Service Six

Suicide Risk Assessment Management Policy

Date: April 2017

Review Due By: April 2018

Lead Role/Manager: Chief Executive

Others involved in implementing: Senior Managers, Managers and Personnel

What this policy covers

This policy outlines the ways in which practitioners assess and manage risk of suicide with clients. The policy applies to practitioners working in all services on the company's behalf.

Risk factors are used to help practitioners to identify clients who may be at greater risk of suicide, however there is risk associated with any clinical intervention and therefore risk assessment and management is an integral part of each practitioner's ongoing work with clients.

The company abides by the British Association for Counselling and Psychotherapy's (BACP) Ethical Framework for Good Practice in Counselling and Psychotherapy (2010) and this policy complies with BACP and NHS guidelines.

The policy is to assess carefully the risk of suicide with all clients, to take appropriate steps to respond to client's needs and to ensure their safety throughout the therapeutic process. In exceptional circumstances, this may include breaching client confidentiality to disclose the risk to other professionals; if the client appears to be in imminent or immediate risk of significant harm and cannot or will not seek appropriate help.

Responsibilities

All staff have a responsibility to act on information that they receive in their role regarding risk to clients and to liaise with practitioners and managers as appropriate.

Practitioners are accountable for ensuring that clinical risk assessments and management of risk are implemented with all clients and appropriate records are maintained. It is also the responsibility of practitioners to consult appropriately with managers and clinical supervisors when significant risk is identified.

Clinical supervisors, who have a three way agreement with supervisees and the service, are responsible for providing advice and guidance to practitioners regarding appropriate action to promote the safety and wellbeing of clients, in ways which are consistent with service procedures. They encourage consultation within the service and in the event of their supervisees not taking adequate action, will report this to the service manager, in accordance with the supervision agreement.

Managers are responsible for coordinating the risk assessment and management process within the service and for providing consultation to practitioners regarding issues of risk. They oversee and co-ordinate referral to and liaison with other agencies. They also identify staff training requirements and ensure that these are met.

Manager's feedback issues arising from this policy and associated procedures to the clinical governance manager and raise matters at managers' meetings in relation to logging, monitoring and responding to client risk.

The Chief Executive supports the managers in interpreting and implementing policy. This includes conducting clinical audits of cases and services to monitor and assess the effectiveness of policies and procedures relating to management of client risk. Outcomes are reported to senior management to inform business planning, the development of safe standards and continuous quality improvement.

The Chief Executive reviews and updates this policy and associated procedures in accordance with published plans and in the light of clinical audits and other systems of feedback.

Risk Assessment

Risk Factors

Various risk factors have been identified as indicators of clients who may be at higher risk of suicide. Although not exact predictors, these provide a useful context in which practitioners can assess a client's risk of suicide:

Client has a plan
The existence of a plan significantly increases the risk of a suicide attempt. This includes a client who has considered how, where or when they might act, or has started to put things in place to be able to act on thoughts of suicide (e.g. stockpiling tablets).

Signs of 'putting things in order'
Putting final arrangements in place might include letters and suicide notes, but could also be a preoccupation with paying bills and leaving things ordered after they have gone.

Alcohol or drug misuse
Alcohol misuse is strongly associated with successful suicide and drug misuse is also increasingly cited as being present in a high number of successful suicides. Mixing prescription medication with alcohol can also turn suicidal thoughts into suicide attempts. Alcohol and/or drug misuse may also indicate a higher risk of spontaneous suicidal acts, where no previous plan has been made.

Mental health history
A history of psychiatric illness, mental health diagnosis and/or admission to secondary care increases the risk of suicidal ideation being acted upon. Severe depression and anxiety are also factors which may increase the risk of suicide.
Previous attempt/self-destructive behaviour
Research has suggested that one in ten people who survive a suicide attempt go on to kill themselves within ten years. A history of deliberate self-harm or destructive behaviour also increases the risk of suicide.

Family history of suicide
Suicide in a client's family is associated with higher risk in the client; the closer the relative, the higher the risk.

Recent loss or anniversary of loss
This includes bereavement, the loss (or threatened loss) of a relationship and separation from children, impending legal action, job/career loss, loss of home and/or significant fall in social standing. Multiple losses increase the risk.

Social isolation

Social isolation is associated with increased risk of suicide and clearly limits the extent of support available outside therapy. It may be a consequence of loss (e.g. separated, widowed, unemployed) or might be a feature of the client's personality or lifestyle.

Age and gender
The highest risk population is younger men. Although women are more likely to attempt suicide and men are proportionately more likely to succeed than women, gender and age are not the most reliable indicators of an individual client's risk.

Assessing levels of risk

There is no evidence that asking questions about suicidal thoughts increases the risk of suicide or puts ideas of suicide into the client's mind. In fact there is evidence that being given 'permission' to talk about suicide is extremely important for clients to be able to explore their feelings and manage distress. The company has a proactive approach to exploring levels of risk with clients.

Once aware of potential risk, the practitioner assesses the extent and urgency of the risk to the client's safety. As a general guide, the more persistent, intense and current are the client's thoughts, the higher the immediate risk:

- A risk matrix (see Appendix A of Clinical Risk Assessment and Management Policy) may be employed to aid practitioners in making a judgement about the level of risk presented; as with any tool of this nature, it is not an exact measure and is used merely as a rough guide to prompt further consideration and reflection.

- The use of outcome measures (e.g. PHQ9 and GAD7), at the assessment or screening stage and at any stage of therapy, may also alert the practitioner to potential risk. This is most obvious in the specific questions related to suicidal thought and feelings of hopelessness, but overall high scores are also indicators of high risk. These tools can provide a helpful structure for further discussion of risk and suicide, but are not considered in isolation, as some clients may be reluctant to admit to suicidal thoughts.

- It is useful to ask a client to rate the intensity of their suicidal thoughts, or the likelihood of acting upon them, on a scale of 0-10 (0 being least intense/likely and 10 being most frequent/almost certain). This helps in gauging the immediacy of the risk, as well as introducing a discussion of triggers which may escalate risk for the client.

- If suicidal thoughts are present currently or within the last 48 hours, they are more likely to be defined as severe and imminent, particularly if the client has a relevant history (see 4.1).

- Suicidal thoughts within the last month are also considered current and high risk. If the thoughts are from more than a month ago and have not returned, the risk would be moderate and less imminent.

- Anything suggesting the client has a plan or is following a plan through is responded to as an immediate risk to the client's safety.

- Any indication that the client was intoxicated, either by alcohol or other substances, when experiencing suicidal urges is also treated as an immediate risk to the client's safety.

Responding to risk of suicide

Helping a client to understand the nature and severity of potential risk and considering ways to manage this to keep him/herself safe is a priority in all cases.

In all cases of identified risk (i.e. low, medium or high)

- Considering the client's own coping strategies is one of the most significant resources in managing suicidal ideas. Exploring ways in which a client has prevented him/herself from acting on thoughts in the past can help to reinforce future coping.

- Discussing support available to clients outside therapy is essential to ensuring clients are able to keep themselves safe. It is important to check out the client's willingness to use these resources and their awareness of other out of hour's professional sources of help and support.

- Securing a client's consent to inform a GP of concerns is good practice and GP contact details will already have been noted at referral, assessment or screening, in accordance with usual procedure. When potential risk has been identified, agreeing written consent to consult with other professionals involved may be useful at this early stage.

- In order to work effectively with clients it may be possible to agree a 'no harm' contract verbally, to the effect that clients will seek necessary help if feeling they may act on suicidal thoughts between sessions. Such an agreement is not a guarantee and is not likely to have an impact on a client who is subject to overwhelming feelings.

- Practitioners consult with clinical/service managers as soon as possible after a session where a risk of suicide has been identified. They also discuss this with their supervisor at the earliest opportunity.

- Notes provide an important record of the interventions that were made and the rationale for those interventions. For example, the practitioner records as much of the following as appropriate to the case:

- how the client expressed their suicidal thoughts or intent

- how the practitioner responded to the expression of risk of suicide (what they said and did

- factors that suggested to the practitioner that suicide was more or less likely

- the outcome of the session, e.g. consultation with third parties, whether permission was forthcoming and whether the client was in agreement with the outcome.

- Practitioners continue to monitor clients throughout their work, for signs of escalating risk. Further intervention may need to be considered to help reduce risk to lower levels; at each stage consultation with the client and managers is essential.

- Prior to an anticipated ending, agreement is reached with the clinical/service manager about recommendations, onward referral or other next steps as appropriate. Use of outcome measures during the final session provides the practitioner with a guide and aid to reflection with the client about any ongoing aspects of risk.

- In cases of unplanned endings or loss of contact, where issues of risk are ongoing, referrers, the GP, or other professionals involved are alerted. Cases are not closed until all necessary steps to manage risk have been carried out and the duty of care to the client is discharged.

Additional actions in cases of high level of risk

High levels of risk are discussed with the clinical/service manager and/ the clinical supervisor before any irreversible action is taken by the practitioner or a manager, although this may not be possible in all circumstances.

- The process of screening or assessment is in itself a key element in reducing the level of risk, in so far as it helps to identify the nature and scope of the risk as well as possible preventative factors, resources and coping strategies for a client.

- Further intervention may need to be considered to help reduce risk to medium/low levels. These could be actions for the client to take or actions which the practitioner or manager may take on the client's behalf, whilst respecting the client's capacity for autonomy.

- Disclosure may be made where appropriate (with or without the client's consent), to the client's GP, the Police (for a safety check and to allow them to coordinate other emergency services as necessary) or the Mental Health Crisis Team (where a number is available).

- In accordance with the confidentiality policy any disclosure of information to a third party is restricted to the issue of concern (safety) and does not include general matters presented in therapy.

- If a client is at imminent risk of acting on suicidal thoughts and is able and willing to take action to protect him/herself he/she will be assisted in attending the nearest hospital A&E service, to make a full disclosure. The practitioner or manager will agree a follow up contact/arrangement to ensure the client's safety.

- If the client is in need of immediate medical attention, the practitioner or manager will coordinate a 999 emergency services call to the client's location, giving only factual information and disengaging once the emergency services are on the scene.

- When a disclosure has been made, the client's GP will also be informed, (confirmed in writing), as the appropriate holder of duty of care for actively suicidal clients.

Reflection, Supervision and Self-Care

It is essential that practitioners and managers have a regard for their own wellbeing in order to work safely and effectively with all clients; this is especially important when working with a caseload including clients with higher levels of risk.

- Working with clients displaying higher levels of risk can be particularly challenging to usual support systems; the longer the exposure and the higher the caseload, the greater the impact on all those involved (including increased risk of vicarious/secondary trauma).

- Whilst client confidentiality is respected, consultation and reflection is encouraged within teams as a means of ensuring that those with clinical responsibility are informed, gaining peer support, mentoring, guidance and learning from the wealth of experience within each team.

- The role of supervision is central to reflection on work with clients at risk of suicide; discussion of possible actions and hypothetical outcomes can help to alleviate anxieties. Clinical supervisors are responsible for providing guidance and advice to practitioners regarding appropriate action, in keeping with service procedures.

- In the event of a supervisee not taking adequate action, for whatever reason, supervisors are expected to raise this with the practitioner concerned, prior to reporting this to the service manager, in accordance with the supervision agreement and in the interests of the duty of care. The matter will then be investigated further by the manager.

In the event of a Client's suicide

- On receiving notification of the death and possible suicide of a client (whether currently engaged with the service or recently discharged), the service manager will take immediate action to respond to the person notifying of the event; and will inform them of subsequent actions and investigation to be carried out where appropriate. Any disclosure of information relating to a deceased client is still subject to confidentiality and will need to be carefully considered with the service manager.

- The manager will take appropriate action to ensure adequate care of the family, practitioner and others involved. In particular, opportunities for de-briefing will be incorporated into the initial response and the practitioner will be offered additional supervision.

- The manager will notify the Chief Executive of the suicide and they will agree subsequent key actions in accordance with the published serious untoward incident procedure. An agreed time-scale will be confirmed for each stage. The Chief Executive will inform the Board of Trustees immediately.

- All records relating to the client will be collected and practitioners and supervisors may be invited to comment on their involvement and review this with the manager.

- The investigation process and final report will be completed by the Chief Executive as soon as is reasonably practical; usually within 21 working days of the acknowledgement of receipt of news of the event; if this is not possible (e.g. when other organisations need to be consulted) those involved will be informed.

- Outcomes of the investigation will be shared with families and practitioners involved as appropriate, with due regard to confidentiality.

- The manager will inform commissioners in accordance with contractual actions only.