**, eg. **fleeting thoughts of self harm or suicide, but no past actions, current plan or immediate means**, low drug and alcohol use, little functional impairment and some positive options and relationships:

- Discuss support options and how to engage them.
- Consider self management as an option.
- Identify relevant community resources and provide contact details.
- **Make review appointment.**

If **MODERATE**, eg. depression, grief or loss, feelings of hopelessness, **suicidal thoughts with past actions but no current clear intent, plans or immediate means,** moderate functional impairment, social isolation, drug and alcohol misuse (but not out of control):

- **Attend to immediate safety.**
- Ask about significant others regarding support.
- Decide on appropriate care:
  - Management by GP?
  - Referral to or opinion from psychiatrist?
  - Involve mental health services? (eg. emergency or community team)?
- Contact relevant people/ services.
- **Follow up.**

If **SIGNIFICANT/EXTREME**, eg. continual, specific suicidal thoughts, intent, plans and means, significant past actions, mental illness, despair, significant functional impairment and social isolation, drug and alcohol misuse:

- **Attend to immediate safety. Don't let the person leave until a safety strategy is in place.**
- Ask about significant others regarding support.
- Decide on appropriate care and make immediate referral to:
  - Emergency Mental Health Services, or
  - Specialist practitioner (e.g. psychiatrist).
- **Follow up.**

square myths about suicide

Myth	Fact
Suicidal people want to die.	Most people are ambivalent and often fluctuate between wanting to live and wanting to die.
Asking about suicidal intent might encourage a suicide attempt.	Not true. In fact your concern is likely to lower anxiety and reduce the likelihood.
People who talk about killing themselves rarely suicide.	Most people who suicide have given some signal of their intention.
People who talk about suicide when under the influence of alcohol or drugs do not need to be taken seriously.	Anyone who talks about suicide should be taken seriously. Alcohol and other drugs are involved in many suicides.
Suicidal people rarely seek medical help.	Most suicidal people visit a GP in the days, weeks or months before they attempt suicide.
Suicidal attempts are just attention-seeking, 'cries for help' or 'acting out'.	Many people who attempt suicide go on to complete it sometimes much later. The attempt may be a rehearsal. Also, a suicidal attempt may well be a cry for help from someone in profound distress, and this should not be ignored.
Suicide is an extremely rare occurrence.	Suicide statistics are likely to be an under-estimate of the real number. There are also many more people who harm themselves or attempt suicide.
Suicide only affects certain sorts of people.	Anyone may be vulnerable when confronting difficult circumstances or when experiencing feelings of depression or hopelessness.
When someone seems to be suicidal, someone else is probably taking care of it. It is not my business to interfere.	Suicide is a community responsibility. Any concerned person can make a difference. Many distraught people do not have networks of support.
If someone talks about their suicidal intent, for confidentiality reasons you must honour this confidence.	You have a duty of care to ensure safety if you believe that the person presents an immediate risk to themselves or others. Ideally, you should always try and seek permission from the client to inform or involve relevant others.

engagement

The single most helpful response for a person who may be suicidal is to engage with them. Effective engagement can offer hope and may save a life.

- **Provide the opportunity and a safe environment for the person to talk.** Many distressed people do not choose to talk about their feelings unless invited to do so.	- **Do not panic or be afraid** of specifically mentioning suicide. Raising it in an appropriate way will **not escalate the possibility of suicide**.
- **Encourage the person to explore and describe what is going on for them.** People often send out a small signal during a conversation (verbally or non-verbally). It is important to let them know that you have 'heard' and that you are interested to know more.	- **Encourage trust.** Give the person information and consult about their preferences. Ask permission if you need to forward information to relevant people or would like to speak with significant people in their life.
- **Be empathic.** Many people do not disclose suicidal thoughts because of the stigma that is attached to being diagnosed with a mental illness or to 'not coping'. Respect and never dispute whatever feelings and experiences the person conveys.	- **Mental health problems are common.** At least 20% of a GP's consultations are likely to relate to anxiety or depression. Most people who suicide or attempt suicide have seen a primary health care professional in the weeks/month before the event. Where mental health issues are present, ask specific questions about suicidal thoughts.
- **Be open to diversity and difference.** If people experience stigma in their everyday lives, they are often quick to notice negative attitudes towards them. It is vital that stigma is not experienced in the very setting where help is being sought – from anyone.	- **Consider options.** If you do not feel able to engage effectively with a person who might be at risk, suggest another practitioner whom you would like them to see. Facilitate the appointment and check on safety issues in the interim. Stay involved — referral is part of management.

duty of care

Health workers have a duty of care to the people they treat. This means that they must take steps to ensure that the people they care for do not come to foreseeable harm by their actions or their failure to act.

Health workers are expected to be up to date with current duty of care protocols and practices and to take reasonable care in undertaking their duties. If a health worker fails to adopt and use the standard of care and skills that a court would reasonably expect from someone with professional skills, appropriate training and experience, they may be found guilty of negligence.

It is important that practitioners regularly assess and document suicide risk and provide appropriate treatment. However, it should also be noted that risk assessments cannot infallibly predict suicide risk; nor can they necessarily prevent suicide. In addition to adequate documentation, it is important that practitioners:

- consult with colleagues and relevant professional Associations to ensure the validity of decisions. (Various support is available for GPs in this regard, including peer support groups and advice from psychiatrists).
- know their legal and ethical responsibilities.
- are adequately aware of risk factors for clients.
- obtain previous risk assessment data or conduct risk assessments.
- critically assess and reflect on their own competencies in regards to suicide risk assessment and, if necessary, seek further training.
- consult with family members, carers and significant others.

Confidentiality

Information about a patient should not be given to anyone else without the patient's permission, unless there is a strong belief that the patient presents an immediate risk to themselves or others. In circumstances like this, duty of care would be more important than a potential breach of confidentiality.

Ideally, practitioners will be able to discuss and negotiate with the patient confidentiality and duty of care issues that may arise when information needs to be provided to other agencies requiring a patient history. It is also advisable that practitioners document (in relevant electronic or hard copy file records) conversations with patients regarding confidentiality and release of information. In this way practitioners would be able to avoid this potential legal dilemma.

risk assessment: clinical questions

The following questions about suicidal thinking and behaviour were designed by Dr Randall Long (Flinders Medical Centre) as part of a risk assessment process to assist health care workers. Dr Long advises that the questions be used in the sequence outlined, with each affirmative response to a question indicating that the next question should be asked. (See the Risk Assessment paper on the CD-ROM/Website for more information).

NB. Remember that these questions are designed to assist professional judgement, not replace it. They should be used in a context of effective interpersonal engagement.

Suicidal thoughts

- **Passive suicidal thoughts**
- Do you wish you didn't have to go on living?
- Do you have thoughts of wanting to die?
- **Active suicidal thoughts**
- Do you have thoughts of wanting to take your own life?
- Do you have suicidal thoughts?

Suicidal threats

- Have you talked with others about killing yourself?
- Have you told anyone that you were going to kill yourself?

Suicide plans

- Have you thought about methods to kill yourself?

If Yes

- **Decision** - Have you decided on a method to kill yourself?
- **Details** - Have you made a plan of exactly what you might do to kill yourself?
- **Resistance** - Have you been able to resist carrying this out?
  What stopped you putting the plan into action?
- **Preparations** - Have you started preparations to suicide?
- **Time Profile** - For how long have you had the plan?
  Have you set a date to kill yourself?
- **Affairs** - Have you put your affairs in order?
  Have you made arrangements for after you die?
  Have you written a note?

square risk assessment: clinical questions

Suicide attempt

- **Circumstances** - What were the circumstances of this attempt?
- **Method** - What did you do?
- **Intent** - What did you want to achieve (to die/to sleep/euphoria)?
- **Lethality** - Did you think it would kill you?
- **Re-attempting suicide** - Have you ever tried to take your own life before?

Willingness for help

- **Desire for help** - Do you want help to avoid killing yourself?
- **Acceptance of care** - Will you accept my help to avoid suiciding?
  Will you accept specialist mental health care?

Current safety

- **Immediate harm** - Do you have thoughts of wanting to suicide immediately?
- **Harm in hospital or clinic** - Do you have thoughts of wanting to suicide here in this office/clinic? Are you thinking of actively wanting to hurt yourself here?
- **Help eliciting** - If you feel like hurting yourself here while you are waiting for me to make some arrangements, could you come back to me and indicate this before doing anything?
- **Dangerous items** - Do you have anything you can use to harm yourself?
  Are you thinking of using something in the immediate vicinity to harm yourself with?

Homicidal thoughts

- **Homicidal ideation** - Do you want to take anyone with you?
  Do you have thoughts of harming or killing others?
- **Homicidal Plan** - Do you have a plan to do this?
- **Weapons** - Do you have access to guns or other weapons?

Note: *A Risk Assessment Guide is included in the* ***Foundations for Effective Practice*** *booklet and the* ***Primary Health Care*** *booklet. There is also a copy in the plastic sleeve at the end of this* ***Desk Guide****.*

management options

Self management for person assessed as Low Risk

This is an option if:

- the person has good social supports
- the person can discuss management
- the person has good rapport with health workers
- strategies are negotiated for vulnerable times (strategies may involve community, family and/or health workers)
- useful information about community resources has been supplied and can be accessed
- review arrangements are negotiated and agreed with health worker.

Note: Taking appropriate action means considering a range of options and sometimes multiple options. Even if risk is judged to be low, stay involved and review in a timely way.

Primary health care or shared care for person assessed as Moderate Risk

This requires:

- a management plan to be in place
- access to appropriate community resources to be facilitated
- the management plan to be clearly communicated and agreed with the person, and other services and people providing support to be informed
- the management plan to include details of a rapid response capacity for re-assessment and appropriate escalation of care level, and circumstances in which this may occur
- contact details to be clearly negotiated with the person and support people, and this to be documented
- face to face re-assessment (within suitable time frame for risk level) to be arranged and conveyed to the person and people providing support
- the management plan to document review arrangements.

Note: Shared care may also involve Emergency Mental Health Services.

Specialist care for person assessed as Significant or Extreme Risk

This requires:
- immediate and continued monitoring
- referral to appropriate specialist mental health services, if appropriate
- consideration of possible role of admission to hospital, possibly under detention
- a management plan to be developed collaboratively between mental health services and primary health care professional
- the management plan to include:
  - steps to ensure safety
  - specific strategies for ongoing review and care
- documentation to flow to all relevant people involved in the person's care in a timely manner.

management plans

A **management plan** is a formal record of decisions about interventions to be taken.

A management plan will:
- provide a brief history and the precipitating factors
- identify roles and responsibilities for actions
- establish timeframes and review dates
- include contingency plans (e.g. to cope with a changeable degree of risk or non-compliance)
- include contact details of supportive persons/family
- provide consent to plan by client
- list other people to whom plan has been copied.

square checklist for a management plan

- Have you ensured safety? Does the person need supervision or removal of lethal means? Is there immediate danger requiring the police?
- Should the person be hospitalised? If you think so, contact the Emergency Mental Health Services to discuss urgently (ph. 131465). Remember that if the person refuses voluntary admission, they may need to be detained and admitted under the Mental Health Act.
- Is the person able and willing to engage with treatment and support options?
- Does the plan involve the person as part of the team and consider their wishes?
- What therapeutic interventions (such as counselling, psychotherapy, medication) are appropriate and available?
- Is referral to a mental health specialist (e.g. a psychiatrist) an option?
- After referral are you still in the loop – ie. do you know what has happened for this person?
- What community support services can be utilised (alone or to supplement other interventions)?
- What aftercare/longer term care arrangements can be set in place?
- Who will provide follow up and review the plan? Avoid gaps in care.
- Have you accessed relevant support if unsure of your decisions, e.g. Emergency Mental Health services (ph. 131465).

management strategies

Coordination

- Communication, collaboration and coordination are key components of managing suicide prevention.
- In co-ordinating a person's care a range of options should be considered.
- Care is ongoing. People requiring medium or long term care are likely to have a number of other needs, in addition to health care.
- A shared care approach involving multiple options, including use of community resources, is likely to be the most effective.
- Identify who is likely to be the most appropriate contact for the person in the longer term. Is this their regular GP? Could it be a key worker in another agency?
- Medication may be an important component of care, but non-drug interventions such as counselling should always be offered as well. In patients with severe depression, combined therapy is more likely to be effective than either antidepressants or psychological treatment alone.

Psychotherapeutic interventions

A range of psychotherapies are often effective in ameliorating distress and building resilience. In General Practice several focussed psychological strategies are available, including: Psychoeducation; Cognitive-Behavioural Therapy (e.g. behaviour management, relaxation, problem solving, social skills); Interpersonal Therapy; and Narrative Therapy (specified circumstances). They may be delivered by trained GPs or GP referral to allied health professionals.

Other service incentive programs also support GPs in their work with those at risk of suicide, including telephone help lines and psychiatrist assistance in assessment and management plans. Additional intervention is available in rural/remote settings through the Divisions of General Practice. Where complex care issues exist, including comorbid medical issues, funding is also provided via the Chronic Disease Management program. For more information about these therapies please see the **Foundations for Effective Practice** booklet.

square

This **desk guide** is part of an integrated suicide prevention resource – **square.** Other components in the **square** package are a series of **nine booklets** and a **CD-ROM/website**. These provide more detailed information and applications for specific health settings.

The **booklets** are:
1 foundations for effective practice
2 the community setting
3 primary health care setting
4 in-patient setting
5 emergency department setting
6 community mental health setting
7 forensic setting
8 mental health in-patient setting
9 suicide postvention counselling.

The content of the **CD-ROM** can also be accessed on the **square website** www.square.org.au. It includes six discussion papers, an annotated resource list (print and electronic), pdf files of the **square** booklets and desk guide, and seven video presentations on topics such as risk assessment, pharmacology, management and referral, and postvention. There is also an interview with a young woman who had attempted suicide.

The **CD-ROM** and a **Risk Assessment Guide** suitable for photocopying can be found in the plastic sleeve inside this desk guide.

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