

Lanarkshire Suicide Assessment & Treatment Pathway

POCKET GUIDE



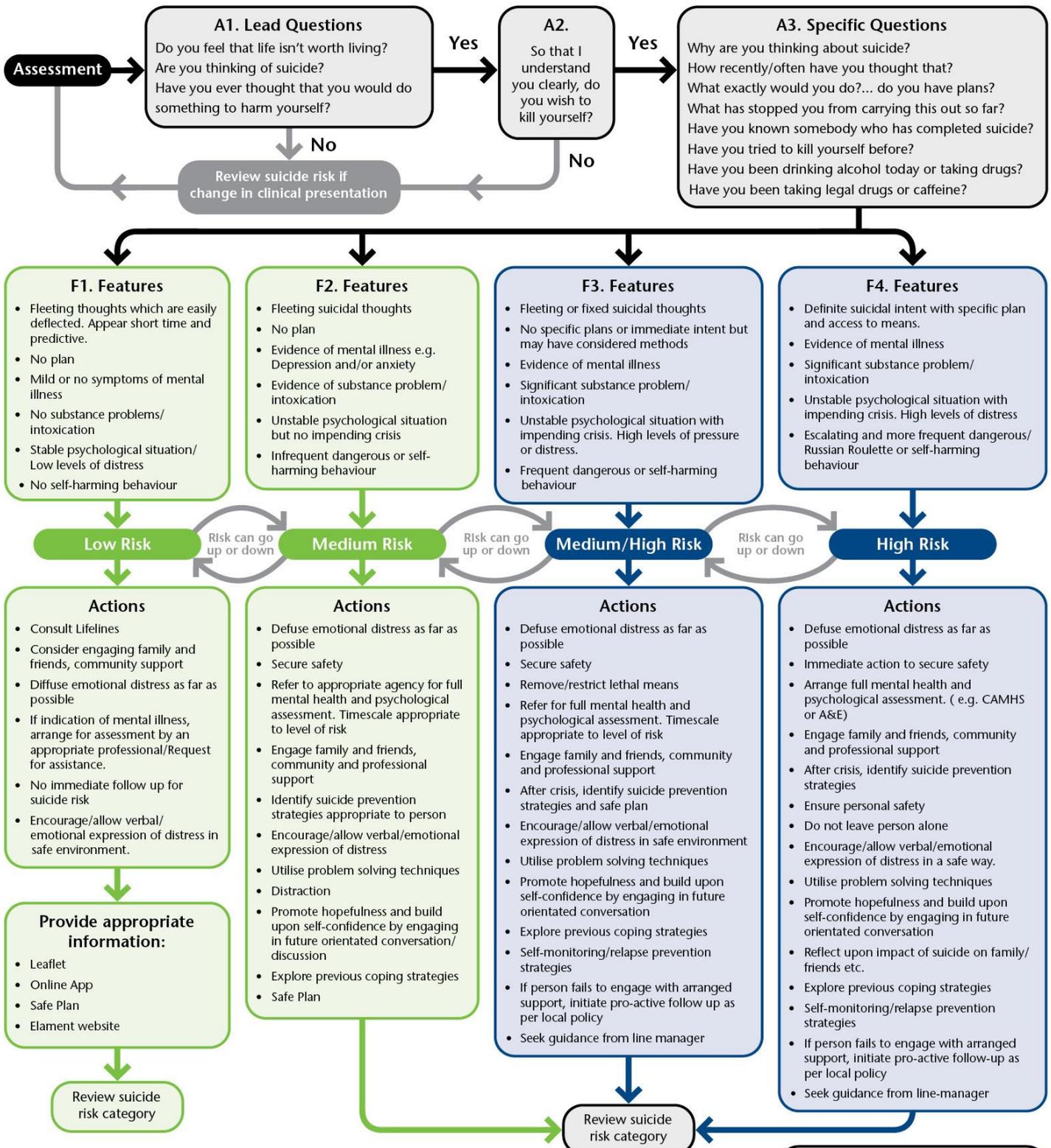
Supporting Guidance

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Help and support can be found by contacting:
Breathing Space 0800 83 85 87 www.breathingspace.scot
Samaritans 116 123 www.samaritans.org
Childline 0800 11 11
For mental health information visit www.elament.org.uk

Suicide Assessment and Treatment Pathway

This pathway should be used in conjunction with the Supporting Guidance document



This pathway is intended as guidance only and staff should use their professional judgement when making decisions



If not in contact with Mental Health services consider referral to:

- General practitioner
- Accident and Emergency (Psychiatric Assessment Team)
- Community Mental Health Team/CAMHS
- Outpatients (Psychiatry)
- Addiction team

At all levels of risk

- ensure compliance with Child Protection Guidance
- record suicide risk, action taken, those involved and review risk in future if change in clinical presentation

In consultation with the person, inform GP and key support agencies regarding outcome of assessment irrespective of level of risk identified

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1. Introduction

The Scottish Government has set the target of reducing suicide in Scotland by 20% by 2022. To do this a national Suicide Prevention Action Plan (Every Life Matters) was launched in 2018. North & South Lanarkshire Multi Agency Suicide Prevention Groups have developed Action Plans focussing on the National key priorities. Local strategy focuses on a broad range of activities particularly awareness raising, promoting access to support such as Breathing Space and Samaritans and suicide intervention training. **It has been highlighted nationally that more focus at a local level needs to be given to ensuring good suicide prevention initiatives are embedded in practice via protocol and procedures.**

It has been estimated that internationally approximately one million die through suicide every year (WHO 2006).

- There were 784 suicides (deaths from intentional self-harm and events of undetermined intent) registered in Scotland in 2018, compared to 680 in 2017. These figures are based on the new coding rules introduced by the National Records of Scotland (NRS). The corresponding estimates based on the old coding rules (see note below) are 753 suicides in 2018 and 664 in 2017.
- In 2018, the suicide rate for males was three times that for females.
- In 2014-18, the suicide rate was more than three times higher in the most deprived tenth of the population (decile) compared to the least deprived decile (21.7 deaths per 100,000 population compared to 7.0).
- While suicide rates are strongly related to deprivation level, this difference or inequality has decreased between 2004-08 and 2014-18.
- The suicide rate varies between different areas within Scotland and fluctuates over time. For 2014-2018, seven NHS Board areas had a higher European age standardised rate than the Scotland average.
- Scotland appears to have had a higher suicide rate than the UK overall since the early 1990s, though this comparison is affected by differences in data recording practices between countries.

The personal, family, community and economic impact of suicide are well documented. **Many suicides can be prevented.**

NHS Lanarkshire, North Lanarkshire Council, South Lanarkshire Council and partners have jointly developed a suicide assessment and treatment pathway. The pathway assists staff within these agencies in the assessment of people at risk of suicide and provide appropriate and timely treatment within appropriate timescales. It is envisaged that this pathway will ensure a more uniform, systematic and accessible response to this significant health issue, combined with training in the assessment and treatment of individuals at risk of suicide through initiatives such as safeTALK, ASIST and STORM.

This supporting guidance document is aimed at all health and social care staff who need to be vigilant of people who desire to kill themselves and has been designed to be read alongside the Suicide Assessment Treatment Pathway. **All threats of suicide require to be taken seriously and thoroughly investigated.**

Although suicide is a multi-faceted phenomenon three main factors require to be identified on assessment of risk: **desire, intent and capability**. 'Buffers' supports and factors, which mitigate and protect against suicide, also require assessment (Joiner et al 2006).

2. How to use

This supporting guidance aims to assist practitioners in identifying risk of suicide and to enable staff to work through the pathway successfully.

It may be used to support your own professional judgement and existing local practice. The individual assessment and plan of care should be recorded in the person's record under all circumstances.

Each section systematically follows the directional flow of the boxes in the pathway.

3. Assessment

Box A1 Lead Questions

Direct and unambiguous questioning clarifies the persons desire to die and allows the person to talk about what can be a taboo subject.

Asking direct questions enables the following to be assessed:

Suicidal desire has been shown to be made up of the following components: no reason for living, wish to die, wish not to carry on and not caring if death occurred. While not the same as distress, other psychological conditions are known contributors to suicide. These include feeling trapped, belief that there is no alternative course of action, feeling hopeless and/or helpless and feeling intolerably alone. Suicidal desire on its own is not necessarily indicative of high of suicide risk. When combined with suicidal capability or suicidal intent the risk of suicide may dramatically increase. (Joiner et al 2006).

Myth: *'Asking people about suicide will increase the risk'*.

Fact: People may be reluctant to talk about suicide for a number of reasons such as stigmatisation, people may be distressed or depressed to talk about their feelings and they may feel they would not be understood. Asking people directly if they are thinking about suicide may open up communication pathways that in itself may reduce the risk of suicide and enable the exploration of alternatives.

Box A2

Staff need to be aware that although a person may exit the pathway, risk of suicide can change rapidly.

Myth: *'There is no way of knowing who is going to complete suicide'*

Fact: Psychological autopsies have identified that there are a range of characteristics changes evident in people who have taken their own life; these include changes in behaviour, changes in cognition or thinking and evidence of increased distress and depression.

Although no risk of suicide has been identified the risk of suicide can fluctuate and change over a short period of time. Changes in presentation may necessitate future review of suicide risk.

Box A3 Specific Questions

Suicidal capability is defined as sense of fearlessness to make a suicidal attempt, sense of competence to make an attempt, availability of means, opportunity, specific plans and preparations. The following factors contribute to suicidal capability, history of suicide attempts, history of violence towards others, exposure to someone else's death by suicide, availability of means, current intoxication, tendency towards frequent intoxication, acute symptoms of mental illness, recent dramatic mood change, out of touch with reality, extreme rage, increased agitation and decreased sleep. (Joiner et al 2006)

Why are you thinking about suicide?

Gives clear information as to the reasons and gives opportunities to explore coping mechanisms and problem solving with person.

How recently/often have you thought that?

Identify whether suicidal thoughts is a reaction to specific crisis or more prolonged.

What exactly would you do....do you have plans?

Suicidal intent identifies if plan or attempt is in progress, imminent plan to hurt self/others, preparatory behaviours, expressed intent to die. (Joiner et al 2006). The more detailed the plan and means to avoid detection indicates greater risk.

What has stopped you from carrying this out so far?

Reasons given can help formulate the starting point for the safety plan. Begin to explore: buffers, barriers, resources and supports open to the person. These may minimise/reduce likelihood of suicide and provide an opportunity to strengthen and expand these factors.

Have you known someone who has completed suicide?

Family history of suicide more than doubles the risk of suicidal behaviour (Roy et al 2005). The risk of suicidal behaviours amongst family members of suicidal individuals is about 4-5 times that observed in relatives of non-suicidal people (American Psychiatric Association 2003). The impact of suicide on those left behind is associated with future suicidal behaviour (Agerbo 2003).

Have you tried to kill yourself before?

This can be the single biggest risk factor for certain demographic group's e.g. older adult (Beeston 2006)

Myth: *'People who are serious about engaging in suicidal behaviour do not tell anyone else'*

Fact: There are a number of assessable factors that can be identified which do not rely on the person talking about suicide or not. These include previous history of self-harm/suicidal actions, family history and risk factors such as substance misuse and risk taking.

Have you been drinking alcohol today?

There is a strong body of evidence demonstrating the link between alcohol and suicide. Alcohol is frequently a contributing factor in suicides and attempted suicides in both the long term (alcohol dependency) and short term (alcohol consumed by non-dependant drinkers prior to suicide taking place). The World Health Organisation (2020) indicates that up to a third of all cases of suicide have been shown to be alcohol dependant whilst The Samaritans (2020) report that people are 8 times more likely to complete suicide if abusing alcohol.

National Confidential Inquiry into Suicide and Homicide by people with mental illness indicates that 58% of those who died by suicide had had history of alcohol misuse and 39% had a history of drug misuse. In 17% alcohol dependence was the primary diagnosis; 9% this was drug dependence and 29% were misusing both alcohol and drugs. Manchester University (2008)

To determine whether alcohol consumption is a contributory factor in relation to suicide risk ask **'Is alcohol being used to assist you in carrying out your suicide plan?'** and **'Has alcohol played a role in any previous suicide attempts?'**

If the person is intoxicated and unable to be adequately assessed ensure an appropriate place of safety is facilitated until full assessment can be undertaken.

Have you been using drugs today?

The second most common single risk factors associated with completed suicide is substance misuse (alcoholism, alcohol dependence and drug misuse). There is international research which reports on the levels of suicide amongst those who use drugs. (Platt, Steven 2007)

In 2005, 30% of drug-related deaths were registered as suicides. It appears that the highest risk of suicide is in those with multiple drug use problems. A report from the Scottish Suicide Information Database (2020) states that 11% of Scottish suicides were people know to various Addiction services on a drug treatment programme.

To determine whether drug misuse is a contributory factor in relation to suicide risk ask **'Are drugs being used to assist you in carrying out your suicide plan?'** and **'have drugs played a role in any previous suicide attempts?'**

If the person is under the influence and unable to be adequately assessed ensure an appropriate place of safety is facilitated until full assessment can be undertaken.

4. F1 Features

F1 Box

Fleeting thoughts: Suicidal thoughts are not uncommon and can be temporary or transient in nature. 1 in 5 people experience suicidal thoughts at some time (Samaritans, 2020).

Mild or no symptoms of mental illness

Myth: *'Suicide only affects people experiencing depression'*.

Fact: Although mood disorders, primarily in depressive phases, are the most common diagnoses in which suicide occurs other psychiatric illness may place people at risk of suicide. 45% of people with a psychotic illness have thoughts of suicide (Scottish Executive 2002) with between 4-15% of people with a schizophrenic illness experiencing a lifetime risk of suicide (Jacobs et al 2003). The relationship between substance misuse, in particular the co-morbidity of substance misuse and mental health problems, and suicide has also clearly been established (Scottish Executive 2006). The fact that 75% of suicides are carried out by individuals with no active involvement from mental health services also indicates that suicide is not exclusively found within this population group (Appleby 2006).

Self-harming Behaviours - Self-harming behaviours can be defined as deliberate self-harming behaviour, self-poisoning or self-injury irrespective of the apparent purpose of the act (NICE 2020). Although self-harm is not necessarily an attempt at suicide the risk of suicide following self-harm increases significantly (STORM). About 3 in 100 people who self-harm will actually kill themselves in the following 15 years. This is more than 50 times the rate for people who don't self-harm.

5. Low Suicide Risk

Actions

Issue of confidentiality should be discussed if it is agreed that family support should be engaged.

No immediate follow-up for suicide risk

Although no immediate follow up in relation to suicidal ideation is required, planned appropriate support or interventions should be continued.

Provide information

Provide contact numbers, resources and support networks for individuals, their families and supports. Timely access to supportive organisations such as Breathing Space, Samaritans, Child Line and Out of Hours services may assist individuals in developing appropriate crisis management and crisis prevention strategies.

6. F2 Features

F2 Box

Unstable psychological situation

People who historically have maladaptive behaviours for dealing with life situations or events.

Myth: *'Crisis prevention is not my responsibility'*.

Fact: Crisis prevention is the responsibility of all staff working within health and social care. Identifying and assisting individuals to work through their distress can prevent suicide from becoming an actionable option.

7. Medium Suicide Risk

Actions

Secure safety

Ensure immediate and appropriate supports are in place, i.e. staying with family member, friend, telephone helplines, community groups/support or admission to hospital.

Full mental health and psychological assessment

This assessment can be undertaken by a number of professional groups i.e. Psychiatrist, Psychiatric Assessment Team (PAT) based in Accident & Emergency Departments, Community Mental Health Teams (CMHT's).

Engage family and friends, community and professional support

Family cohesion and support act as buffers and protective factors against suicide across cultures (Goldsmith et al 2002). The identification and engagement of appropriate support networks is a key component of both crisis management and crisis prevention.

Identify suicide prevention strategies

Suicide prevention strategies and actions should be appropriate to the person and may include distraction and utilisation of problem solving techniques.

Promote hopefulness and build upon self confidence

Hopelessness has been identified as a single biggest psychological characteristic effecting suicide. Hopelessness promotes a sense of helplessness, feeling trapped and an inability to explore alternative strategies.

Explore previous coping strategies

When people experience psychological distress they often negate or minimise past coping mechanisms (Williams 2002). Exploring previous coping strategies with the person can reinforce and build upon their own abilities to deal with current stress.

8. F3 Features

F3 Box

What is meant by impending crisis

Impending crisis is when an individual is facing personal difficulties with personal loss or changes such as legal, emotional, practical, relationship, children, housing, and benefits, etc, that contribute to crisis.

Myth: *'There is no way of knowing who is going to complete suicide'*

Fact: Psychological autopsies have identified that there are a range of characteristics changes evident in people who have taken their own life-changes such as in behaviour, changes in cognition or thinking and evidence of increased distress and depression.

9. Medium/High Suicide Risk

Actions

Secure safety

Consider safety not just for the individual but also for family and staff. Suicidal behaviours directed towards others can be an aspect of suicidal behaviour (Gonda et al 2007). In very rare and extreme cases homicide-suicide behaviours can occur (Cohen 2000).

Remove/restrict lethal means

Working in cooperation with the person but involving other agencies as required (family, GP, police, pharmacy, those involved in care).

Self-monitoring

Crisis prevention/recovery action-plan. Encouraging person to identify changes in mood and behaviour and recognise crisis situations, which may precipitate thoughts of suicide. This helps formulate actions that the individual may take to address these factors.

Reflect upon impact of person's suicide on family

Explore what would be the effect/impact on individual's family, friends and community i.e. "What would be the effect on the person that found your body?" "How would your suicide affect your children?"

Pro-active follow up

If person fails to engage with arranged support consider contacting person, support agencies, family, GP or relevant professionals as per local policy.

10. F4 Features

F4 Box

Escalating and more frequent dangerous behaviours

Is there an increase in 'Russian Roulette' or risk taking behaviour?

Myth: "If a person has made previous suicide attempts they won't do it for real."

Fact: Those who have attempted suicide once are at increased risk of attempting again. They need to be taken seriously and given support to help towards finding a resolution for their suicidal thoughts and actions.

11. High Suicide Risk

Actions

Immediate action to secure safety.

Ensure/arrange for 24hr support mechanisms (person specific) which may involve medical services.

12. Factors which increase suicide risk

- Gender – young and old males
- Ethnicity – e.g. Indian and East African women (Raleigh 1996)
- Alcohol or drug problems
- Current mental illness
- Social isolation
- An immediate intention to carry out suicide
- Role change
- A choice of violent method
- The likelihood of further bad news – “the last straw”
- Recent separation/divorce/bereavement
- Poor physical health especially if not treatment responsive
- A self-imposed deadline has passed
- History of violence towards others
- Homicidal thoughts
- History of violent self-harm
- Recent escalation of: suicidal behaviour, maladaptive behaviour, help seeking behaviour, self-harming behaviour
- High suicide risk indicated if increased frequency and/or seriousness of attempts
- Perfectionism (O’Connor, in press)

13. Factors which decrease suicide risk

- Looking forward to future events
- Suggesting that suicide is not intended if particular event occurs – lowers immediate risk only
- Afraid of: death, physical or mental damage inflicted if attempt fails, impact on family or friends, no-one to care for children and/or significant others
- No access to the means of suicide (STORM 2007)
- Perceived immediate supports
- Other social supports
- Engagement with helper
- Core beliefs
- Orthodoxy (commitment to core beliefs)
- Sense of purpose/hope
- Religiosity
- Optimistic attributional style (Sheehy et al 2007)

14. Evidence Base

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