Unit 2.4

Suicide Risk Assessment and Safety Plans

Unit 2.4 Suicide Risk Assessment and Safety Plans

Unit Descriptor

This unit introduces the CYMHS clinician to suicide risk assessment of children and adolescents. It discusses factors to consider when conducting a risk assessment,

Learning Objectives

Completion of this module and clinical experience will enable staff to describe major risk factors and identify warning signs of suicidal children and adolescents within a CYMHS setting. At the end of this unit, staff will be able to:

- Describe major risk factors and identify warning signs for suicidal clients.
- Outline major areas that contribute to the aetiology and pathogenesis of suicide
- Outline key areas of risk assessment of children and/or adolescents in the CYMHS setting
- Review assessment and treatment strategies used in CYMHS for young people that are suicidal
- Identify the aims of postvention in suicide
- Discuss appropriate communication strategies useful when communicating with a suicidal young person
- Identify strategies to manage personal stress in relation to caring for suicidal clients

Unit 2.4

Suicide Risk Assessment and Safety Plans

DVDs and Associated Learning Materials

DVD 6: Assessing Suicide Risk

Presenter: Matthew Parkyn

DVD Overview

This DVD provides a brief introduction to suicide assessment in a child and youth mental health context. Within the DVD, rates of suicide across Australia, and more specifically within Queensland, are discussed. The risk and protective factors that are empirically supported by the literature are highlighted. The roles that these factors play in conducting a suicide risk assessment are discussed. The elements of a suicide risk assessment and safety plan are addressed.

The DVD contains 2 parts:

- An overview of the issues surrounding suicide in young people in Australia and accompanying statistics for Australia and Queensland
- A brief role-play demonstrating how to conduct a Suicide and Self Harm Risk Assessment with an adolescent and the development of a safety plan

Presenter:

- Matthew Parkyn - Psychologist Child & Youth Forensic Outreach Service
- Pamela Siebrecht (Actor) - Consumer, Project Support & Administration Consumer & Carer Participation Project; and Child & Family Therapy Unit

Case Study Notes:
This case study was based solely on fictional characters. Similarities to persons or real events are purely co-incidental.

Associated Learning Materials

Assessing Suicide Risk - The Child and Youth Mental Health Perspective

DVD Accompanying Power Point Materials as presented by Matthew Parkyn

Suicide Statistics

- World-wide nearly 1million people complete suicide every year (WHO, 2003)
- In Australia in 2005 – 2101 deaths registered as suicides (1657 males; 444 females)
- In Qld in 2005 – 459 deaths registered as suicides (360 males; 99 females)
- Rates per 100 000 – males 16.4; females 4.3; persons 10.3.
- Ratio of Male to Female - 3.8:1
- Suicides represented 26.2% of all deaths from external causes.
- Highest rates observed in males aged 30-34 years (27.5 per 100 000)
- Lowest rates observed in males aged 15-19 (9.5 per 100 000)
- Highest rates observed in females aged 35-39 (6.9 per 100 000)
- Lowest rates observed ion females aged 15-19 (3.6 per 100 000)
- The most frequently used method was hanging (which includes strangulation and suffocation) (51% of all suicide deaths).
- Deaths by poisoning (including drugs and motor vehicle exhausts) (28% of all suicide deaths)
- Firearms accounted for 7% of all suicide deaths; and
- The remaining 14% included all other methods(drowning, jumping & other methods)

Suicide Statistics – Limitations

- Statistics generally 2-3 years behind
- Not a true reflection on the number of suicides
- Statistics for children (i.e. those younger than 15) are relatively low and therefore tend not to be reported.

Risk factors

- Sex (Males higher than females for suicide. Reverse for self harm)
- Location
- Previous History of suicide attempts
- History of suicide/suicidal behaviours in the family
- History of suicide/suicidal behaviours in the immediate peer group
- History of mental illness
- Depression – Hopelessness
- Aboriginality
- CALD (Culturally And Linguistically Diverse) backgrounds

Risk factors continued:

- Substance Use/Misuse
- Serious physical Illness / disability
- Child Sexual Abuse
- Stressful life events
- Young people in custody/ In trouble with the law
- GLBT youth
- Unemployed youth

Protective factors

- Very Few Protective factors have been identified in the literature compared with risk factors so far!!!
- Family patterns
- Cognitive style and personality
- Cultural and socio-demographic factors

Suicide Methods – Lethality

- Most Lethal (+) to Least Lethal (-) Maris, Berman and Silverman (2000)
- Gunshot
- Carbon monoxide (with reduced emission cars this method is becoming less lethal)
- Hanging
- Drowning
- Plastic bag over head
- Impact
- Fire
- Poison
- Drugs
- Cutting

Assessment

- What do you think about suicide?
- Ideation
- Perturbation
- Plan
- Lethality
- Intent
- Reversibility
- Homicidality

Other factors to consider

- AMBIVALENCE
- Future orientation
- Religiosity
- Support
- Supervision

State-Wide Policies

- Queensland Health Incident Management Policy
- Clinical Incident Management Implementation Standard
- Guidelines for the Management of Patients at Risk of Serious Self-harm and Suicide

DVD 6 - Exercises from Case Study

1. What are the main stressors that the client presented with and what were/are the triggers for her decompensation?

_____
_____
_____

2. What suicide risk factors did you identify from the role play?

_____
_____
_____

3. What protective factors did you identify from the role play?

_____
_____
_____
_____

4. What level of risk do you think Rachael was at (low, medium or high)? Discuss the clinical reasoning you used to determine the level of risk?

_____
_____
_____
_____

5. What further information do you require to assist in determining level of risk and the subsequent plan?

_____
_____
_____
_____

1. Based on the information above and the suicide assessment seen on the DVD,

Complete the following sections of the trial Consumer Assessment Form for Rachel (for current forms please see the section of this package entitled 'Forms'):

- MSE (page 5)
- Risk Screen (page 7)
- Clinical and risk formulation/ assessment summary (page 9)
- CYMHS immediate plan (page 10)

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DVD 6 -Suggested Responses to Case Study

1. What are the main stressors that the client presented with and the triggers for her decompensation?

- Upcoming exams
- Recent relationship break-up
- Some difficulties communicating openly with parents
- Medication concerns – feeling nauseous on medication and not enjoying the identity as a 'sick person'
- Feeling that her friends don't understand her at present
- Not having things to enjoy – usually does art but not doing this at school currently. Usually plays softball but season finished
- Not sleeping well. Having difficulty getting to sleep

2. What suicide risk factors did you identify from the role play?

- Multiple stressors and significant life events
  - o Exams, Recent relationship break-up, Communication with parents, Medication concerns
- Major mental health disorder
- Expressing suicidal ideas
- Expressing vague plan
- Has access to the means
- Denying intent
- Low level lethality
- Expressing low-moderate levels of distress
- Expresses feelings of hopelessness/worthlessness
- Reports depressed mood
- Reports feelings of guilt
- Being alone is a risk factor that Rachel identified

3. What protective factors did you identify from the role play?

- Parents
- Friends
- Guidance Officer
- Interests/hobbies –Softball and Art
- Seeks help and regularly attends appointments at CYMHS
- Able to problem solve around possible helpful ideas
- Showed some hope that some of the ideas might work and appeared interested in trying them

4. What level of risk do you think Rachael was at (low, medium or high)? Discuss the clinical reasoning you used to determine the level of risk?

- Moderate Risk
- Some protective factors were present (as above)
- Rachel was willing and interested to engage supports
- Rachel was living at home and was OK for her mother to be made aware of her current distress and be part of supervising and supporting her through this difficult time.
- But Rachel also carried a level of hopelessness that was perpetuated by a cyclical and ongoing periods of depressed mood with minimal resolution of symptoms
- Her recent loss of relationship with her boyfriend and pressures coming up to exams have her at a mod-high level of distress

5. What further information do you require to assist in determining level of risk and the subsequent plan?

- Previous attempts on life
- Nature, severity and triggers of previous attempts
- Family history of suicide
- Any physical illnesses/disabilities
- Use of drugs/alcohol
- Parent's willingness to be involved
- Who may be able to monitor Rachael during the crisis
- Assessment of aggression/violence risk
- If Rachel is able to see hopes for the future (in relationships, career, mental health, hobbies and life in general)
- Ask if Rachel would contact supports if suicidal or self harming ideation became worse

6. Based on the information above and the suicide assessment seen on the DVD, Complete the following sections of the trial Consumer Assessment Form for Rachel (for current forms please see the section of this package entitled 'Forms'):

- MSE (page 5)
- Risk Screen (page 7)
- Clinical and risk formulation/ assessment summary (page 9)
- CYMHS immediate plan (page 10)

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See Trial Consumer Assessment following.

TRIAL FORM

Queensland Government
Queensland Health

Child and Youth Mental Health Services

CONSUMER ASSESSMENT

Facility: .....

Date: / / Time: .....

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

MENTAL STATE EXAMINATION

Appearance (physical development, nutrition body type and physique, skin, hair, clothing, grooming , hygiene distinguishing features)

Motor Behaviour (activity level, posture, gait, balance, co-ordination abnormal movements, startle response, habits, rituals, mannerisms)

Voice, Speech and Language (amplitude, pitch, tone, tempo, prosody, phonation, rhythm, fluency, articulation, accent, comprehension, vocabulary, syntax, conversational ability, use of gesture)

Interaction with Examiner (eye contact, cooperativeness, dependence, friendliness, withdrawal, evasiveness, fear, anxiety, hostility, suspiciousness, indifference, invasiveness, dramatism, suggestibility)

Mood and Affect (range, control, congruity, elevation, depression, suspicion, anxiety, fear, anger, issues related to particular affects)

Thought Processes (slowing, acceleration, interruptions, blocking, circumlocution, circumstantiality, perseveration, concreteness, flight of ideas, goal-direction, coherence, looseness of associations, tangential thinking)

Thought Content (obsession, compulsion, hallucination, delusion, illusion, depersonalisation, de-realisation, déjà vu, phobia, flashbacks [intrusive/traumatic/ imagery] abnormality of general or special sensation, abnormality of body image, distortion of the sense of time, confabulation, fabrication, preoccupation with identity, physical health, mental health, personal competence, or the past or future)

Cognitive Functioning (orientation, concentration, memory [immediate, recent, remote], general knowledge, social judgement abstracting ability, estimated intelligence)

Fantasy (dreams, wishes, drawings, free play: productivity, themes, capacity to distinguish fantasy from reality)

Concept of Self (dreams, wishes, drawings, free play, coherence, concepts of personal intelligence, strength, attractiveness, relationship with others)

Insight/Desire for Help (awareness of being unwell, awareness of nature of problem, desire for help, level of co-operation., awareness of impact of their behaviour on others)

Physiological Functions (energy, concentration, memory, interest in people and activities, appetite, weight, sleep, libido, sexual functioning, menstrual history, last menstrual period)

Rachel is a 17 year old young woman of medium build, dressed in a clean T-shirt and trousers, with neatly groomed dark brown hair and wearing nail polish. Rachel wore no jewelry. No other distinguishing marks or features other than a couple of small spots her right hand that she picked at occasionally during the interview.

Rachel sat upright in her chair but hung her head down giving no eye contact throughout most of the interview. She was restless in her chair constantly and could not keep her hands still. She played with her purse throughout the interview reflecting distress and agitation.

Rachel was fluent and articulate. Language used was appropriate in conversation. Speech rate was slowed and volume was quiet. Range of tone was restricted and consistent with the depressed mood she described.

Rachel gave nearly no eye contact but was co-operative with and friendly towards the case manager. She responded positively towards suggestions and demonstrated trust in the examiner.

Affect was flat and restricted, consistent with reported depressed mood.

Thoughts processes were clear. Thought content was appropriate and consistent with themes of depressed mood, described interpersonal distress and hopelessness.

Rachel was oriented to person, place and time. She appeared to be a person of normal intelligence. Memory was generally intact although she described having hazy memories about what information was communicated to her parents at the time of distress with the recent relationship breakup.

Rachel described experiencing feelings of low self worth and feeling that she is a burden to family and friends. She was aware of the concerns of others for her.

Rachel appeared to be aware of her need for support and was willing to seek help and try suggestions. She appeared to have insight into the things that may provide her relief.

Physiological Functions: Sleep - Rachel described having difficulty getting to sleep. She appeared to have low energy levels despite psychomotor agitation.

Clinician's name:	Designation:	Signature:	Team:

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Child and Youth Mental Health Services

CONSUMER ASSESSMENT

Facility: .....

Date: ... / ... / ... Time: .....

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

Parent/Carer/Significant others drug and/or alcohol use: .....

.....

.....

DRUG SCREEN

It is strongly recommended that the Drug Screen is completed with consumers of primary school age and above.

Clinicians may contact the Alcohol and Drug Information Service (ADIS) on 1800 177 833 for assistance in completing this form.

Drug name	Have you used? Y / N	Age first used	Date / time last used	Average amount	Frequency of use	Route of administration
Caffeine *(tea / coffee / stimulant, energy, cola drinks)*						
Nicotine *(cigarettes / tobacco)*						
Alcohol *(including methylated spirits)*						
Cannabis *(marijuana / hash / bongs / ganja)*						
Amphetamines *(speed / goey / ice / cocaine)*						
Opioids *(methadone / heroin / morphine)*						
Benzodiazepines *(Temazepam / Diazepam / Valium / Normison)*						
Designer drugs *(MDA; ecstacy / MDMA)*						
Inhalants *(glue / petrol / paint / others)*						
Others *(pain killers / PCP / Ketamine / over the counter drugs etc.)* Specify:						

Unable to complete due to consumer's circumstances? ☐ Yes ☐ No

Further drug screen required? ☐ Yes ☐ No

Further alcohol screen required? ☐ Yes ☐ No

Additional Information *(Record current access to means/attitude of significant others/ effects of withdrawal if appropriate or other relevant information)*:

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.....

.....

.....

.....

Clinician's name:	Designation:	Signature:	Team:

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Child and Youth Mental Health Services

CONSUMER ASSESSMENT

Facility: .....

Date: / / Time: .....

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

RISK SCREEN

Suicide / self harm

Static factors

- ☐ Previous serious suicide attempt(s)
- ☐ History of self harm
- ☐ History of suicide attempt(s)
- ☐ Family history of suicide
- ☐ Exposure to suicide of friend/peer
- ☑ Long-standing problems (eg. unemployment, physical illness / pain, mental disorder)

Dynamic factors

- ☑ Intent / plan / thoughts
- ☑ Access to means
- ☐ Current suicide attempt
- ☐ Homelessness / multiple out of home placements
- ☐ Marked decline in functioning/school performance
- ☑ Hopelessness / perceived lack of control over life
- ☑ Distress / anger / high level of agitation
- ☑ Isolation / loneliness
- ☑ Stressors in last 6 months (eg. loss, family / peer conflict)
- ☐ Psychotic symptoms (eg. command hallucinations)
- ☑ Evidence of moderate to severe depression / mood disorder
- ☐ Misuse of drugs/alcohol
- ☐ Evidence of high level risk taking behaviours
- ☐ Evidence of poor impulse control

Vulnerability

- ☐ At risk of being sexually abused by others
- ☐ At risk of domestic / family violence
- ☐ Lack of family protective factors
- ☐ Family history of mental illness
- ☐ At risk of self neglect (basic ADLs, complex living skills)
- ☐ Cognitive impairment / intellectual disability
- ☐ History of poor engagement with services
- ☐ Developmental issues
- ☐ School expulsion/suspension
- ☐ Indigenous and or cultural issues

Violence

(including sexual violence)

Static factors

- ☐ History of violence
- ☐ History of sexual offence
- ☐ Criminal history
- ☐ Conduct disorder
- ☐ Cognitions supporting violence

Dynamic factors

- ☐ Recent threats or other aggressive actions/thoughts
- ☐ Carries weapon/access to firearm
- ☐ Psychotic symptoms (command hallucinations, threat-control-override and misidentification symptoms, morbid jealousy)
- ☐ Bullying
- ☐ Substance use

Comments:

Rachel describes feeling overwhelmed by current stressors against a background of ongoing depressed mood with suicidal ideation.

She has no immediate plans to die but has recurrent ruminations about this and is contemplating it as an option if she feels further unable to cope. She feels the period where this pressure could peak is in the next week prior to exams.

Rachel states she recently 'played with a knife' and caused herself some pain as a distraction from 'other stuff' but she didn't go on with this. She stated it was not very helpful as it didn't distract her for long. She carries a nail file to remind her of the options of hurting herself or killing herself if she felt she needed to.

Main Stressors:

- Upcoming exams
- Recent relationship break-up
- Some difficulties communicating openly with parents
- Medication concerns - feeling nauseous on medication and not enjoying the identity as a `sick person'
- Feeling that her friends don't understand her at present
- Not having things to enjoy - usually does art but not doing this at school currently. Usually plays softball but season finished
- Not sleeping well. Having difficulty getting to sleep

Risk Factors:

- Major mental health disorder - depressed mod
- Expressing suicidal ideas
- Expressing vague plan
- Has access to the means
- Denying intent
- Low level lethality
- Expressing low-moderate levels of distress
- Expresses feelings of hopelessness/worthlessness
- Reports feelings of guilt
- Feeling alone is a risk factor that Rachel identified

Protective Factors:

Parents
Friends
Guidance Officer
Interests/hobbies -Softball and Art
Seeks help and regularly attends appointments at CYMHS
Able to problem solve around possible helpful ideas
Showed some hope that some of the ideas might work and appeared interested in trying them

Clinician's name:	Designation:	Signature:	Team:

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CONSUMER ASSESSMENT

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(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

RISK SCREEN

Absence Without Approval
(for inpatients)

- ☐ History of absconding
- ☐ History of Limited Community Treatment breach
- ☐ Treatment refusal
- ☐ Frustration regarding hospitalisation/involuntary treatment

Child Protection Risk Screen

Does the consumer have custody or care responsibilities for children (full time or periodic)? ☐ Yes ☐ No ☐ Unknown

Is consumer in the care of a parent/carer with a suspected mental illness or problematic drug and/or alcohol use? ☐ Yes ☐ No ☐ Unknown

If ***yes*** to either of the above questions, the *Mental Health Child Protection Form* must be completed.

Completed by:

Name: .....

Signature: .....

Overall Risk Summary

	Low	Med.	High
Suicide risk	☑	☐	☐
Other self harm risk	☐	☑	☐
Aggression risk	☐	☐	☐
Vulnerability risk	☐	☐	☐
Absconding risk	☐	☐	☐

Dependent children / others? ☐ Yes ☑ No

Is further risk assessment required? ☑ Yes ☐ No

(If ***yes***, detail in plan on page 9)

Comments:

Clinician's name:	Designation:	Signature:	Team:

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Child and Youth Mental Health Services

CONSUMER ASSESSMENT

Facility: .....

Date: / / Time: .....

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

CLINICAL AND RISK FORMULATION / ASSESSMENT SUMMARY

Include:
- Presentation / Predisposition / Precipitation / Perpetuating factors / Protective factors (resources/strengths/ supports) / Prognosis / Symptom pattern (coping style) / Stressors
- Is consumer experiencing early symptoms of psychosis (prodromal)?
- Consider historical information in relation to current dynamic and contextual factors
- What will increase or decrease the consumer's risk?
- Document strategies to address the identified risk factors

Rachel is a 17 year old young lady presenting to CYMHS with depressed and anxious mood and recurring ideas of self harm and suicidal ideation. She attended today with her mother. She has been a client of this CYMHS service for approximately 6 months and is currently taking medication for depression.

The precipitation for this presentation includes increasing sense of helplessness and hopelessness resulting from current stressors. The main ones being recent relationship break up with boyfriend and upcoming exams.

Perpetuating factors include ongoing depressed mood, poor sleep and feelings of nausea possibly related to the medication, some communication issues with her parents, loss of activities previously found pleasurable (art and softball) and a lack of connectedness and time with friends.

Predisposing factors include major diagnosed mental health disorder - depression.

The pattern that Rachel currently presents with is feeling overwhelmed and unable to cope, trying self harm as a coping mechanism to distract herself, withdrawing from family and friends, taking the medication but with some resistance, taking a long time to get to sleep and feeling hopeless and that she is a burden to others.

Potentials include supportive parents, friends and Guidance Officer, Rachel had interests/ hobbies -Softball and Art. She seeks help and regularly attends appointments at CYMHS, is able to problem solve around possible helpful ideas and showed some hope that some of the ideas might work and appeared interested in trying them. Thinking is logical and sequential and Rachel appears to have a co-operative therapeutic relationship with the case manager.

Strategies to minimise risk include engaging current supports (family, friends and school), accessing crisis services if required, using strategies as per Crisis plan (see attached) and maintaining supportive relationship with CYMHS case manager.

(The risk screen and clinical formulation can also be used as a standalone risk screen at regular and ad-hoc reviews)

Clinician's name:	Designation:	Signature:	Team:

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Facility: .....

Date: / / Time: .....

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

Principal diagnosis: ..... ICD10AM code: .....

Additional diagnoses: ..... ICD10AM code: .....

..... ICD10AM code: .....

Mental Health Act (MHA) status: ☑ None ☐ Involuntary Assessment ☐ Involuntary Treatment Order
☐ Justice Examination Order ☐ Emergency Examination Order ☐ Forensic Order
☐ Special Notification Forensic Patient ☐ Classified

Conditions of order if appropriate: .....

Outcome Measures completed? ☐ Yes ☐ No Entered on CIMHA? ☐ Yes ☐ No

Outline significant clinical issues from HoNOSCA, SDQ and CGAS:

.....

.....

BRIEF SUMMARY FOR FOLLOW UP MANAGEMENT:

Is there a need for follow up / treatment?

☑ Yes, from a Child and Youth Mental Health Service (CYMHS) *(detail in CYMHS plan below)*

☐ Yes, from a service other than a CYMHS *(detail follow-up with other agencies below)*

☐ No

Agency: ..... Date: ..... Time: .....

Agency: ..... Date: ..... Time: .....

CYMHS IMMEDIATE PLAN

Include any immediate actions required to maintain the consumer's safety (eg. aggressive behaviour management).

Consider:

- Treatment goals and location
- Recommended actions to manage / reduce risk
- Information / education
- Carer / family involvement
- Child protection issues
- Liaison with other service providers
- Cultural and language issues
- Medication changes
- Investigations
- Referrals

For inpatients, consider:

- Level of observations
- Early discharge requirements
- PRN medications

1. Engage supports at home - conversation with mother and Rachel. In collaboration with Rachel, informing mother of Rachel's current vulnerabilities, thoughts, needs for support and safety plan. Help alleviate mother's concern, minimise need for mother to ask questions that Rachel finds difficult to answer. Provide ideas for mother to increase safety at home eg: remove knives from kitchen.

2. Engage supports at school - Discuss same with Guidance Officer. Problem solve ways of minimising exam stress and increasing immediate school supports. Look at opportunities for mental health promotion eg: education through health/ PE classes for general school population.

3. Engage supports through friends - Rachel will contact friends from school and softball and organise some social contact to distract herself from immediate stressful thoughts

4. Contact Mental Health Supports - Extended hours service ph:____, Lifeline ph 131114 or Kids Helpline 1800 555 1800. Rachel will ring from local public phone box if she feels that she wants privacy.

5. Minimise distress at night - keep bedroom light on at night. Inform parents about need for this
6. Engage in sports/ activities to distract from stressful thoughts and to give Rachel something to look forward to - Rachel to look into increasing art again at school and enrol in an alternate sport as Softball is finished for this season.

7. Case Manager to provide supportive telephone follow-up as agreed on _____

8. Medication review - to see if physical symptoms (eg: nausea) can be relieved and mood can be improved. 9. Next CYMHS appt as agreed upon _____

Information about consumer need and service response to be provided to:

☐ Consumer ☐ Carer ☐ Referrer ☐ GP ☐ Other service provider (specify): .....

Information provided by (staff name): ..... (date): .....

Information to be delivered: ☐ By telephone ☐ By email ☐ By fax ☐ By post ☐ In person

Additional forms, notes or information attached? ☐ Yes (specify: .....) ☐ No

Clinician's name:	Designation:	Signature:	Team:

DO NOT WRITE IN THIS BINDING MARGIN

Additional Case Studies

Using the information from the DVD presentation and the power point notes attached, identify the risk and protective factors for suicide in the following case studies, and indicate the level of risk.

Case Study 1- Nick

Nick is a 13 year old male who has presented to CYMHS with depression. As a part of his depression were prominent thoughts about death.

Nick has also identified to his family that he wants to kill himself.

Nick was diagnosed with Autism at the age of 3, but this diagnosis is not believed to be the correct diagnosis for Nick, who is currently believed to have a speech and language disorder. Nick does not have the impaired social interactions associated with Autism, nor does he have the stereotyped preoccupations. Nicks thinking is very concrete however, and this is believed to be influence by the speech and language difficulties.

While Nick has clear suicidal ideation, he has no immediate intent to kill himself. He has identified that he would use a knife to kill himself, as he does not have access to a gun. Nick however has also identified that he does not have ready access to a knife as his mother locks all knives in the house away as Nick has a younger Autistic sister who has a fascination for knives. As such, Nick does not believe he has ready access to such weapons.

Nick comes from an intact family who have strong religious views. Nick frequently hears his parents talking about all of the evil in the world, and has been told by his family members that sex is something that is reserved for the sacrament of marriage.
Messages about masturbation have been quite clear that it is wrong.

Nick was recently caught masturbating while looking at a Playboy magazine by his mother, who's immediate response was to tell him how bad he is.
Nick has expressed that he thinks he should die due to his 'badness'.

1. What are the risk factors?

2. What are the protective factors?

3. What do you think the level of risk is and what is your clinical reasoning?

Case Study 2 - Jane

Jane is a 17.9 year old female. She initially presented to CYMHS at the age of 11 due to extreme suicidal ideation. The suicidal ideation was in the context of repeated sexual assault over a 2 week period by her Step Mother's brother who had come from interstate to visit. She was discharged from CYMHS after a short time after her father and step mother disengaged from the service.

Jane presents with resentment that not enough was done in her initial presentation. Her current presentation is the result of her being taken to the Emergency Department following her phoning an ambulance after she had engaged in self-harming behaviour and taken a large number of tablets that she had found in her Step Mother's cupboard.
Jane has made a number of impulsive suicide attempts which have resulted from arguments she has had with family and friends. All methods used have been of low lethality.

Jane has an extensive history of self-harming behaviour with both of her arms being covered in scars from cutting. She reports that she does this to relieve her physical numbness, and that she knows she is alive when she cuts.

Jane also uses drugs (cannabis) and alcohol excessively which appears to be related to the peer group with whom she identifies.

Jane's mother died from a brain tumour when Jane was four, and had been sick for all of Jane's life.

Jane's father is a member of the Australia Federal Police and was frequently absent from Jane's life as she was growing up. He remarried 3 years after Jane's mother died but this relationship broke down 2 years ago.

Jane's father was a strong disciplinarian and has reported that she was frequently unable to sit down after she had committed some transgression of the 'Family Rules'.

Jane resided with her father up until 12 months ago, but now lives with her Step Mother and disabled half brother as her father has re-partnered and Jane does not get along with his new partner.

Jane was diagnosed with diabetes 6 months ago and is currently considered by her GP to be morbidly obese. She has received education around management of her illness, but is somewhat non-compliant with her treatment.

Jane is intelligent and has aspirations of becoming a journalist. She is currently employed on a part time basis with Hungry Jacks and when she recently suggested to her manager that she wanted to resign he talked her out of doing so as she is one of his best workers.

Jane despite her intelligence has very poor social skills, and presents in quite an aggressive manner at times. Due to such she has a small group of friends who engage in drug taking behaviours.

Jane reports using alcohol to fit in with her friends and has indicated that she is sexually promiscuous when under the influence of the substances.

Jane has a diagnosis of complex PTSD and is depressed and irritable, but does not meet the criteria for a Major Depressive Episode. Jane reports nightmares and flashbacks of her abuse. She is currently sleeping in the room where the abuse took place. She still occasionally sees the perpetrator.

Jane has a strong desire to change her life but at times presents as though she has learned helplessness, and that she cannot change anything about her life.

Traits of borderline personality disorder, particularly efforts to avoid abandonment and splitting are noticeable in Jane's presentation.

1. What are the risk factors?

2. What are the protective factors?

3. What do you think the level of risk is and what is your clinical reasoning?

Suggested Responses to the Case Studies

Case Study 1 - Nick

1. **What are the risk factors?**

- Male
- Under age 35
- Depression – Major mental illness
- Suicidal thoughts
- Has identified wants to kill himself
- No immediate intent
- Low lethality
- Minimal access to means
- Distress caused by moral and ethical dilemmas in the home
- Concrete black and white thinking patterns, perhaps limited problem solving abilities
- Speech language difficulties possibly limiting self expression and tendencies to seek help
-

2. **What are the protective factors?**

- Intact Family
- Mother attending to safety needs for daughter presently

3. **What do you think the level of risk is?**

- Low Risk

Case Study 2 - Jane

1. **What are the risk factors?**

- Suicide ideation
- Previous suicide ideation
- Recent attempt (overdose – low lethality)
- Multiple previous impulsive suicide attempts – low lethality
- Self harming behaviour
- Victim of sexual assault
- Drug and Alcohol use
- Drug using peers
- Sexual promiscuity
- Physical illness
    - Obesity
    - Diabetes (non compliant with treatment)
- Query attachment problems
    - Absent and violent father
    - Mother died when Jane aged 4
- Poor social skills
- Mental health disorder – PTSD
    - Recent escalation in symptoms
- Lack of family supports
- Learned helplessness

2. **What are the protective factors?**

- Good worker
- Intelligent
- Future focus and hopeful
- Supportive manager

3. **What do you think the level of risk is and what is your clinical reasoning?**

- Moderate- High Risk

Unit 2.4

Suicide Risk Assessment and Safety Plans

Additional Learning Materials

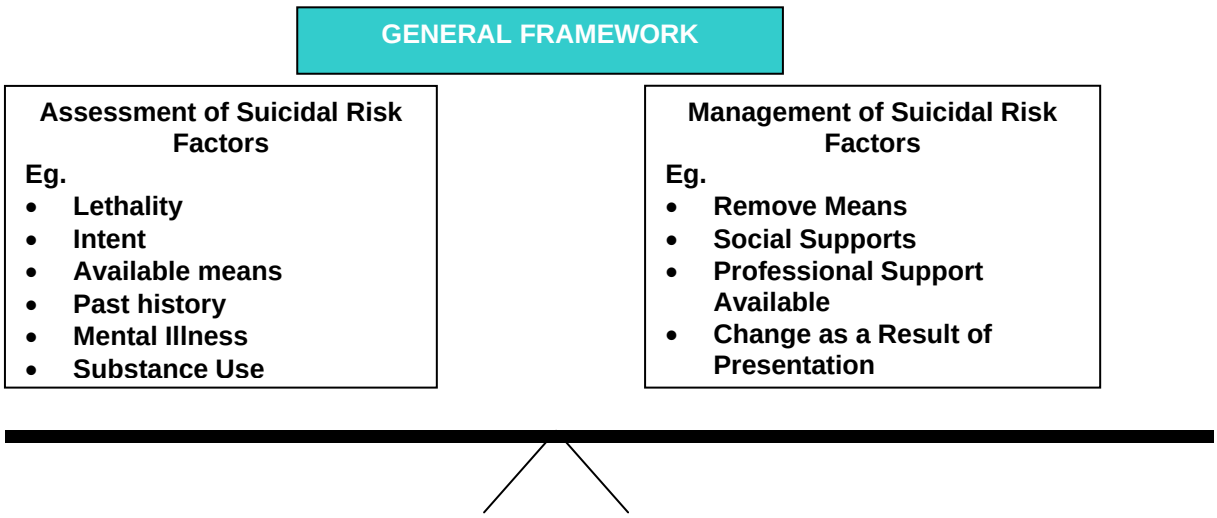
Additional Learning Materials

Assessment of Suicide Risk and Self Harm

The following information on the next 8 pages is taken from the Queensland Health Child and Youth Mental Health Services State-wide Standardised Suite of Clinical Documentation – User Guide. The complete guide is found in the section of this package entitled 'Forms'.

Suicide / Self Harm

Southern Health in Victoria, use the following diagram on their lanyards as a cue to support clinicians when performing a suicide risk assessment:



Assessment involves the collection of data which assists the clinician to develop an informed opinion of overall risk and the capability to manage that risk

Framework for Suicide Risk Assessment and Management

The following information regarding the assessment of suicide risk is from: *Framework for Suicide Risk Assessment and Management for NSW Health Staff – 2004.* This document contains much useful information regarding how to conduct a suicide risk assessment. In this section of the Consumer Assessment form, consider the information below regarding what information should be collected and documented.

Assessing Suicide Risk

A hierarchy of screening questions that gently leads to asking about suicidal ideas is a generally accepted procedure for all health professionals.

- Have things been so badly lately that you have thought you would rather not be here?
- Have you any thoughts of harming yourself?
- Are you thinking of suicide?
- Have you ever tried to harm yourself?
- Have you made any current plans?
- Do you have access to a firearm? Access to other lethal means?

Framework for Suicide Risk Assessment and Management for NSW Health Staff

Research suggests that suicidal behaviour commonly results from a convergence of multiple predisposing and concurrent risk factors that combine to elevate the risk of suicide.

A broad view of all of the risk factors associated with suicidal behaviour is important for the clinician to consider during the assessment. However, the **most important risk factors** for estimating the *current and immediate risk* are the **personal risk factors** (the current mental state) that are impacting on the individual's life at the present time.

Important personal risk factors include how depressed an individual is and whether they have made suicidal plans (as opposed to having passive suicidal thoughts). It is also important to note that a person might not reveal their plans and might try to hide their suicidal intent.
Other current personal risk factors include:

- recent major life events especially involving loss, humiliation
- 'at risk' mental states especially hopelessness, despair, agitation, shame, guilt, anger, psychosis
- recent suicide attempt
- personality/vulnerability, for example, challenges to dependency, impulsivity.

Hopelessness is one of the main factors mediating the relationship between depression and suicidal intent. Some people experiencing hopelessness may conclude that death is a better alternative than living a life in which they believe there is no hope for a positive future.
Hopelessness can be determined by exploring how a person feels about his/her future. Lack of positive expectancies and a negative view on life are important factors in suicidal behaviour.

The first **28 days following** discharge from a psychiatric in-patient facility is a period of **increased risk** for suicide.

Protective factors have also been identified that may protect a person from suicide.
These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem-solving skills
- positive values and beliefs
- ability to seek and access help

Comprehensive suicide risk assessment
A comprehensive suicide risk assessment should explore the following elements.

Distress, psychic pain
- What is the nature and level of the person's inner distress and pain?

- What are the main sources of this person's distress?

Meaning, motivation
- What is the person's understanding of their predicament? What is the meaning of recent events for them?

- What is motivating this person to harm himself or herself? Has the person lost his/her main reason for living?

- Does the person believe that it might be possible for their predicament to change and that they might be able to bring this about?

- Explore cultural aspects of meaning and motivation with persons from culturally and linguistically diverse backgrounds.

'At risk' mental states
- The presence of certain 'at risk' mental states including hopelessness, despair, agitation, shame, anger, guilt or psychosis escalate the level of suicide risk. These emotions may be associated with specific body language and specific cues exhibited in the assessment interaction. Clinicians should look for and directly inquire about such feelings.

History of suicidal behaviour
- Has the person felt like this before?

- Has the person harmed himself or herself before?

- What were the details and circumstances of the previous attempt/s?

- Are there similarities to the current circumstances?

- Is there a history of suicide of a family member or friend?

A history of suicide attempt or self-harm greatly elevates a person's risk of suicide. This elevated risk is independent of the apparent level of intent of previous attempts. Suicide often follows an initial suicidal gesture.

Current suicidal thoughts

- Are suicidal thoughts and feelings present?
- What are these thoughts (determine the content, for example, guilt, delusions or thoughts of reunion)?
- When did these thoughts begin?
- How frequent are they?
- How persistent are they?
- What has happened since these thoughts commenced?
- Can the person control them?
- What has stopped the person from acting on their thoughts so far?

Intent, lethality

- What is the person's degree of suicidal intent? How determined were/are they?
- Was their attempt carefully planned or impulsive?
- Was 'rescue' anticipated or likely? Were there elaborate preparations and measures taken to ensure death was likely?
- Did the person believe they would die? (Objectively question the person's perception of lethality.)
- Has the person finalised personal business, for example, made a will, made arrangements for pets, debts, goodbyes and giving away possessions?

Intent and lethality are very important to explore with the person. Sometimes they may be obvious from his or her account. However, they might be more complex; for example, it is possible that a person who attempts to overdose using paracetamol may assume it is a safe drug on the basis that it can be purchased without prescription. Such an attempt would be assessed as low intent, but high lethality.

Intent and lethality may also be more complex with people from culturally and linguistically diverse backgrounds. For example, planning may not be part of a culture's 'scripts', or culturally influenced methods which are of lower lethality in an extended family (due to likelihood of discovery) may be very lethal to an isolated refugee.

* Questions need to be asked in the past tense for assessment of a person following a suicide attempt and asked in the present and future tenses for assessment of a person contemplating suicide.

Presence of a suicide plan

- How far has the suicide planning process proceeded?
- Has the person made any plans?
- Is there a specific method, place, time?
- How long has the person had the plans?
- How often does the person think about them?
- How realistic are the plans?

A suicide plan or preparation for death, such as saying good byes, making arrangements for pets or settling debts indicates serious suicidal intent.

Access to means and knowledge

- Does the person have access to lethal means? Is there a firearm available? (If a person at long-term high risk of suicide has access to a firearm, the police should be contacted before the person is discharged to discuss the possibility of removing the firearm). Are there poisons in the house or shed? Are there lethal medications such as insulin, cardiovascular medications or tricyclic antidepressants available to the person? Ensure these questions are also asked of a reliable corroborative source.
- Is the chosen method irreversible, for example, shooting, jumping?
- Has the person made a special effort to find out information about methods of suicide or do they have particular knowledge about using lethal means?
- Type of occupation? For example, police officer, farmer (access to guns), health worker (access to drugs).

In most cases, if a person has developed a potentially fatal or effective plan and has the means and knowledge to carry it out, the chances of dying from a suicide attempt are much higher.

It is important to assess the level of intention and the person's understanding of

Safety of others

- Have the person's thoughts ever included harming someone else?
- Has the person harmed anyone else?
- What is the person's rationale for harming another person?
- Is there a risk of murder-suicide?
  Is the person psychotic?
- Are there issues with custody of children and/or financial issues?
- Are the children safe?
- Is there evidence of postnatal depression?

Coping potential or capacity

- Does the person have the capacity to enter into a therapeutic alliance/partnership?
- Does the person recognise any personal strengths or effective coping strategies?
- How have they managed previous life events and stressors? What problem-solving strategies are they open to?
- Are there social or community supports (for example, family, friends, church, general practitioner)? Can the person use these?
- Is the person willing to comply with the treatment plan?
- Can the person acknowledge self-destructive behaviours? Can the person agree to abstain from or limit alcohol or drug consumption? Can they see how substance abuse can make them more at risk?
- Does the person have a history of aggression or impulsive behaviour? (Aggression and impulsivity make risk status less predictable.)
- Can the clinician assist the person to manage the risk of impulsive behaviour?

Self-harming behaviour

■ Self-harming behaviour usually occurs in one of two contexts: the person with a vulnerable personality who is acting out inner distress or the person who is psychotic.

■ A person who is acting out inner distress in this manner often feels he/she is not able to communicate distress in less harmful ways.

■ Although the vulnerable person's self-harming is frequently acting out inner turmoil or an act of self-soothing rather than an attempt to die, people who self-mutilate do sometimes attempt suicide.

■ The self-harming by the person who is psychotic (or the underlying rationale) is frequently bizarre.

Distinguishing between 'self-harm without suicidal intent' and 'attempted suicide' can at times be difficult. Regardless of motivation or intention, both are dangerous behaviours associated with a heightened risk of dying. Self-harm is a maladaptive behaviour that reflects severe internal distress (which may not always be evident in the external demeanour) and a limited ability to develop effective coping strategies to deal with difficulties

Suicide Risk Assessment Guide

To be used as a guide only and not to replace clinical decision-making and practice.

ISSUE	HIGH RISK	MEDIUM RISK	LOW RISK
'At risk' Mental State • depression • psychotic • hopelessness, despair • guilt, shame, anger, agitation • impulsivity.	Eg. Severe depression; Command hallucinations or delusions about dying Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts • intentionality • lethality • access to means • previous suicide attempt/s •	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality
Substance disorder • current misuse of alcohol and other drugs	Eg. Current substance intoxication, abuse or dependence.	Eg. Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History • family, carers • medical records • other service providers/sources	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information: Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account o f events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) • expressed communication • availability of supports • Willingness / capacity of support person/s • safety of person & others	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; Few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting of help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective Practice • level & quality of engagement • changeability of risk level • assessment confidence in risk level.	Low assessment confidence or high changeability or no rapport, poor engagement.		High assessment confidence / low changeability; Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there's is no evidence of current risk to the person. No thought of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable? **Highly Changeable Yes ■ No ■**

Are there factors that indicate a level of uncertainty in this risk assessment?
Eg: poor engagement, gaps in/on conflicting information. **Low Assessment Confidence Yes ■ No ■**

Suicide Risk

Adapted from: CYMHS Inpatient Training Program – 2001, developed by Matthew Cartwright, Senior Project Officer, CYMHS

INTRODUCTION

As a CYMHS worker, you may see young people presenting to your local hospital's Emergency Department or CYMHS service who are in crisis and are in danger of self harm and/or suicide. They may also be presenting to hospital directly following a suicide attempt. They may be ambivalent, feel hopeless, worthless, guilty and ashamed. The hospital experience and therapeutic relationships with staff are vitally important to the personal journey to hope and survival.

The nature of adolescence is confusing and anxiety provoking. No longer do they think like a child, now they have increasingly developed cognitions and emotions combined with physical development but complicated by self absorption and struggle for separation from the family as a unique individual. At this time life becomes complex and confusing with growing need and importance of peer relationships and the emergence of sexuality. They are faced with choices of educational and career pressures, a sense of identity confusion and a changing body image. The present and future for some is all too much causing despair and isolation. A young person's perceived lack of control over life may threaten their own existence, hence by the time the young person reaches hospital in crisis, the complexities might also threaten their supports, their family and possibly the novice and expert clinician.

Suicidal ideation, suicidal attempts and deliberate self harm of a young person is a source of stress for the individual, family, and possibly the child and adolescent mental health staff. Organisational and personal strategies to manage work related stress will be addressed in this module briefly. It is useful to consider issues of professional boundaries, therapeutic relationships, staff involvement, transference and counter transference issues as well. Suicide is a complex issue and is best understood in the broader context, hence, you are encouraged to consider these issues as integral parts to human life and not an isolated problem or behaviour.

This module highlights the importance of developing increased knowledge, skills, and professional attitudes to assess, intervene, and reduce the suicide risk. Planning care should always be done in collaboration within the multidisciplinary team, with communication being supportive, clear, and prompt.

The context of managing a young person in a suicidal crisis is never done in isolation, the team is always there to support, guide and make decisions together. The role for many staff will be to carry out the plan as a team. This module serves as a resource guide and learning tool. It is anticipated that with further training, reading and experience you will be able to safely assess and contribute to the care plan of a young person at risk of suicide.

Reflection

Have personal or past experiences of caring for suicidal people influenced your thinking about suicide now? How?

What concerns do you have about your own ability to manage and plan care for a suicidal young person?

What do you believe are the essential needs of a suicidal young person in crisis?

Question

What aspects of the therapeutic relationship communicate empathy with a child/adolescent?

Are you confident in planning and implementing care for a suicidal adolescent?

What knowledge and skills do you need to develop to improve the delivery of care for a suicidal adolescent?

Consider what feelings, reactions, thoughts or images you have when talking about suicide in adolescents?

Have you been involved in care of a patient who completed suicide?

Were you given adequate organisational support post suicide? If so, what helped?

What could have been done better? If you still believe issues are unresolved, it is advisable to discuss these issues with your professional supervisor to look at resolution before becoming too involved with another patient.

If you find the area of suicide uncomfortable, stressful, and anxiety provoking, to a stage where it may be interfering with your personal life it is important that you identify this to your supervisor. They might be able to assist you to develop the knowledge, skills and attitudes relevant to being more confident and comfortable to deal with issues of concern.

Activity to be done in private; keep this somewhere safe but easily accessible.
You are important and add value to the people you care for, your work team, family and friends. It is important to recognise when caring for acutely and chronically suicidal young people that your personal self-care needs to be a priority. Be proactive about it.

Identify your social supports you could talk to if you were feeling personally stressed or down.

Identify people at work you trust and could confide in regards stress related to caring for a suicidal person.

List personal activities you enjoy doing outside of work.

List the things you like about yourself.

Outline some of your personal life goals.

Outline your personal stress management strategies.

Make a plan of action that includes who you would contact if you were feeling despondent, anxious or stressed and activities that would help improve your mood or decrease the level of stress? Include professional and social supports.

NOTE: Plan to review and implement these lists regularly as a way of balancing work and life.

MYTHS OR MISCONCEPTIONS ABOUT SUICIDE

Do you hold any of these myths or misconceptions?

- People commit suicide without warning - out of the blue.
- Only crazy people commit suicide.
- Everybody who commits suicide is depressed.
- If the person committed suicide, the situation was so bad for them that death was the best solution.
- People who really want to die will find a way. It won't help to try to stop them.
- One should not try to discuss suicide with depressed people - it might give them the idea - push them over the edge.
- Improvement following suicidal crisis means suicide risk is over.
- If someone survives a suicide attempt it must have been manipulation.
- If the person talks about suicide they are most likely not going to do it.
- Suicide is expected in cases of severe hardship - especially in cases of terminal illness.
- A person who makes a non life threatening attempt - or one with a high chance of rescue - must not have been serious about dying and is not a high risk.

Fremouw, W.J., de Perczel, M., & Ellis, T.E. (1990). *Suicide Risk: Assessment and Response Guidelines* New Work: Pergamon Press cited in Treatment Protocol Project (1999).

NOTE: Discussing suicide will not make the individual more likely to attempt. It gives the person the opportunity to talk and look at alternative solutions to problems. See the appendix for strategies on how to communicate with young people.

Suicidal Behaviour and Young People

Due to the complex nature of suicide, there is no consensus of opinion among suicidologists about why young people suicide.

Queensland Health, (1999) *Life focus, A resource package for workers on the prevention of youth suicide and self harm,* Young People at Risk Program,

The concept of suicidal behaviour includes:
Suicidal ideation: are any thoughts of suicide or persistent thinking of engaging in a suicidal act, even to the point of making specific plans, but not actually carrying through with the act.

Suicide attempts: Potentially may be lethal acts but not all suicide attempts are lethal in nature. People that attempt suicide tend to believe that their act is more lethal than it actually is. Suicide attempts are aimed at ending life that does not result in death. Intent may be to end psychological pain.

Non-Suicidal Self-Harm refers to: A deliberate act of harm to ones owns body. It is done to oneself, without the aid of another person, and can be severe enough to cause tissue damage. This may include cutting, burning, scratching. Intent is to release emotional pressure.

Contributing Factors

In this module they are referred in two main areas, Predisposing and Precipitating factors and a third useful group are the Perpetuating factors.

Predisposing factors are: Individual and environmental factors that, by their presence in the young person's life, increases their vulnerability and risk for suicide. If one or more factors are present, the greater the risk:

Factors include:
- Some personality traits
- Social and cultural factors
- Family stresses
- Mental illness
- Prior suicidal behaviour
- Biochemical and genetic factors
- Exposure to attempted or completed suicide
- Feeling alienated

Precipitating factors are: Recent life events that increase the young person's sense of vulnerability or hopelessness due to heightened emotional distress, shame, and guilt or sense of failure. These factors can create despair and helplessness.

Precipitating Factors include:

- Recent loss of a significant person
- Major disappointment
- Suppression of emotions
- Lack of resolution of psychological crisis
- Peer pressure
- Fear of rejection or the prediction of punishment such as disciplinary action
- Sexual identity conflict
- Injustice- desire for revenge
- Education system- stress it causes or failure in it
- Media violence/publicity
- Violent attack/assault
- Rape
- Rejection by family or supports.

Perpetuating factors are: Predisposed or unresolved precipitating factors that perpetuate the person's vulnerability.

Source: Queensland Health, (1999) Life focus, A resource package for workers on the prevention of youth suicide and self-harm, Young People at Risk Program

Aetiology and Pathogenesis

The majority of the content following has been sourced from the Resource Book (1998) *Assessment and Treatment Planning in Child and Adolescent Mental Health CYO1,* Professional Development Program, Queensland Health and University of Queensland, Brisbane.

Primary Psychiatric Disorders

Recent studies have demonstrated that at least 90% of young people who complete suicide have evidence of psychiatric illness before their death. The strongest correlates for adolescent male suicide are a history of a suicide attempt, followed by current major depression and current substance abuse. The strongest correlate for adolescent female suicide is current major depression. A history of a suicide attempt is less strongly correlated.

One study found that 53% of younger persons (less than 30 years) who had completed suicide had abused substances.

A case-control study of adolescents found that the presence of major depressive disorder increased risk of suicide by 27 times. 82% of suicided people had a mood disorder.

Suicidal tendencies have been associated with severity of depressed mood, intensity of negative self-evaluation, increased level of hopelessness, and high levels of anhedonia. Hopelessness is the most important variable. When the effect of hopelessness is controlled, depression ceases to be predictor of completed suicide; however, when the effect of depression is controlled, hopelessness remains a significant predictor

Developmental and Personality Traits

Young people with specific developmental disorders that impair their learning skills are at increased risk.
IQ is not a predictor.
Impulsivity and intense aggression have been associated with suicidal behaviour in children and adolescents.
Borderline and antisocial personality traits and disorders have been associated with both completed and attempted suicide in adolescents.

Biological Factors

Some reports indicate a role for excessive hypothalamopituitary-adrenal axis functioning among suicidal youth (high plasma cortisol).

Aberrations in neurotransmitter systems have been implicated, as for suicidal adults (lowered 5-HIAA in CSF, low platelet imipramine binding).

Stress, Loss and Emotional Trauma

Research suggests a significant relationship between stressful life events and suicidal behaviour in children and adolescents. Stressful events include deaths, separations, family discord, births of siblings, illness, hospitalisation and family moves (lifetime and recent).

Exposure to suicidal behaviour among relatives or friends (a family history of suicide increases adolescent suicide risk by 3-5 times).

High rates of mood disorders, antisocial personality disorder, violence and substance abuse among first-degree relatives have also been described.

Violence, especially a history of physical and/or sexual abuse, has been described as a strong risk factor for youth suicidal behaviour.

Longitudinal follow-up studies are required to determine if friends of an adolescent who commits suicide are at increased risk for suicidal acts. For vulnerable young people, the suicide of another may serve as a precipitant. For others, the reality of the event may act as a deterrent in self-harming or suicidal behaviours?

Unemployment, homelessness, and incarceration are risk factors for suicidal behaviour among young people.

Social Functioning

Poor social adjustment may be one factor that accounts for the long-term vulnerability of children and adolescents to suicidal acts (difficult interpersonal relationships with parents, siblings and peers; lack of available, empathic individuals; school failure; unpredictable social support network; sense of isolation).

A sense of hopelessness and poor problem-solving skills intensify suicidal risk.

Suicide occurs in the presence of multiple risk factors coming together in the absence of multiple protective factors. Suicide is an individual act arising out of an individual context of despair – the reason that suicide prediction tends to be extremely poor even amongst the most experienced of clinicians, except retrospectively (when specific risk factors tend to be attributed a causal status)

Aboriginal and Torres Strait Islanders

Widespread under-reporting makes it difficult to examine the incidence of suicide attempts and deaths among indigenous young people. However, a Queensland study found disturbingly high rates of suicide in indigenous youth (*Suicide in Queensland, 1990-1992*):

Indigenous Youth: **Suicide Death Rate per 100,000** **Total Population ATSI**		
AGE	**15-29 years**	**15-29 years**
Males **Females** **Total**	**34.1** **7.5** 21.0	**70.1** **9.4** 39.5

It has been suggested that these high rates are associated with the complex effects of socio-economic problems on indigenous people. For example: historical factors, incarceration, effects of racism past and present.

High levels of anxiety and depression have been reported in young Aboriginal people (under 35 years) who attempt suicide and also those who do not attempt.

The social context of violence and alcohol abuse in some communities is likely to play a role as it may in all communities

Aboriginals most at risk of death in custody are the young, those affected by alcohol, and those confined alone.

Suicide Contagion and Clustering

"Copy-cat" suicides occur among young people. Young people may be more at risk due to the developmental context, however anniversary and copycat suicides are documented as occurring throughout the life span. The death of a friend may precipitate suicidal thinking in a vulnerable young person. Media publicity of suicide may have an effect on copycat suicides.

SUICIDE WARNING SIGNS

It has been estimated that at least 8 out of 10 people who contemplate suicide give warning signs that they need help.
Source: Queensland Health, (1999) *Life focus*, *A resource package for workers on the prevention of youth suicide and self-harm*, Young People at Risk Program

The behaviours and feelings that are commonly referred to as suicide warning signs are very subjective. It is not uncommon to see a combination of these behaviours present in a young person, especially during the developmental years of adolescence. This is often referred to as teenage angst. Many of the warning signs are indicators of depression. Any one of the following signs does not necessarily indicate a risk of suicide, but a combination of attitudes and actions may indicate the person is undergoing serious problems, which could lead to a suicide attempt.

It is essential to take into account the following points:

- Contextualise the situation.
- What are the risk factors?
- What are the protective factors?
- Look for recurring or underlying thoughts, feelings or behaviours rather than one-off incidents.
- What is "normal" for this young person?

EXAMPLE OF SUICIDE WARNING SIGNS

SITUATIONAL CLUES: loss, failure, legal, injury, relationship, pregnancy, family, violence etc.

DEPRESSIVE CLUES: Neurovegetative features, guilt, worthless, Hopeless, helpless, preoccupation, apathy, crying, isolation, etc.

VERBAL CLUES: "I've lived long enough"
"I wish I were dead"
"My family is better off without me"
"I don' need these anymore"
"I can' take it anymore"
"You'll be sorry"
"You won't see me again" etc.

BEHAVIOURAL CLUES: past and current attempts
give away possessions
disregard
promiscuous
withdraws
says goodbye
disorientation
suicide note/poem/songs
self harm
run away
aggression
impulsivity,

Risk Assessment

What do we mean by risk assessment when we refer to suicidal patients and why do we do it?

What do you consider are the most important components of suicide risk assessment?

High-risk parameters for youth suicidal behaviour include:

1. History of previous attempt
2. Circumstances of suicidal behaviour (i.e., alone, planned, lethal method, access to lethal means), however, especially for adolescents/youth, impulsivity is a huge factor
3. Clear intent to die, however most suicidal people are quite ambivalent about dying – ending the pain, "psych-ache" is the clearest intent
4. Severe psychopathology (especially major depressive disorder, substance use disorder, intermittent explosive disorder)
5. Impaired coping mechanisms: poor judgment, impulsivity, severe hopelessness and helplessness
6. Poor or ambivalent communication
7. Inconsistent family support or lack of support
8. High levels of environmental stress (especially interparental or family discord)
9. Recent loss
10. Recent drop out from school or refusal to attend school
11. Refusal to enter into a "suicide contract."
12. History of violence: sexual, physical, homophobic, racist, exposure to domestic violence.
13. Indigenous clients incarcerated in prison or institutions.
14. Intoxication or impairment of mental function.

One of the aims of the assessment is to **determine the degree of immediate danger** by directly interviewing the child or adolescent. Clinical interviews should be conducted sensitively before and at the time of maximum suicidal risk and repeated frequently until risk is diminished. At the time of maximum suicidal risk the person should not be left alone, or grilled. At this point, the person needs someone to hear them talk of their pain.

Treatment

The immediate goal of treatment is to reduce the risk that injury or death could occur. Hospitalisation may require close observation and protection of the person. Close observation of the patient offers support, protection and communicates a sense of worth. For inpatient nursing staff this can be a very difficult responsibility, requiring the ability to be empathic, supportive, tolerate anxiety, be vigilant and aware of potential risks and tolerating the hopelessness, despair and pessimism of the patient for long periods of time. Staff will need extra support from the team at this time and generally need to be relieved of their duties after prolonged contact with an actively suicidal client during a shift. This issue needs to be sensitively addressed to avoid communication or misinterpretation that staff cannot stand to be with the patient. Always be aware the suicidal risks may be increased at changeover of shifts or lack of staff supervision.

Question

How do regular changes in staffing affect the establishment and maintenance of rapport with the suicidal young person?

How will this affect the young person's sense of worth and connectedness to staff?

Longer-term goals include psychological and social stabilisation and the reversal of self-defeating attitudes to the self and others.

Psychotherapeutic intervention should focus on establishing a trusting relationship and incorporating crisis intervention. The main “need” of the suicidal person is “to be heard.” Interpreting, confronting, trying to talk out of their views at this point will only tell the suicidal person that you’re not willing to hear their story, understand their pain, and will subsequently be dismissed.

Pharmacotherapy may be indicated for specific psychiatric disorders, for example major depression. Treatment of parents and other relatives should be considered with marital counselling, individual psychotherapy, pharmacotherapy and referral to community support services.

Interagency collaboration with involved schools, GPs, Inpatient Unit staff, CYMHS staff, etc during assessment, treatment and discharge planning should be carefully considered at the beginning of an admission.

Conducting a Suicide Risk Assessment

When you first meet a young person at the local hospital emergency department you are probably not going to be the first person that has asked them their story. It is important to consider the person's feelings on admission as they may have spent a number of hours discussing all of this information previously with their GP, teacher, parent, ambulance officer and /or hospital triage staff. If the risks are identified clearly then the focus of staff might be to consider forming a therapeutic relationship that fosters trust and support.

However, it is not always clear on admission that a young person is a high risk but, as issues unfold, the risk may be heightened. Key areas in deciding if someone is at risk is simply outlined in the following areas:

Mood,
Suicidal Ideation
Suicidal Plans
Person's Self Control and Intent
(Sommers-Flannagan & Sommers-Flannagan, 1995).

See pages 8-12 of this module for guidelines currently recommended by Queensland Health. A narrative style interview, taking into consideration the areas identified in the Consumer Assessment Form is preferred to using a checklist style screening tool. This is so all the necessary information can be discussed and so clinicians are able to clearly document the clinical reasoning used in the decision making process.

DISCUSSING SUICIDE

Adults often feel uncomfortable discussing suicide with young people, fearing that they may instil the idea in the young person's mind. Before asking questions about suicide, it is essential that you have established a rapport with the young person so that disclosures about suicidal thoughts or behaviour are made in a safe context.

Ways of framing your question could be:

- "Are you thinking about killing yourself?"
- "Have you felt so bad you've wanted to hurt yourself?" or
- "When you feel this way, have you ever wanted to kill yourself and end if all?"

PRESENT FEELINGS AND THOUGHTS

It is important to understand the young person's feelings and thoughts. This tells you how hopeless they feel and how much control they believe they have over their situation. It is also important to know how frequently their thoughts are centred on killing themselves.

You can ask:

- "What hopes do you have for the future?"
- "How long have you felt like this?"
- "How often do you feel like this?"
- "It sounds as though it's hard to get these ideas out of your head"
- "Do you feel as though you've got no control over what is happening?"
- "Do you ever see or hear things that tell you to harm yourself?"

SERIOUSNESS OF PRESENT PLAN AND OF ANY PAST ATTEMPTS

Sensitive questioning about the seriousness of their plan helps you to understand the extent of their intention to die. Previous attempts are one of the strongest indicators that a person may try to kill himself or herself at a time of crisis.

You can say:

- "Do you have a plan how you would hurt (kill) yourself?"
- "How far have you got in this plan?" "When do you intend to do this?"
- "Where would you do this?"
- "Have you thought about how to get hold of a car (gun, pills)?"
- "Are you able to get hold of these?"
- "Have you ever tried to kill yourself before?"
- "When you tried to kill yourself before, what did you expect to happen?" “How did you try last time(s)?”
- "Did you expect to die?"
- How did you feel later about what happened?"

ALTERNATIVE COPING STRATEGIES

It is important for you and the young person to identify and know what their coping strategies are in order to explore those that negate suicide as an option.

THOUGHTS, FEELINGS AND BELIEFS ABOUT SUICIDE

Does the young person have beliefs that oppose suicide as a solution? How realistic is the young person about suicide? What has stopped them so far?

Ask them:

- "Have you thought about what might happen if you try and kill yourself but are unsuccessful?"
- "What things make you have second thoughts about killing yourself?"
- "What do you think happens when people die?"
- "What helps you to keep going?"

AVAILABLE SOCIAL SUPPORTS AND HOW INVOLVED THEY CAN BE

You need to know whether the young person is trying to cope on their own or if there is support available. If there is support, the person may not have considered using it or may have difficulties in doing so.

Find out:

- "Who do you usually share problems with?"
- "Are they able to listen and help?"
- "What would they do, or say, if they knew your plans?"
- "Who would you like to have here with you?"
- "What would you like to have happen?"

Question

Recall developmental or cultural issues that may impact on an adolescent and contribute to increased suicide risk.

What are likely predisposing and precipitating factors that contribute to adolescent ATSI suicide?

Who is the Aboriginal Liaison worker in your area?

Assessing the risk of suicide in patients experiencing psychosis

An acute episode of psychosis, particularly the first episode, is terrifying and confusing. Suicidal ideas are especially likely if the individual is hearing voices that are commanding self-harm or suicide. The strength of these thoughts and the individual's ability to act on them must be assessed vigilantly.

Question

What are the clinical features of a psychotic young person at risk of suicide?

If a patient is psychotic and becomes suicidal, what is the most likely immediate treatment option?

Questions To Help Assess Risk of Suicide with clients experiencing psychosis:

Questions to help assess risk of suicide (positive responses indicate increased risk)

- Has the individual attempted suicide in the past?
- Do voices command the individual to harm himself or herself? (What exactly are the voices saying?)
- Is the individual unable to resist the commands at present?
- Is it likely that the individual will continue to be unable to resist the commands?
- Is the individual extremely depressed or expressing suicidal ideation?
- Was the individual recently diagnosed?
- Does the individual live alone or unsupervised?
- Is the individual also using illegal drugs?
- Is there evidence of impulsive behaviour?

Key questions to assess suicidality

- What are your feelings about living and dying?
- Are you at the end of your tether?
- Do you feel that life is not worth living?
- Have you felt like ending it?
- Have you made any plans?
- Have you already tried?

Source: Treatment Protocol Project (1999). *Acute Inpatient Care: A Source Book*. World Health Organisation Collaborating Centre for Mental health and Substance Abuse, 299 Forbes St, Darlinghurst, NSW, 2010

Difficulties in Assessing Suicide Risk

What difficulties have you experienced when assessing suicide risk in young people? How did you overcome these problems? What do you need to learn?

Difficulties in assessment of suicide risk

- Deliberate denial
- Variable degree of risk
- False improvement
- Lack of trust
- Feeling manipulated
- Avoiding the issue
- Dealing with anger, resentment and lack of co-operation

Individuals who refuse to talk

A particular difficulty in assessment is those individuals who are not willing to discuss their previous suicide attempt or current thoughts of plans.
Reasons for such refusal include (Treatment Protocol Project, 1997):

- Fear that they will be prevented from committing suicide.
- Embarrassment or shame about having such thoughts or about previous attempts.
- Fear of being labelled "mentally ill".
- Doubt about the confidentiality of the interview.
- A person who is oppositional or manipulative.
- Belief that there is nothing anyone can do.

NOTE: In risk assessment it is up to staff to find out what suicidal thoughts or behaviours mean to the young person, help them achieve their needs in other ways, and not make the assumption that "things will be OK".

The prediction of suicide is relatively subjective. While warning signs are useful indicators of distress, there is no one tool that can predict which at-risk suicidal person will actually suicide. However, the body of knowledge of suicide has identified a series of risk factors that make a person more vulnerable to suicidal behaviour. Consider these factors in assessment of inpatients that present at risk.

Source: Life Focus (1999), *A resource package for workers on the prevention of youth suicide and self-harm*, Young People at Risk Program. Queensland Health

A patient discloses a suicidal plan to you. You immediately inform other CYMHS staff or inpatient unit staff on duty. Who else should be informed?

What other interventions would you consider implementing to manage the patient's safety?

What will you document in the file?

What type of support is most effective for the family at this time?

General Management Strategies

It is recommended that you read your hospital or unit protocol. The following strategies are to be used as a guide and reference. Individual treatment planning should be considered carefully and planned individually within a multidisciplinary team.

What are the key elements when planning treatment for suicidal young people?

Guidelines for Treating Suicidal Patients

Adapted from Wilson, H.S. & Kneisl, C.R. (1992) *Psychiatric nursing.* (4th ed). California: Addison-Wesley Nursing

General Procedures Sample Protocol

1. Talk about suicide openly and matter-of-factly.
2. Avoid pejorative explanations of suicidal behaviour or motives.
3. After “crisis” has passed, present a problem-solving theory of suicidal behaviour, and maintain the stance that suicide is an ineffective solution.
4. Involve significant others, including other therapists.
5. Schedule sessions frequently enough and maintain session discipline such that at least some therapy time is devoted to long-term treatment goals.
6. Stay aware of the multitude of variables impinging on patients, and avoid omnipotent taking or accepting of responsibility for patient's suicidal behaviours.
7. Maintain professional consultation with a colleague.
8. Maintain contact with persons who reject therapy.

Being with, reaching, and tolerating the adolescents suicidality is vitally important. Do not fear the patient's suicidality, as their cognitions are often very distorted.
Avoid deliberate non-discussion of suicidal feelings. Take this opportunity to listen to their psychic pain, instil hope, reassure them (However, make no promises you cannot fulfil, e.g., “It’s all going to be alright”- you can’t assure this, so don’t say it). Be supportive, explain to them people don't want them to die, assist them to problem solve, restructure cognitive distortions if not in "crisis,” and plan positive steps focussed on living.

Using cognitive and behavioural approaches can be useful but so can other therapies which address history and experiences rather than current symptoms. When people are suicidal they make inaccurate perceptions of their options. If they are in an inpatient unit, get them involved in peer activities or listening to music. Discourage them sitting by themselves for long periods of time. Make them aware that you notice them, offer praise and comment on their positive contributions.

The above protocols give an outline of general strategies. Consider the following questions.

What do you say to a patient who feels suicidal?

How will you instil hope?

Emphasis thus far has focussed on the person at risk. Consider the reactions of the parents/ carers and siblings.

What are the likely reactions of the parents/ carers?

What are the likely reactions of siblings to their sibling admitted and at risk?

What supportive and educative measures can the team provide to reduce the emotional distress and improve the coping abilities of the family?

Suicide Postvention

In the event of an inpatient or a CYMHS client suicide there will be support provided to staff, inpatients and the family involved. This may be done differently across organisations. Suicide Postvention refers to activity following/responding to a completed suicide. Debriefing or supervision should occur for staff when dealing with a patient that completes or attempts suicide. Staff responses will differ for both self-harm and completed suicide. It is important to recognise that your colleagues' personal experience may be influenced and shaped by their own experiences of death, values, cultural and spiritual beliefs. A number of issues may impact on the grieving process. Awareness and acceptance of your team's reactions will also assist you to manage your reactions.

The personal reactions of staff, family and others following suicide is somewhat unpredictable. However understanding the range of emotions most likely experienced within the team and family guide processes to facilitate bereavement. The process of communicating suicide to the family is difficult and should always be handled by experienced staff. It may be helpful in these situations to have experienced professionals outside the immediate team to assist the bereavement process as well, eg hospital chaplain, religious or cultural support, grief counsellor etc

What is postvention?

What are the aims of postvention?

Postvention is the term used to describe strategies implemented to respond to a suicide and other major adverse events. It encompasses a number of activities

The aims of postvention activities are:

- To facilitate the expression of feelings about the suicide of the person who died.
- Minimise the romanticisation of the death.
- To provide support and debriefing to those affected.
- To identify those most affected by the suicide
- To prevent the possibility of suicide contagion.

Debriefing:

- Must be coordinated and responsive to the needs of the group
- Contextualised in an understanding of young people's grieving processes
- Use a variety of methods e.g., ritual, group work, discussion, information sharing.
- Primary focus is psychoeducational and support but may also provide counselling
- Use both individual and group processes
- Includes family where possible
- Does not seek to explain away the suicide but to provide terms of reference by which to understand it.

For further understanding of this area you are encouraged to read Life Focus (1999), *A resource package for workers on the prevention of youth suicide and self-harm,* Young People at Risk Program. Queensland Health

Summary

Treatment and management of suicide is a shared team responsibility. No one should ever feel alone about managing a child/adolescent at risk.

Due to the complex nature of suicide, there is no consensus of opinion among suicidologists about why young people suicide.

Contributing factors to youth suicide can best be described as predisposing, precipitating and perpetuating factors.

It has been estimated that at least 8 out of 10 people who contemplate suicide give warning signs that they need help.

The concept of suicidal behaviour includes: *Suicidal ideation*, *Suicide attempts and Suicide.*

Aetiology and Pathogenesis is based in the outlined areas

- Primary Psychiatric Disorders
- Developmental and Personality traits
- Biological Factors
- Stress
- Loss
- Social Functioning
- Aboriginal and Torres Strait Islanders
- Social and environmental factors

The immediate goals of treatment are to build rapport and trust with the person and reduce the risk that injury or death could occur.

Hospitalisation emphasises safety and protection including close observation, support and education of the family.

Longer-term goals include psychological and social stabilisation and the reversal of self-defeating attitudes to the self and others.

The prediction of suicide is relatively subjective. While warning signs are useful indicators of distress, there is no one tool that can predict which at-risk suicidal person will actually suicide.

Postvention is the term used to describe strategies implemented to respond to a suicide or adverse life event, it generally includes debriefing of staff, family and possibly inpatients.

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Unit 2.4
Suicide Risk Assessment and Safety Plans

Record of Learning and Resources

Record of Learning
Unit 2.4 Suicide Risk Assessment and Safety Plans

The following activities are suggestions for assessing your learning from this unit. They may be used as a self assessment tool or be reviewed with your team leader or supervisor.

1. Watch DVD 6 on Suicide Risk assessment and Safety Plans
2. Study the Associated Learning Materials and complete the Case Study Questions.
3. Study the Additional Learning Materials and complete the Reflection Questions.
4. Review the answers and discuss issues that may arise with your supervisor or team leader.
5. During supervision, review one of your current clients for whom you have had to complete a risk assessment. Review the MSE and risk assessment and discuss your clinical reasoning that contributed to the decision making process for this client.
6. Present the safety plan and treatment plan that you developed in collaboration with this client.
7. Use supervision to reflect on any difficult situations you have encountered related to clients that have been suicidal. You may also wish to speak about any personal issues that have come up for you during the completion of this unit.
8. Complete the following Record of Learning on the following page:

Record of Learning
Unit 2.4 Suicide Risk Assessment and Safety Plans

Clinician Name _____

Record of Learning	Date achieved	Signed
Describes major risk factors and identifies warning signs for suicidal clients.		
Outlines major areas that contribute to the aetiology and pathogenesis of suicide		
Outlines key areas of risk assessment of children and/or adolescents in the CYMHS setting		
Identifies assessment and treatment strategies used in CYMHS for young people that are suicidal		
Completes a suicide risk assessment using the approved Qld Health forms and describes clinical reasoning used		
Develops an appropriate safety plan and treatment plan in collaboration with the client (and carers if appropriate)		
Describes appropriate communication strategies that are useful when communicating with a suicidal young person		
Identifies some of the issues for families/ carers of a suicidal young person		
Identify the aims of postvention in suicide		
Identifies strategies to manage personal stress in relation to caring for suicidal clients		

Additional Supervisor/ Team Leader feedback and comments:

_____

_____

_____

_____

Signed _____

Congratulations and well done for completing this unit of learning. We hope it has been useful and interesting.

Please now complete and return the evaluation/ feedback forms. There is a form for you as the clinician and one for your supervisor to complete. Both of these forms are found in the section 'Evaluation/ Feedback Forms at end of this package.

Thank you