

sak

suicide
assessment
kit

*A comprehensive assessment
& policy development package*



UNSW
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The Difference is Research

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Legal disclaimer

This document is a general guide to appropriate practice, to be followed only subject to the practitioner's judgement in each individual case.

The Kit is designed to assist decision making and is based on the best information available at the date of publication.

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Glossary

- **Alcohol and/or other drug (AOD) use disorders** – the presence of abuse or dependence on AOD as defined by the commonly accepted classification systems, such as the Diagnostic and Statistical Manual (DSM) of Mental Disorders and the International Classification of Diseases (ICD). This term is used interchangeably with “substance use disorders” and includes substance abuse and substance dependence.
- **AOD treatment services** – refers to specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone or buprenorphine for opiate dependence), and outpatient counselling services. These services may be in the government or non-government sector.
- **AOD workers** – refers to all those who work in AOD treatment settings in a clinical capacity. This includes, but is not limited to, nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and case workers.
- **Mental illness** – refers to the presence of a mental health disorder (other than a substance use disorder) as defined by the DSM or ICD. Also known as psychopathology.
- **Comprehensive suicide risk assessment** – a comprehensive evaluation of a client’s level of suicide risk. In addition to screening, the comprehensive assessment provides a thorough review of a range past and present factors.
- **Safety plan** – a plan devised with client that includes intervention and reassessment and a particular course of action they can follow when the risk of suicidal behaviour is heightened. The safety plan will detail who the client can contact for support, including family, friends, carers and service providers. Involve client and their families/carers where possible in this process.
- **Self-harming behaviour** – the direct, deliberate act of harming one’s body without the conscious intention to die. Self-harm may result in death and is a risk factor for suicide.
- **Suicidal ideation** – thoughts of engaging in suicidal behaviour, with or without a specific plan.
- **Suicide** – self-injurious act intended to end one’s life which results in death.
- **Suicide attempt** – potentially self-injurious act intended to end one’s life, but which does not result in death.
- **Suicide plan** – individual strategy for suicide inclusive of timeframe and means to complete suicide.
- **Suicide risk screening** – the process of briefly ascertaining a basic overview of a client’s suicide risk status (often through use of a standardised screening tool).

Preface

The Suicide Assessment Kit, or 'SAK', was developed by the National Drug and Alcohol Research Centre (NDARC) in partnership with the Network of Alcohol and Other Drug Agencies (NADA), and aims to provide alcohol and other drug (AOD) workers with evidence based resources to assist them in the assessment and management of suicide risk. Suicide is a leading cause of death among people who misuse drugs and alcohol. Staff in residential rehabilitation services can expect that approximately a half of women and a third of men entering treatment will have attempted suicide at some stage. The detection of suicide risk among those in treatment for drug use problems, and linkage of those at risk with the necessary services, is essential to save lives.

We developed the SAK in response to a need that was identified as a result of interviewing managers and staff of residential rehabilitation services nationally. The SAK contains three key resources: 1) the *Suicide Risk Screener*, 2) the *Suicide Risk Formulation Template*, and 3) the *Suicide Policies and Procedures Pro-forma*. During 2013-2014 the SAK was evaluated in frontline treatment services, and modifications were made on the basis of the feedback received.

When integrating SAK resources within existing documentation at a treatment service, it is recommended that managers begin by reviewing their policies and procedures using the *Policies and Procedures Pro-Forma* as a guide. This will ensure that appropriate policies are in place to support the use of the *Suicide Risk Screener* and *Risk Formulation Template*. Further information about the SAK is available from the NDARC website (<https://ndarc.med.unsw.edu.au>)

This package could not have been produced without the generous assistance of residential rehabilitation staff across Australia, and we thank them for sharing their knowledge of current suicide risk assessment practices.

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Introduction

Suicide is a leading cause of death among people who misuse drugs and alcohol, and the relative risk of completed suicide is far higher than that of the general population ¹⁻³. Among those who die by suicide, recent contact with health services prior to death is common ⁴. It has been estimated that up to 90% of people who die by suicide suffer from a diagnosable mental disorder, the most frequent of which are substance use disorders ⁵. Detecting suicide risk within this population, and linking those at risk with the necessary services, is essential to save lives. Furthermore, suicidal thoughts and behaviours may also indicate the presence of other mental disorders. These need to be assessed, diagnosed and addressed to effectively manage suicide risk and improve treatment outcomes for substance misuse. As a result it is important that treatment services have useful tools to assess and manage this risk. Suicide risk assessment is necessary in order to gain insight into a client's suicidal risk level. It then allows this risk to be managed accordingly, either within the service, or in collaboration with mental health and emergency services.

Despite this need, many residential drug and alcohol services have either no written suicide risk assessment policy, unclear procedures regarding assessment and intervention, or policies and procedures staff are unaware of ⁶. In addition, there is a lack of tools available to frontline staff to adequately assess and manage suicidality. The first stage of the current project identified the need for a number of resources and tools to better equip staff and management to assess suicide risk and establish policies and procedures to manage this risk. While having broad application to a range of organisations in the human services field, the following set of resources form a toolkit designed specifically to provide alcohol and/or other drug (AOD) workers with the tools necessary to effectively assess and manage suicide risk in their clients.

It is important to stress that suicide risk assessment should be an ongoing process and not a once-off event. Ongoing assessment is important because clients' suicidality may change throughout treatment. For example, a person may present with suicidal ideation upon treatment entry. These thoughts, however, may subside with abstinence. Alternatively, a person may enter treatment with no suicidality, but may develop such tendencies after a period of reduced use or abstinence, particularly if the person has been using substances to self-medicate ⁷. Importantly, it has been established that carefully eliciting suicidal ideation does **not** increase the risk of suicide ^{10, 11}. It is vital that whenever suicide risk is at all suspected, AOD staff members enquire as to the presence of the client's thoughts and feelings related to suicide.

The resources provided in this kit have been developed to aid staff in identifying and managing suicide risk. The kit is divided into two broad sections, one dedicated to staff and the other to management. The staff resources (and supporting documents) provide practical tools for dealing with suicidal behaviour at an individual level. The manager resources (and supporting documents) provide the tools for services to manage suicide risk at an organisational level. These are summarised below.

The *Suicide Risk Screener* is a simple screening tool designed for use at set time points in treatment (e.g. admission, transition points, discharge) and when a staff member suspects the client may be at heightened risk.

Throughout treatment AOD services frequently gather information about their clients that needs to be considered as part of the individual's suicide risk profile. The *Suicide Risk Formulation Template* within this resource package has been designed to assist AOD staff in creating a comprehensive picture of the background factors that may influence suicide risk as well as client strengths that can be drawn upon. This information is likely to come from a range of different sources and is often only apparent over time after a relationship has developed between the AOD worker and client. This tool can also help staff develop strategies to overcome suicide risk in the client's treatment plan.

In addition to access to screening and assessment tools, agencies should also have policies and procedures in place surrounding timeliness of assessment and management of risk, along with file keeping and information sharing/referral resources and procedures. The *Suicide Policies and Procedures Pro-forma* aims to support and facilitate agencies to create such policies and procedures regarding suicide risk identification and management.

A number of other supporting documents and resources are also included in the SAK to aid in the process of identification and management of suicide risk. These include a list of *Warning Signs for Suicide* risk identification, a list of *Keep Safe Strategies* (for clients), *Safety Plan* and *Safety Plan on Exit* templates (for clients) and a *Commitment to Treatment* contract outline (for staff and clients to collaboratively agree to). In addition to these staff resources a *Memorandum of Understanding* template is provided to aid management in creating links with external services) and referral guidance section containing a *Letter of Referral* template and a *Client Identification Information Sheet*.

It is recommended that services make photocopies of the different resources and have these copies easily accessible for staff.

In developing these resources, it is our hope that they may support agencies and their individual staff in the clinical care of clients and the identification and management of suicidal risk. While the SAK addresses the broad clinical issue of assessing and managing suicide risk, training in

suicide risk assessment and crisis intervention, through programs such as ASIST, remains a critical component of staff professional development.

1. Staff Resources

1.1 Suicide Risk Screener

Aims of the Suicide Risk Screener

1. To ascertain the client's level of suicidal risk;
2. To determine what intervention and management strategies are necessary; and
3. To develop a safety plan to reduce risk.

When to complete the Suicide Risk Screener

Suicide risk should be assessed at any significant transition points within treatment (e.g., intake, discharge), in addition to any time where client crisis is clearly visible or suspected (see warning signs in supporting documents, page 25). Your service should ideally have in place its own policy regarding the timeliness of ongoing suicide assessment. In addition to suicide assessments conducted at fixed time points in treatment, it is vital to screen for suicidal thoughts and behaviours based on the staff member's informal assessment of a client's presentation, behaviour, personal situation or ominous utterances.

It should be noted that suicidal ideation can vary in intensity over relatively short periods of time. Staff are encouraged to familiarise themselves with the instructions which follow the *Suicide Risk Screener* in order to understand the importance of each item and how to respond to risk level following the screen.

Role play videos, demonstrating the difference between low, moderate and high risk, as assessed by the screener, are available for download from the NDARC website (<https://ndarc.med.unsw.edu.au/>).

Client:

Screen completed by:

Date:

Suicide Risk Screener

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I need to ask you a few questions on how you have been feeling, is that ok?

1	In the past 4 weeks did you feel so sad that nothing could cheer you up?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
2	In the past 4 weeks, how often did you feel no hope for the future?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
3	In the past 4 weeks, how often did you feel intense shame or guilt?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
4	In the past 4 weeks, how often did you feel worthless?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
5	Have you ever tried to kill yourself?	<div>Yes* <input checked="" type="checkbox"/> No <input type="checkbox"/></div> <div>If Yes:</div> <div>a. How many times have you tried to kill yourself? <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 +</div> <div>b. How long ago was the last attempt? _____ (mark below) Have things changed since? _____</div> <div><input type="checkbox"/> In the last 2 months <input type="checkbox"/> 2-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> More than 2 years ago</div>				
6	Have you gone through any upsetting events recently? (tick all that apply)	<div>Yes <input type="checkbox"/> No <input type="checkbox"/></div> <div> <input type="checkbox"/> Family breakdown <input type="checkbox"/> Conflict relating to sexual identity <input type="checkbox"/> Child custody issues <input type="checkbox"/> Other (specify) _____ </div> <div> <input type="checkbox"/> Relationship problem <input type="checkbox"/> Chronic pain/illness <input type="checkbox"/> Trauma </div> <div> <input type="checkbox"/> Loss of loved one <input type="checkbox"/> Impending legal prosecution </div>				
7	Have things been so bad lately that you have thought about killing yourself?	<div>Yes* <input checked="" type="checkbox"/> No <input type="checkbox"/></div> <div>If Yes:</div> <div>a. How often do you have thoughts of suicide? _____</div> <div>b. How long have you been having these thoughts? _____</div> <div>c. How intense are these thoughts when they are most severe?</div> <div> <input type="checkbox"/> Very intense <input type="checkbox"/> Intense <input type="checkbox"/> Somewhat intense <input type="checkbox"/> Not at all intense </div> <div>d. How intense have these thoughts been in the last week?</div> <div> <input type="checkbox"/> Very intense <input type="checkbox"/> Intense <input type="checkbox"/> Somewhat intense <input type="checkbox"/> Not at all intense </div> <div>If No: skip to 10</div>				
8	Do you have a current plan for how you would attempt suicide?	<div>Yes* <input checked="" type="checkbox"/> No <input type="checkbox"/></div> <div>If Yes:</div> <div>a. What method would you use? _____ (Access to means? Yes No)</div> <div>b. Where would this occur? _____ (Have all necessary preparations been made? Yes No)</div> <div>c. How likely are you to act on this plan in the near future?</div> <div> <input type="checkbox"/> Very likely <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely <input type="checkbox"/> Very unlikely </div>				
9	What has stopped you acting on these suicidal thoughts? _____ _____ _____					
10	Do you have any friends/family members you can confide in if you have a serious problem?	<div>Yes <input type="checkbox"/> No <input type="checkbox"/></div> <div>a. Who is/are this/these person/people? _____</div> <div>b. How often are you in contact with this/these person/people? _____</div> <div> <input type="checkbox"/> Daily <input type="checkbox"/> A few days a week <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once a month </div>				
11	What has helped you through difficult times in the past? _____ _____ _____					

☒ * Indicates high or moderate risk answer

Client presentation/statements (tick all that apply)	
<input type="checkbox"/> Agitated <input type="checkbox"/> Disorientated/confused <input type="checkbox"/> Delusional/ hallucinating	<input type="checkbox"/> Intoxicated <input type="checkbox"/> Self-harm <input type="checkbox"/> Other: _____

NOTE: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically HIGH

Worker rated risk level:	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
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Level of risk	Suggested response
Low: <ul style="list-style-type: none"> No plans or intent No prior attempt/s Few risk factors Identifiable ‘protective’ factors 	<ul style="list-style-type: none"> Monitor and review risk frequently Identify potential supports/contacts and provide contact details Consult with a colleague or supervisor for guidance and support Refer client to safety plan and keep safe strategies should they start to feel suicidal.
Moderate: <ul style="list-style-type: none"> Suicidal thoughts of limited frequency, intensity and duration No plans or intent Some risk factors present Some ‘protective’ factors 	<ul style="list-style-type: none"> Request permission to organise a specialist mental health service assessment as soon as possible Refer client to safety plan and keep safe strategies as above Consult with a colleague or supervisor for guidance and support Remove means where possible Review daily
High*: <ul style="list-style-type: none"> Frequent, intense, enduring suicidal thoughts Clear intent, specific/well thought out plans Prior attempt/s Many risk factors Few/no ‘protective’ factors <p>*or highly changeable</p>	<ul style="list-style-type: none"> If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone Remove means where possible Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available Consult with a colleague or supervisor for guidance and support

Instructions

How to complete the Suicide Risk Screener

As stress can reduce a client's capacity to concentrate, it is important to speak clearly, slowly and calmly when completing the screener. Furthermore, client intoxication prevents an accurate assessment. Importantly, however, the resulting lack of inhibition and increased impulsivity caused by intoxication may greatly increase the risk of suicide ⁷. If the client is intoxicated and reporting suicidal ideation, the client's suicidal risk level is automatically deemed to be high.

Items 1 – 4:

Hopelessness and other depressive symptoms (e.g., guilt, shame) are important risk factors for suicide. The broad aim of the first four items on the screener is to assess the client's current emotional state. These items use '*the past four weeks*' as a timeframe. It may be helpful to read all response categories to the client in order for them to choose the most correct answer. These questions are modified versions of items on the Kessler 10 scale of psychological distress ⁸.

Item 5:

Item 5 is a flagged question. This means that a response of "yes" shifts a client automatically into the moderate or high risk categories (depending on responses to ideation (7) and planning (8) questions). Generally, a client scoring two out of three positive responses to these items should be considered 'high' risk. This item is emphasised because previous suicide attempts are arguably the clearest predictor for future suicide attempts ⁹.

After this question has been asked, if the client's response is "no," the staff member moves on to Item 6. If the client's response is "yes," however, it is necessary to ask and code questions 5a and 5b, relating to the number of past attempts and the recency of these attempts, respectively. The client's response to question 5b should be written in the space provided and coded in the boxes below it.

Item 6:

Suicidal thoughts and behaviours often follow a significantly distressing event (e.g., a relationship breakdown or legal issues). The purpose of Item 6 is to establish whether the client has experienced any such personal stressor of late. More than one "event" may be relevant and where this is the case the staff member should tick all that apply. It may be necessary to prompt the client where s/he fails to comprehend what kind of event is being elicited. Where the "upsetting event," does not fall into any of the listed categories, specify this event in the "other" section.

Item 7:

Like Item 5, Item 7 is also flagged. This means that a response of “yes” shifts a client automatically into the moderate or high risk categories (depending on responses to the previous attempts (5) and the planning (8) items). This Item aims to establish whether the client is having thoughts of suicide, a preceding factor to any attempt.

If the client’s response is “no,” the staff member ‘skips’ to Item 10. If the client’s response is “yes,” however, it is necessary to ask and code questions 7a, 7b, 7c and 7d, relating to the frequency and intensity of these thoughts. The client’s response to question’s 7a and 7b should be written in the space provided, while question’s 7c and 7d are to be coded in the boxes provided. It may be appropriate to read all response categories to the client in order for them to pick their most correct answer.

Item 8:

Like Items 5 and 7, Item 8 is also flagged. Having a plan for suicide indicates premeditation and a serious suicidal intent. This is not to discount the impulsive nature of many suicides, but this level of preparation shows a substantial amount of time has gone into thinking about the act.

After this question has been asked, if the client’s response is “no,” Item 9 is asked. If the client’s response is “yes,” however, and the client does not reveal specific details without prompting, questions 8a, 8b, and 8c, relating to the means, location and likelihood of these plans are asked and coded. The client’s response to question’s 8a and 8b should be written in the space provided. After both questions there is a question in parentheses, staff are **NOT** to read this out, but rather to consider, based on what they have been told by the client, if the answers to these questions are “yes” or “no.” Finally, the client’s response to question 8c is to be coded in the boxes provided.

Item 9:

The purpose of Item 9 is two-fold. Firstly, it is important to ascertain what ‘protective’ factors may be operating and how stable these factors are. Secondly, the nature of these factors may directly impact upon the stability of the entire assessment. For instance, if the only thing preventing a client acting on suicidal thoughts is his/her children, but there is a current custody battle taking place, the stability of the suicide risk is likely to be low. Conversely, this question might also highlight for the client his/her “reasons for living” and similarly, might indicate to staff the factors which are crucially important to the client and should be a focal point in any treatment plan.

Item 10:

The purpose of Item 10 is to directly determine the client's level of social support. Social isolation is a key risk factor for suicide, so it is important to establish whether the client has anyone in their life that they feel they can confide in (and thus draw support from).

If the client's response to Item 10 is "no," Item 11 is asked. If the client's response is "yes," however, questions 10a and 10b, naming who these people are, and how often s/he is in contact with said people, are asked and coded. The client's response to question's 10a should be written in the space provided. The client's response to question 10b should be written in the space provided and coded in the boxes below.

Item 11:

Like Item 9, Item 11 can help the client understand their means of coping and similarly, might indicate to staff the factors which are crucially important to the client and should be a focal point in any treatment plan.

How to score the Suicide Risk Screener***Risk level***

Based on the completed screener the client's level of suicide risk is coded. There are three distinct categories: low, moderate and high risk. Despite the variation in every client's presentation, all clients will fall into one of these three broad categories.

A guide outlining the above categories is included as part of the screener (see "suggested response" below). Classification into the high risk category does not require the client to fulfil the above table perfectly, merely two of these high risk indicators is sufficient. For instance, frequent, intense suicidal ideation in combination with either a clear plan, or a previous attempt, automatically classifies a client as high risk. **Irrespective of the staff member's level of experience, it is crucial that they never attempt to manage suicide risk alone.** It is anticipated that treatment agencies will have a policy in place outlining the expected consultation process.

Risk level	Presentation
Low	<ul style="list-style-type: none"> • A client in the low risk category would present no plans or intent; • No prior attempts; • Negative thinking patterns only a little/some/none of the time; • Few risk factors; and • Identifiable 'protective' factors.
Moderate	<ul style="list-style-type: none"> • Suicidal thoughts of limited frequency, intensity and duration; • No plans or intent; • Negative thinking patterns only some of the time; • Some risk factors present; and • Some 'protective' factors.
High	<ul style="list-style-type: none"> • Frequent, enduring and intense suicidal thoughts and clear intent; • A definite plan and available means; • No perceived social support or hope for the future, intense depressive symptoms; • Previous attempts; • Many risk factors; and • Few/no 'protective' factors.

Client presentation

It is also useful to record the presentation of client at the time of the assessment. Certain presentations in the presence of even mild suicidal ideation can place the client in the **HIGH** risk category. These presentations include agitation, disorientation, recent self-harm, intoxication and hallucinating/delusional (e.g., hearing voices, fixed false beliefs). This section of the screener allows the AOD worker to assess how the client appears and provides some key high risk presentations which may be apparent. If the client presents in a high risk way which is not listed, it can be coded in the "other" section.

Suggested response to identified risk

The response to suicide risk categories will depend on the policies and procedures established by your individual service. A guide to both risk level assessment and the appropriate response, however, is presented at the end of the screener. Client's whose risk level appears changeable require careful re-assessment as soon as possible and should be treated as high risk until this can occur.

Where the guide refers to Safety Plan and Keep Safe Strategies, these resources are contained in the supporting documentation of this resource (pages 29 – 39). It is important to stress that where any suicidal thoughts exist there is a risk to the individual.

On entry to treatment your service may choose to ask clients to sign a Commitment to Treatment contract an example of which is on page 41 of this document.

Risk level	Suggested response
Low	<ul style="list-style-type: none"> • Monitor and review risk frequently • Identify potential supports/contacts and provide contact details • Consult with a colleague or supervisor for guidance and support • Refer client to safety plan and keep safe strategies should they start to feel suicidal.
Moderate	<ul style="list-style-type: none"> • Request permission to organise a specialist mental health service assessment as soon as possible • Refer client to safety plan and keep safe strategies as above • Consult with a colleague or supervisor for guidance and support • Remove means where possible • Review daily
High	<ul style="list-style-type: none"> • If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone • Remove means where possible • Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available • Consult with a colleague or supervisor for guidance and support

1.2 Suicide Risk Formulation Template

Aims of the Suicide Risk Formulation Template

1. To collate (in the client record) the various risk factors and client strengths from different sources;
2. To identify how the known risk factors are being addressed by the current treatment plan;
3. To identify gaps in what is currently known about the client's suicide risk profile; and
4. To assist staff in communicating the client's suicide risk to support services.

When to complete the Suicide Risk Formulation Template

The Suicide Risk Formulation Template is designed to be continuously updated and revised as new background information regarding a client's suicide risk profile becomes available. The Suicide Risk Formulation Template should be undertaken at the assessment interview on entry to treatment and updated as new information becomes available throughout treatment. This new information should be added to the template in the update column, and should also be regularly reviewed at case meetings.

A significant amount of information is likely to be collected early on in the relationship with the client, such as details regarding demographics and history. Some of this might come from the client themselves, their families or from other professionals involved with the client (e.g., general practitioners, psychologists). Other information, however, may not be uncovered until further into the treatment process. Finally, some factors may change throughout service contact with the client.

Staff are encouraged to familiarise themselves with the instructions which follow the Suicide Risk Formulation Template in order to understand the importance of each item.

Suicide Risk Formulation Template

DEMOGRAPHICS				YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown									
Sexual identity: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay male <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown									
Homelessness									
Details:									
Aboriginal or Torres Strait Islander									
RISK FACTORS									
HISTORY				YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)	
Family history of suicide/ suicide of a loved one or close other									
Details: (include recency)									
Parental mental disorder									
Details:									
History of sexual and/or physical abuse and/or neglect									
Details: (include recency)									
History of: <input type="checkbox"/> suicide attempts and/or <input type="checkbox"/> self-harm									
Details: (include recency)									
HEALTH				YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)	
'At risk mental status' (e.g., hopelessness, agitation, shame, psychotic, self harm, intoxicated, suicidal thoughts, confused, hallucinating/ delusional)									
Details:									
Diagnosed mental illness									
Details:									

RISK FACTORS	YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)
Chronic pain/illness and/or physical disability					
Details:					
RECENT EVENTS	YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)
Recently discharged psychiatric in-patient					
Victim of domestic violence					
Details:					
Recent interpersonal crisis, especially rejection, humiliation					
Details:					
Major life crisis (tick all that apply)					
<input type="checkbox"/> Family breakdown	<input type="checkbox"/> Child custody issues			<input type="checkbox"/> Significant anniversary	
<input type="checkbox"/> Trauma	<input type="checkbox"/> Relationship problem			<input type="checkbox"/> Other (specify)	
<input type="checkbox"/> Loss of loved one	<input type="checkbox"/> Impending legal prosecution				
Details:					
OTHER	YES	NO	DON'T KNOW	SOURCE	UPDATED INFORMATION (sign & date)
Impulsivity/loss of rationality					
Lack of social support network					
Difficulty (unwillingness) in accessing help due to language barriers, lack of information or support, or negative experiences with mental health services					
Details:					

CLIENT STRENGTHS RELEVANT TO TREATMENT	YES	NO	DON'T KNOW	SPECIFY	UPDATED INFORMATION (sign & date)
Currently accessing appropriate clinical services for mental /physical disorders (applicable to outpatient services)					
Strong social connections (family cohesion, peer group affiliation, partner, community, etc) e.g., regular contact with family/friends he/she can rely upon/confide in					
Good physical health					
Cultural and religious beliefs that discourage suicide and support self preservation					
Hopeful plans for future/Perceived reasons for living					
Stable daily routine					
Demonstrated resiliency, self esteem, optimism, and empathy					
Demonstrated skills in problem solving, conflict resolution, and nonviolent handling of disputes					

Client Care Plan

It is important to outline the way in which a client's risk factors and strengths are incorporated into treatment or care. For instance, what actions are required to manage the risk factors and how might client strengths be useful. These actions should be detailed below and referred to during treatment.

For example:

- Support groups
- Therapeutic community involvement
- Counselling
- Referral and consultation with outside services
- Community housing
- Indigenous support worker
- Medication

Instructions

How to complete the Suicide Risk Formulation Template

The *Suicide Risk Formulation Template* contains three broad sections; the first consists of some important demographic information, the second outlines client risk factors for suicide, while the third details some client strengths which may potentially aid in treatment.

Due to the wide range of potential risk factors, these have been grouped into sub-sections, discussed below. Most items are scored as “yes”, “no” or “don't know”. Others are broken down into separate categories, which require staff to tick the appropriate box/es. Following this, staff can provide details relating to the factor where appropriate in the space below the item. The middle column allows staff to record the source of this piece of information (e.g., psychiatrist report, client interview), while the far right column should be used when information has been updated and revised (this should be dated and signed by whoever updates this information). Beneath the three broad sections is a separate lined space which relates to how this information will be dealt with in the client's treatment plan (i.e. what interventions or actions are required in order to deal with the different risk factors or incorporate the different client strengths).

Demographics

There are a number of population groups who have been found to have a higher risk of suicide. These include indigenous Australians, gay males, lesbians and transgender individuals (particularly anyone who appears to be struggling with their sexual identity) and the homeless. It is generally not these factors that increase suicide risk, but rather the experience of stigma, discrimination, and marginalisation faced by these groups that lead to a higher suicide rate.

Risk factors included in the Suicide Risk Formulation Template

History

Certain factors in an individual's history can increase the likelihood of attempting suicide. One of the strongest predictors of a future suicide attempt is the presence of a past one and the more recent the attempt, the higher the risk ¹⁰. Therefore, it is crucial to obtain this information from the client or any other viable sources. Similarly, a family history of suicide also increases risk. Some studies suggest that even knowing someone who has committed suicide may normalise the behaviour for an individual ¹¹.

A personal or family history of mental illness also puts an individual at higher risk of suicide than those without this history. Mental illness has been shown to run in families ¹¹, and as such it is

important to ask about clients' personal and family history of mental illness. Suicide is also common among those with a history of abuse or neglect are at particular risk ¹⁰.

Self-harm, even when there is no intention of death, is a concern both in relation to suicide and as a separate concern itself. Research suggests people who self-harm are at increased risk of a future suicide attempt, and even where a self-harming individual has no intention of dying, but uses the self-harm as a means of coping, the risk of accidental death is very real.

Health

Both mental and physical health concerns can increase the risk of suicide. Psychotic disorders, mood disorders, anxiety disorders and personality disorders are all associated with a highly elevated risk of both attempted and completed suicide. This risk is even greater in substance misusing populations.

Even where a diagnosis is not present, symptoms of mental disorders such as hopelessness, despair and suicidal thoughts may be present and indicate considerable suicide risk. In a substance misusing population these emotions and patterns of thought are particularly common, especially during withdrawal.

Rates of suicide have also been found to be elevated in individuals with chronic pain, illness and/or physical disability. This may be particularly relevant in older individuals.

Recent events

Certain life events commonly occur prior to suicide attempts, these include instances of domestic violence/abuse, recent psychiatric discharge, various interpersonal crises, loss of a loved one, trauma, financial/legal/child custody issues, or a significant anniversary (e.g., a spouse's death). It is important that staff be mindful of the occurrence of such life events and the impact of these on a client.

Other

Some other factors which are relevant to the assessment of suicide risk include social isolation, impulsivity and/or loss of rationality and difficulty/inability/unwillingness to access appropriate services.

Client strengths relevant to treatment

In contrast to the factors that put individuals at risk for suicide there are a number of factors which can help an individual deal with circumstances that they might otherwise find overwhelming. Of course, no one of these 'protective' factors can reliably indicate that the client is safe.

For this set of factors the middle column is labelled, “specify” rather than, “source.” In this column staff should specify how this strength has been demonstrated or specifically what the strength is.

While some mental and physical disorders might lead to an increased risk of suicide, appropriate treatment and intervention can greatly reduce both suicidality and the associated symptoms of these disorders. Thus, it is important that where these disorders exist, the client is currently accessing appropriate clinical services. Where this is not the case it is crucial that they be given the means, guidance and encouragement to do so.

A perceived lack of social support heightens the risk of suicide. Conversely, strong social connections can be particularly helpful in combating suicidal behaviour. This generally means feeling that an individual has someone (or preferably numerous people) they can both rely upon and confide in, people who are available and with whom they feel comfortable divulging personal and sensitive information. Strong social ties can relate to family, a reliable partner or peer group, or even more general ties to a community. For either professional or personal support to be an effective protective factor, however, the individual must be willing and able to seek and access this help.

Stability across other aspects of one’s life can help counteract difficulties faced in other areas. Thus, a stable daily routine, good physical health, a stable living environment and so on can be protective for clients receiving treatment for substance misuse problems and individuals recovering from such problems. Sometimes religious beliefs and cultural values can help prevent an individual acting on suicidal thoughts (in a sense this might be thought of as a kind of ‘spiritual stability’)

A fundamental protective factor against suicidal behaviour is any reason the individual might have for living. These reasons can vary greatly, with more stable and numerous reasons offering greater protection than less stable singular ones. Similarly, an individual who has hopeful plans for the future is likely to feel a reason to live and therefore tend to have a reduced likelihood of suicide.

Finally, certain personality attributes and skills can also help counteract suicidal thoughts both immersing and progressing. For instance, skills in problem solving and non-violent resolution of conflict and disputes can help an individual to consider other options. Attributes like strong self-esteem and self-worth, optimism, empathy and resiliency can also be beneficial when faced with difficult circumstances and may help safeguard against suicidal thoughts and behaviours.

2. Supporting Documents For Staff

A number of supporting documents have been developed in order to aid in the assessment and management of suicide risk. Some of these resources can help alert staff to the client indicators of suicidality (*Warning Signs for Suicide*). While others should be provided to clients, preferably early on in treatment even if suicide risk is not apparent (*Keep Safe Strategies*, *Commitment to Treatment*, *Safety Plan* and *Safety Plan on Exit*). Agencies may also find it useful to display these tools within their services for quick reference.

2.1 Warning signs for suicide

Instructions

Warning signs for suicide can generally be defined as any indication of elevated risk. Like suicide risk generally, warning signs may be immediately apparent at intake or may arise during the course of treatment. Warning signs are a staff member's cue to conduct screening and gather information regarding suicidality. If the service deems it appropriate, it can also be helpful to provide copies of these indicators to clients themselves so they might be alert to the signs in others. Warning signs can be either direct or indirect ¹². **Direct** warning signs for suicide are given the highest priority and can include:

- **Suicidal communication:** Someone threatening to hurt or kill themselves or talking of wanting to do so. This includes ominous utterances, such as, speaking of going away or of others being better off without them.
- **Seeking access to a method:** Someone looking for ways to kill themselves by seeking access to pills, rope, or other means.
- **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

Indirect warning signs tend to be less readily identifiable and can therefore often require a heightened level of awareness, particularly as many of these signs are also likely to be present in substance abuse clients who are not suicidal. Nevertheless, these warning signs can be critical to determining suicide risk. A useful way of remembering these signs is the phrase, IS PATH WARM ¹³:

- | | | |
|------------------------------|------------------------------|---------------------------|
| • I = Ideation | • P = Purposelessness | • W = Withdrawal |
| • S = Substance abuse | • A = Anxiety | • A = Anger |
| | • T = Trapped | • R = Recklessness |
| | • H = Hopelessness | • M = Mood changes |

"Purposelessness" refers to a lack of a sense of purpose in life or reason for living. "Trapped" refers to perceiving a terrible situation from which there is no escape. "Withdrawal" refers to increasing social isolation. "Anger" refers to rage, uncontrolled anger, or revenge-seeking. "Anxiety" is a broad term that refers to severe anxiety, agitation, and/or sleep disturbance. "Mood changes" refers to dramatic shifts in emotions.

Recent significant life events can increase the likelihood of suicide and therefore, warning signs can be particularly prominent during such times. These might include:

- Break-up of a partner relationship/significant relationship problems.
- Experience of trauma.
- Impending legal event
- Child custody issues.
- Past history of suicide attempt/family history of suicide or suicide attempt/recent suicide of friend
- Loss of loved one.
- Financial crisis, job loss or other major employment setback.
- Family conflict or breakdown.
- Withdrawal.
- Chronic pain/illness.
- Relapse.
- Intoxication.
- Recent discharge from treatment service.

The presence of **direct** warning signs indicate immediate assessment and intervention is required, while the presence of indirect warning signs may or may not indicate acute suicide risk but do require follow-up questions to determine if they may indeed indicate acute suicidality and a degree of judgement on the part of the staff member. It is important to stress that carefully eliciting suicidal ideation does not increase the risk of suicide ^{14, 15} and, therefore, when in any doubt it is vital that staff ask directly, as it may never be evident unless this occurs.

The following is a quick reference guide to the warning signs for suicide. Services may wish to make copies of this guide for ease of use.

Warning Signs for Suicide

What can alert you to someone else's suicidal thoughts or feelings?

Direct signs:

- **Suicidal communication:** Someone threatening to hurt or kill themselves or talking of wanting to do so. This includes ominous utterances, such as, speaking of going away or of others being better off without them.
- **Seeking access to a method:** Someone looking for ways to kill themselves by seeking access to pills, rope, or other means.
- **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

Indirect signs:

- **I** = Ideation
- **S** = Substance abuse
- **P** = Purposelessness (loss of purpose/reason for living)
- **A** = Anxiety (worry, agitation, sleep disturbances)
- **T** = Trapped (feeling of being unable to escape situation)
- **H** = Hopelessness
- **W** = Withdrawal (from others)
- **A** = Anger (rage, aggression)
- **R** = Recklessness
- **M** = Mood changes

Significant recent events:

- Break-up of a partner relationship/significant relationship problems
- Experience of trauma
- Impending legal event or child custody issues
- Past history of suicide attempt/family history of suicide or suicide attempt/recent suicide of friend
- Loss of loved one
- Financial crisis, job loss or other major employment setback
- Family conflict or breakdown
- Withdrawal or intoxication

- Chronic pain/illness
- Recent discharge from treatment service
- Relapse

Source: Rudd MD, Berman AL, Joiner Jr TE, Nock MK, Silverman MM, Mandrusiak M, et al. Warning signs for suicide: Theory, research and clinical applications. *Suicide and Life-Threatening Behaviour*. 2006; 36:255-62.

2.2 Keep Safe Strategies

Instructions

This is a list of helpful strategies a client might employ when confronted by suicidal thoughts. This can be extended and revised but should be provided to all existing clients and at intake to all new clients. At this time staff should explain that the strategies are provided to all clients to help them through difficult times that may arise during treatment, or even after treatment has been completed. It is also useful to discuss the strategies with clients and consider other options (strategy 7) so this can be easily recalled and applied in a crisis situation. Staff should encourage clients to keep the list in a safe, convenient location for ease of use and provide extra copies where necessary and throughout the service.

Keep Safe Strategies

1. Create a safe environment

This includes avoiding drugs/alcohol as they often increase disinhibition and therefore increase impulsivity. They often feed negative thoughts and make you feel sad or bad.

Similarly, a suicide attempt will be more likely to occur if you have the means readily available to you (such as weapons or unnecessary medications). Remove those means of harm/suicide from your environment or go somewhere where you will not have access to such means.

Identify several places you can go where you would be less likely to hurt yourself. The best places are areas with a lot of people. Once in that location, immerse yourself in that environment. Pay attention and be mindful of all the sights and sounds around you. This will help put some distance between you and your suicidal thoughts.

2. Talk to someone supportive

Social support can be a wonderful way of coping when you are in a crisis. Call a family member or friend. Let them know you need someone to talk to and would like their support. Change your environment by asking them if you can spend some time with them. It can be useful to nominate a 'good Samaritan' who will stay with you for the next 24-48 hours until the crisis has settled to some degree.

You can also call a suicide prevention hotline to talk to someone supportive (e.g., lifeline: 13 11 14).

3. Talk to your case worker

Discuss with your case worker when you are experiencing suicidal thoughts. They can help you assess the seriousness of the situation, as well as assist you in coming up with ways of coping with those thoughts. Clarify how to handle this situation outside of therapy hours.

4. Know the nature of the thoughts and challenge them

Suicidal thoughts come in waves, reaching a peak and then subsiding over a few hours. Recognising this wave-like presentation can help you handle thoughts. The thoughts may often be worse at particular times (e.g., at night). When people feel down and depressed, it is common to have thoughts that are consistent with those moods, and as our moods change, so will our thoughts. Therefore, even though things may feel hopeless, this may just be a consequence of your mood and not necessarily how things really are.

Try to monitor and identify hopeless thoughts and challenge them. (E.g., is it not possible that your mood might change? Is there really no hope for the future? Have you felt like this before, and if so, did things eventually get better?).

5. Be Mindful of Your Thoughts

Try to “Take a step back” from your thoughts and watch them. Imagine your thoughts as clouds drifting across the sky. Try not to look at your thoughts as “good” or “bad,” but simply as thoughts or objects in your mind. This can limit the power of thoughts of suicide or hopelessness.

6. List reasons to not hurt yourself and reasons to live

Try to think of all the reasons why you should not end your life. Write down anything you can come up with. Write about your fears of dying or regrets you might have. Think about how ending your life might affect others.

7. List other helpful strategies

Be familiar with these strategies even when you're not in a crisis situation. Plan out what might be effective for you. Think about what has worked for you in the past and add it to this list. Discuss other options with your therapist/case worker. The more strategies you have available to you, the better off you will be in a time of crisis.

2.3 Safety Planning

Instructions

The Safety Plan is intended to act as a crisis response or contingency strategy. It is an agreed plan between a staff member and client on how best to deal with suicidal thoughts when they occur. These strategies will differ depending upon client and service but should follow a similar structure, whereby a range of different strategies are employed to counter the negative thoughts, beginning with the most simple and increasing in intensity if thoughts persist.

The Safety Plan on Exit is a related document but operates when a client has left the service. The readjustment faced by clients after discharge can often be a difficult time and without the structure and support of the AOD service these clients can frequently struggle with past or even new suicidal thoughts. It is fundamental, therefore, that early on in treatment clients are prepared for how they will face the world upon discharge. This process is comparable to learning relapse prevention strategies for their AOD use.

Like the general Safety Plan, the Safety Plan on Exit is a set of strategies devised by AOD worker and client on how best to facilitate their successful reintegration into the community and how to both avoid suicidal thoughts and deal with any of these thoughts as they arise.

The authors acknowledge and thank the staff and management of the Buttery Rehabilitation Service for their input. The Safety Plan on Exit has been adapted from a Buttery document.

Safety Plan

This safety plan is an agreement between:

Client: and

Staff member: on

Date:

When I feel like harming myself I will instead:

- ❖ Try to identify exactly what's upsetting me.
- ❖ Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others and the future.
- ❖ Refer to my 'Keep Safe Strategies'
- ❖ Try and do the things that help me feel better for at least 30 minutes (listen to music, exercise, focus on nature, call my best friend).
- ❖ If the thoughts continue, contact my drug and alcohol worker to talk it over.
- ❖ Contact the lifeline service (ph.: 13 11 14)

I, agree to try these strategies when I feel things are becoming too overwhelming. I agree to go to the emergency department or call 000 if, after trying these strategies my feelings are still unbearable.

Client signature:

Staff member signature:

Safety Plan on Exit

Client Name: _____

Leaving Safely

- *Whom should I notify when I leave this treatment service?*
 - ☐ Family
 - ☐ Friends
 - ☐ Other
- *Whom should I turn to for assistance: lifts, accommodation or support? (Names and contact details)*

- *What are my immediate plans if asked to leave, or if I decide to leave this treatment service?*
 - ☐ Stay in local area ☐ Go back to _____
 - ☐ Other: _____
- *Where will I stay in the short term? Will I need emergency accommodation? (ask case worker)*

- *How will I get to where I need to go? (especially if interstate)*
 - ☐ Bus ☐ Train ☐ Air-travel ☐ Car
- *How much will I need and how will I resource my first few days out of this treatment service? E.g. savings, loans? Current Centrelink payments? If Centrelink, how will it impact on my current budget?*

CONSIDER COSTS OF:

HOW WILL I AFFORD?

- | | |
|--|-------|
| <input type="checkbox"/> Food _____ | _____ |
| <input type="checkbox"/> Transport _____ | _____ |
| <input type="checkbox"/> Accommodation _____ | _____ |
| <input type="checkbox"/> Medications _____ | _____ |
| <input type="checkbox"/> Other Costs _____ | _____ |

Keeping Myself Safe

- *How do I avoid and stay away from substances in this vulnerable time?*

SUGGESTIONS:

- ☐ DELAY my decision to use – give myself 15 minutes, one hour etc
- ☐ DISTRACT myself – watch TV, listen to music, do some exercise
- ☐ DECIDE – is it worth it? Remember why I gave up in the first place.
- ☐ TALK IT THROUGH – connect to sponsors, friends who don't use - GO TO MEETINGS
- ☐ CHANGE THOUGHTS & ATTITUDES – challenge myself talk—tell myself I'll be okay.
- ☐ AVOID self pity, resentments, and being HALTS (hungry, angry, lonely, tired or serious)
- ☐ ESCAPE people who use; places (old haunts, bars, clubs etc) and activities associated with using.
- ☐ CONNECT to my higher Power (spirituality) and BE GRATEFUL for what I have.

MY OWN STRATEGIES:

OVERDOSE ALERT:

Since you've been in treatment, your body is now more sensitive to the effects of drugs and alcohol and your tolerance has decreased. You must take EXTRA CARE not to use; or make sure that should you use, to do so SAFELY and to use LESS than you would normally. Otherwise you are in danger of OVERDOSING.

- *If I do end up using, how will I minimise any RISK or HARM to myself?*

SUGGESTIONS:

- ☐ I won't use ALONE (in case something goes wrong)
- ☐ I will use less than I normally would use
- ☐ If injecting, I will NOT share needles
- ☐ I will use condoms when having sex
- ☐ I will NOT drive or operate machinery

MORE STRATEGIES I CAN THINK OF TO MINIMISE HARM:

- *How will I continue to get support for my recovery after I leave this treatment service?*

SUGGESTIONS:

- | | | |
|--|--|--|
| <input type="checkbox"/> 12 Step Meetings | <input type="checkbox"/> AOD Counsellors | <input type="checkbox"/> Outreach Services |
| <input type="checkbox"/> General counselling | <input type="checkbox"/> Other Rehab | <input type="checkbox"/> SMART groups |

WHAT ELSE CAN I DO?

If things go wrong, who will I reach out to and what will I do?

EMERGENCY ACCOMMODATION:

MEDICAL / MENTAL HEALTH: Which Doctor? Counsellor? Hospital?

FINANCIAL HELP: Centrelink?

LEGAL ASSISTANCE: Legal Aid?

HARM MINIMISATION: (Needle Syringe Exchange, Condoms)

OTHER SUPPORT:

Client Signature: _____

Date: _____

2.4 Commitment to Treatment

Instructions

A popular practice in the management of suicide by a range of services is the 'no-suicide' ('no-harm') contract. In essence, an agreement, sometimes verbal but usually written ¹⁶, between a client and clinician, whereby the client pledges not to harm themselves ¹⁷. Despite being popular, however, there is evidence to suggest this practice may not only be ineffective, but may potentially cause harm ¹⁷⁻²⁰. A suggested alternative to this practice is a commitment from the client to participate in the therapeutic process and all that it entails.

This commitment covers such things as session attendance and participation, goal setting, voicing of opinions, homework, medication compliance, open-mindedness, implementation of safety plan. It should have a specified timeframe and review date. This is a collaborative process and, as it is a requirement that the client make a commitment to living, it is necessary to discuss with the client how long they feel they can make such a commitment for.

Commitment to Treatment

I, _____, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment including:

1. Attending sessions (or letting my drug and alcohol worker know when I can't make it).
2. Setting goals.
3. Not leaving the facility without appropriate permission (if applicable).
4. Voicing my opinions, thoughts, and feelings honestly and openly with my drug and alcohol worker (whether they are negative or positive).
5. Being actively involved during sessions.
6. Completing homework assignments.
7. Taking my medications as prescribed (if applicable).
8. Experimenting with new behaviours and new ways of doing things.
9. Implementing my Safety Plan and Keep Safe Strategies where necessary.

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my drug and alcohol worker and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, *I agree to make a commitment to living*. This agreement will apply for the next three months, at which time it will be reviewed and modified.

Signed: _____

Date: _____

Case Worker: _____

Adapted from: Rudd MD, Joiner T, Rajab MH. Treating Suicidal Behaviour: An effective, time-limited approach. New York: Guilford Press; 2004.

3. Manager Resources

3.1 Suicide Policies and Procedures

Pro-Forma

Aims of the policies and procedures pro-forma

1. To provide an overview of the issues that must be considered in the development of written policies and procedures;
2. To form a template for agencies to structure their own policies and procedures from; and
3. To provide supporting documentation for management of suicide risk.

Structure of the policies and procedures pro-forma

The pro-forma is structured to assist agencies to consider:

- Overarching principles and organisational roles and responsibilities;
- Practical considerations in working with people at risk of suicide and self-harm, including assessment, intervention, management and referral.
- Organisational practices which underpin effective responses to people at risk of suicide, including supervision and training, record keeping and policy review and evaluation.

Instructions

Suggested process for developing policies and procedures

Due to the elevated suicide risk among clients in substance abuse treatment, it is important for services to have a clear policy statement affirming that all clients entering substance abuse treatment be screened for suicidal thoughts and behaviours. While this pro-forma framework highlights a range of important matters and issues for consideration, it cannot be a comprehensive model for suicide risk assessment without unduly restricting agencies with a wide range of differing services, needs, staff and clientele. Not all considerations will be relevant to all services. For instance, considerations relating to residential care will be inappropriate to those agencies that do not provide this type of care. Similarly, some agencies will be equipped to provide more thorough assessment and intervention practices than others who may immediately refer on to an external service any client indicating a relevant risk of suicide.

Agencies are encouraged to give careful consideration to the development of individualised policies and procedures which are relevant to their organisational and regional contexts, using this pro-forma as a guide. The following is a list of steps which may assist agencies when developing policies and procedures for assessing and responding to client suicidality in their service ²¹:

1. Read these principles as a starting point for thinking about your organisation's policies and procedures.
2. Identify any other sources of information which could be used to inform your service's policies and procedures process.
3. Review any existing policies and procedures in light of the issues raised in these principles and other sources of information. Identify strengths and gaps in existing policies and procedures.
4. Engage service staff and management to develop service-specific guidelines to ensure relevance.
5. Draft policies and procedures and seek feedback from staff and management and any external sources of expertise (e.g., local mental health professionals).
6. Incorporate this feedback into your draft document, finalise and distribute where appropriate.
7. Ensure existing staff familiarise themselves with the policies and procedures and ensure the document is easily accessible. Check that organisational resources are in place to support the standards set out in your policies and procedures.
8. Conduct any necessary training with the workforce and ensure appropriate induction for new staff to be educated and trained in the issues pertaining to suicide risk and the policies and procedures set out by your service.
9. Ensure policies and procedures regarding suicide risk assessment and intervention are consistent with the standards set out in any other relevant organisational policies where appropriate.
10. Monitor and evaluate the practical application of the policies and procedures.
11. Identify a date to review and update your policies and procedures.

See the SAK integration checklist in the *Supporting Documentation*, for use when reviewing your policies and procedures using the SAK. Some brief feedback from a Service Director on implementation of the SAK in a residential rehabilitation setting is also provided.

Suicide Policies and Procedures Pro-Forma

Suggested layout

i. Definitions

ii. Policies

- a. Overarching principles
- b. Roles and responsibilities
- c. Confidentiality and duty of care
- d. Documentation and record keeping
- e. Consultation and information sharing
- f. Timeliness of assessment

iii. Assessment procedures

- a. Acute suicide risk screening
- b. Comprehensive suicide risk assessment
- c. Other issues to consider

iv. Management and intervention procedures

- a. Risk management
- b. Referral procedure
- c. Acute crisis care
- d. Discharge and re-entry

v. Professional development, supervision and support

vi. Review and evaluation

vii. Appendices

- Appendix A: Onsite incident procedure
- Appendix B: Bereavement
- Appendix C: Special populations

i. Definitions

A definition section (or glossary) is necessary to explicitly describe key terms and concepts used within the policies and procedures document and avoid misinterpretation and ambiguity. This section should aim to define key terms and technical jargon clearly and concisely. It might appear early on or at the conclusion of the document. Some terms and concepts to consider may include:

- **Comprehensive suicide risk assessment** – a comprehensive evaluation of a client's level of suicide risk. In addition to screening, the comprehensive assessment provides a thorough review of a range past and present factors.
- **Safety plan** – a plan devised with client that includes intervention and reassessment and a particular course of action they can follow when the risk of suicidal behaviour is heightened. The safety plan will detail who the client can contact for support, including family, friends, carers and service providers. Involve client and their families/carers where possible in this process.
- **Self-harming behaviour** – the direct, deliberate act of harming one's body without the conscious intention to die. Self-harm may result in death and is a risk factor for suicide.
- **Suicidal ideation** – thoughts of engaging in suicidal behaviour, with or without a specific plan.
- **Suicide** – self-injurious act intended to end one's life which results in death.
- **Suicide attempt** – potentially self-injurious act intended to end one's life, but which does not result in death.
- **Suicide plan** – individual strategy for suicide inclusive of timeframe and means to complete suicide.

ii. Policies

It is important that the policies surrounding suicide risk assessment and management be comprehensive in order to cover the variety of circumstances and matters fundamentally important to suicide assessment and intervention within the service. The following sub-headings are a range of areas where policy directives might be necessary.

a. Overarching principles

These represent the overarching practice principles which underpin your service's policies and procedures. They are general codes of practice standards and values that the service and the staff within it ascribe to concerning the issue of suicide. For instance:

- It is the policy of the service to actively respond in any situation where a client verbally or behaviourally indicates an intention to attempt suicide or to do physical harm to himself/herself.
- The agency is committed to good practice in the prevention of suicide through the development, implementation and review of policies and procedures based on current evidence.
- When responding to issues relating to suicide, the physical and emotional safety of the client, family, carers and service staff is paramount at all times.
- All staff members have a role in detecting acute suicide risk, identifying background risk factors and ensuring that appropriate assessment and intervention is undertaken.
- All clients who demonstrate suicidal and self-harming behaviours will receive a timely and professional response.
- There will be an emphasis on regular, intermittent assessment procedures.
- The service will ensure that its staff members receive a level of training and supervision appropriate to their role in responding to clients at risk of suicide.
- Where appropriate the service will liaise with, and share information with other experts and professionals in the field in a timely and open manner in relation client suicidality.

b. Roles and responsibilities

It is important to clearly define the capability of the service and the responsibilities of staff in responding to clients at risk of suicide. Drug and alcohol treatment agencies provide a wide variety of different services and have a vast array of differing capabilities. Similarly, staff members within these agencies differ in their roles and competencies. It is important to consider the unique strengths and abilities of your staff and service, but as a minimum requirement it is the responsibility of the service to ensure all staff are capable of conducting and documenting basic suicide risk assessment, and it is the responsibility of all staff to do so. Some examples of policy relating to roles and responsibilities might be:

- The service will identify, manage and actively refer (where necessary) clients deemed to be at-risk of suicide.
- The service will work in collaboration with local mental health and other specialist services to provide intensive case management for clients who are considered at-risk of suicide.
- *Managers/Coordinators* – monitor implementation and review of policies and procedures; provide support to supervisors, staff and volunteers as required; ensure staff and volunteers receive appropriate training, supervision and debriefing.
- *Supervisors* – provide professional support and supervision to staff and volunteers working with clients identified as being “at risk” of suicide; work in consultation with counselling and support staff to develop case management plans for clients at risk of suicide; regularly review case management plans in consultation with relevant staff.
- *Counsellors/nurses/drug and alcohol workers/social workers/psychologists* – undertake initial assessment of clients; identify “at risk” clients and notify supervisor; develop case management plans for clients in consultation with supervisor; implement case management plans; participate in review of case management plans in consultation with supervisor.
- *Administration staff* – immediately notify a counsellor or supervisor if a client directly or indirectly indicates any risk of suicide.
- All staff and volunteers must recognise the limits of their individual roles and competencies and actively facilitate links to further levels of care where necessary. Suicide risk should never be managed by one staff member in isolation.
- At least two staff members should be on duty at all times. In rare circumstances where this is not possible, an “on-call” staff member should be available for staff to consult and debrief over the phone. If conducting telephone assessments the staff member should have access to the help of another staff member if needed to notify emergency service while the at-risk person is kept talking on the phone.

c. Confidentiality and duty of care

It is important to clearly identify issues surrounding confidentiality and the limits to such confidentiality in upholding proper duty of care. These two areas are fundamental to the therapeutic relationship but where suicide is an issue they can often be in conflict with one and other. All legal, professional and moral obligations should be outlined clearly to avoid uncertainty and these policies and limits to confidentiality should be discussed with the client at the initiation of treatment. Some good practice guidelines surrounding duty of care and confidentiality might include:

- The organisation has a duty of care to do everything reasonable to prevent a client's suicide.
- Staff have a duty of care to clients and must take appropriate steps to ensure that clients do not come to foreseeable harm by the action or inaction of staff.
- It is the responsibility of staff to be familiarised with the policies and procedures of the agency and act in accordance in providing duty of care.
- Confidentiality is not absolute and should be balanced against duty of care where harm to the client or others is suspected. The organisation has a legal and professional responsibility to disclose information where not reporting might cause harm to a client or another person.
- Clients will be advised about the limits of confidentiality. How this is done should be outlined in the policy.
- Client consent for sharing information with mental health services where the AOD worker is concerned for the client's welfare, should be built into initial admission process.
- Disclosure of confidential information is restricted to those who are potentially of assistance and information is restricted to only that which is necessary
- Clients will be kept informed of the disclosure of confidential information.

d. Documentation and record keeping

Record keeping and documentation of assessment findings and intervention outcomes is crucial for good practice. There are both legal and practical reasons why comprehensive records be kept and the service may already have policies and procedures concerning documentation. There is, however, also a potential need for file sharing between services and this must be factored into the record keeping procedure relating to suicide risk. The *Suicide Risk Formulation Template* and any *Suicide Risk Screener* forms can be particularly useful for file sharing between services. Some examples of good practice and considerations to bear in mind when developing a policy regarding documentation of suicide risk include:

- All details of risk assessment, management plans and observations are to be clearly documented in the person's file using the relevant service documentation procedure.
- Consideration should be given to the potential need for record sharing and potential freedom of information claims.
- Document relevant sources of corroborative history and outcomes from contact with each source.
- Response to clinical interventions should be noted.
- The rationale and reasons for the decision to manage the person in the community as opposed to hospitalisation and the management plan to support the decision should be documented.
- Contact details for the person, relatives and treating professionals should also be noted.
- If family or other care providers and health professionals contact an AOD staff member in regard to a person at risk, all concerns should be documented.
- Referral documentation and feedback from referral organisation must also be filed.

e. Consultation and referral

A key reason for the importance of good record keeping practice regarding suicide relates to the frequent need for consultation with other service providers. Assessment of people at risk of suicide is a complex and demanding task and it requires involvement of skilled professionals. It is important to have a clear policy and protocol relating to this consultation process, both within and outside of the agency (depending on service). Some examples of good practice are outlined below; agencies are also encouraged to refer to the referral procedure section of this pro-forma as required.

- Assessments of suicide should be discussed with a colleague or senior AOD staff member at some stage of the assessment process.
- High suicide risk requires immediate consultation.
- All staff and volunteers must recognise the limits of their competencies and actively facilitate links to further levels of care where necessary.
- Senior AOD workers and management should be made available should staff require case review or discussion.
- Memoranda of Understanding should be drafted with relevant services (e.g., local emergency departments, crisis and mental health teams) and the appropriate referral process should be clearly specified in the policy and procedures document for staff to follow (see supporting documentation for a *Memorandum of Understanding* template). While some support services may be reluctant to sign a Memorandum of Understanding, managers should at least meet with local services about what information they require, and attempt to establish an informal referral process.

f. Timeliness of assessment

Assessment is not a one-off event. It is important to assess the risk a client poses to him/herself throughout treatment, this includes suicidal thoughts/plans/attempts and self-harm. Clients of AOD treatment services are at high-risk of suicide ²² and this risk is increased with presence of comorbid mental health disorders ²³. It is therefore important to conduct regular suicide risk assessments both in the initial consultation phase and set time points throughout treatment. The *Suicide Risk Screener* can be used at intake, but the clinical nature of some items in the screener (and the resulting duty of care issues) means staff should **not** complete the screener prior to intake. Staff should closely monitor this risk during treatment. Ideally, there should always be at least two people on duty when routine risk assessments are being carried out—particularly when being carried out over the phone. In rare circumstances where this is not possible, an “on-call” staff member should be available for staff to consult and debrief over the phone.

Intoxication can prevent a valid immediate assessment, however, the presence of suicidal thoughts in clients who are also intoxicated puts the client at high risk, and should be dealt with accordingly.

iii. Assessment Procedures

Discussing suicide with clients is vital and does **not** increase the risk of suicidal behaviour¹⁵. Rather, sensitive questioning by a member of staff can be a relief for clients who have been harbouring thoughts of self-harm, and an opportunity to receive the help and support that is needed^{14, 24}.

a. Acute suicide risk screening

A screening tool is a useful means to briefly and quickly ascertain approximate risk level upon entry to treatment and at set time points throughout. As a component of the Suicide Assessment Kit a *Suicide Risk Screener* has been developed. This provides guidance concerning management of differing levels of risk. This tool can be used even where there is no clearly apparent suicide risk as a screening instrument at specific transition points of treatment (e.g., intake, during withdrawal, discharge). It is, however, crucial that this screening process also take place where a staff member's informal assessment of a client's presentation or circumstance elicits concern. This includes:

- General appearance (agitation, distress, psychomotor retardation)
- Form of thought (person's speech is illogical and not making sense)
- Content of thought (hopelessness, ominous utterances, despair, anger, shame or guilt)
- Mood and affect (depressed, low, flat or inappropriate)
- Attitude (lacking insight, uncooperative).

b. Comprehensive suicide risk assessment

There is no current rating scale that has proven predictive value in the clinical assessment of suicide risk^{4, 5, 25}. Therefore, thorough risk assessment of the client requires an awareness of a range of factors (both past and present) and their interaction. As a component of the current set of tools a *Suicide Risk Formulation Template* has been developed. This should be kept on a client's file and can be continuously updated and revised as new and different pieces of information regarding a client's suicidality become available. This should not replace clinical decision making and practice, but rather support it²⁶. Consequently, there is not one set time at which an AOD worker should complete the template, but instead the staff member should add to the template throughout treatment in order to keep an updated account of a client's suicidality. This template also guides staff in developing a treatment plan for the client based on their individual circumstances.

c. Other issues to consider

There are some factors that are not mentioned in the *Suicide Risk Formulation Template*, but which are necessary to consider when developing a thorough assessment procedure.

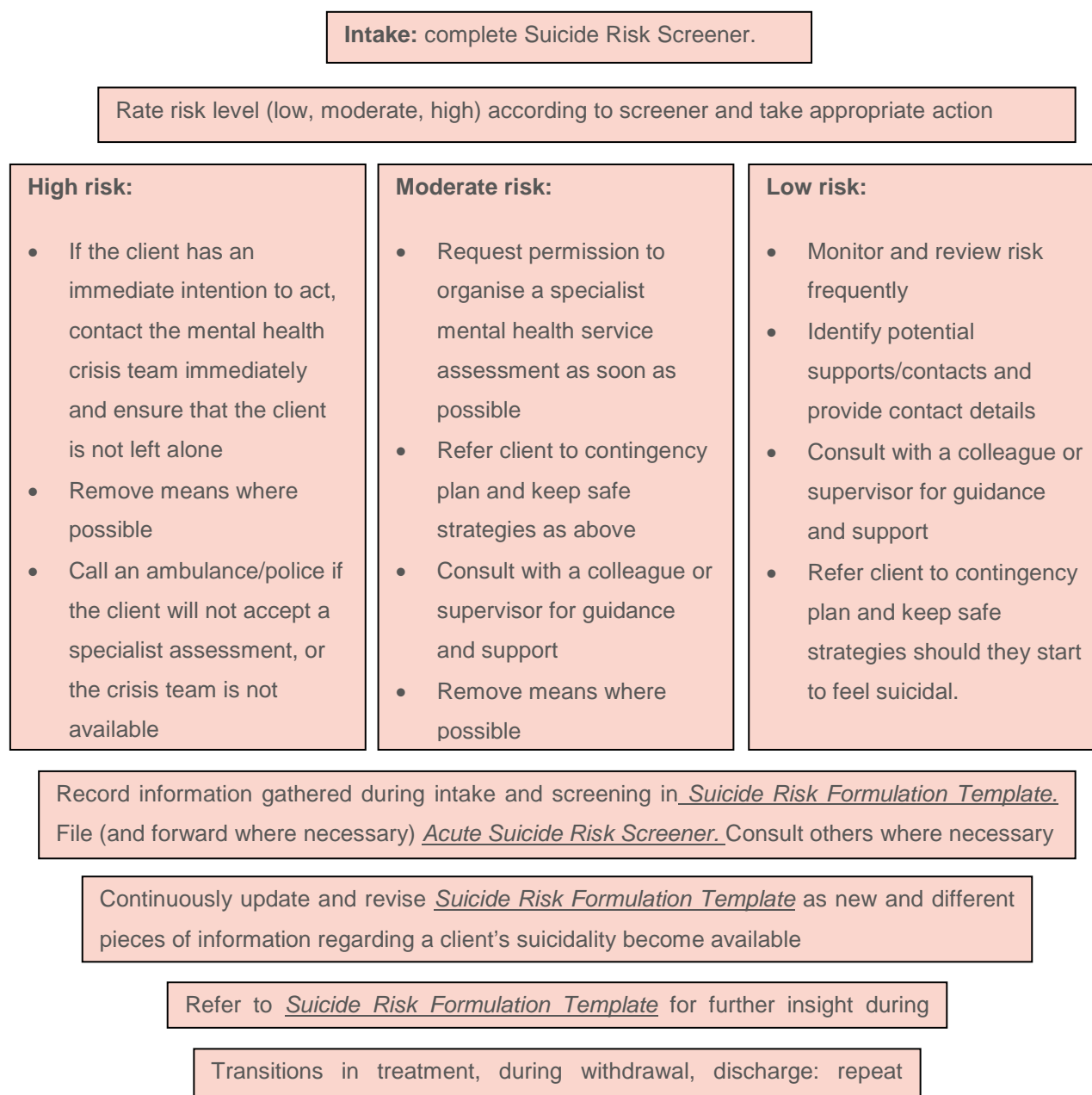
- Safety of others: Is the safety of anyone else potentially at risk (e.g., children, partner)? Is the person psychotic? Are there issues with custody of children and/or financial issues? Is there evidence of postnatal depression?
- Corroborative evidence (family/carer/support network etc.): Verification of risk factors helps to provide accuracy around the changeability of suicide risk status and enhances the assessment reliability. This verification also provides opportunities to assess family support and assists with collaboration about management and discharge planning. Be aware of issues of stigma and shame within families and across cultures. Assess the family/carer's willingness and capacity to facilitate a protective environment for the person at risk on discharge (monitoring safety, removal of means).
- Assessment reliability/confidence in assessment: Consider how reliable this overall assessment has been. If unreliable or risk level appears highly-changeable, re-assessment may be required and a more vigilant risk management and safety plan should be adopted. Factors that may result in an unreliable assessment include:
 - Person factors (e.g., impulsivity, drug or alcohol abuse, present intoxication, inability to engage)
 - Social environment factors (e.g., impending court case, custody dispute, recent change in living situation)
 - Assessment factors (e.g., incomplete assessment, inability to obtain collateral information).

d. Re-assessment

An important component of managing a person at risk of suicide is the re-assessment of that risk. The date of this re-assessment should be outlined in the management plan and should re-evaluate risk and protective factors, assessment confidence and review outcomes of treatment. Continuity of the AOD worker should occur wherever possible to facilitate engagement, rapport and accuracy of the assessment. Collateral information, particularly from the family or support person should always be sought as part of the re-assessment of suicide risk. Consultation with any other professionals involved in the client's treatment (e.g., local mental health providers) should also occur and be documented.

Figure 1: Potential guide to assessment procedure

Note: This figure is a guide and should incorporate the specific response options that have been established for the service and outlined in the service's policy and procedures documentation.



iv. Management and intervention Procedures

Where the assessment process establishes that a significant suicide risk exists what will be the management procedure and referral process? Similarly, in the case of an attempt what is the correct protocol?

a. Risk management

The *Suicide Risk Screener* provides a guide to managing different levels of risk. Services may wish to tailor these recommendations to their service.

b. Referral procedure

It is essential to detail how and when staff must refer clients on to other services (internal or external) and what services are recommended. This may involve establishing Memoranda of Understanding with appropriate services and providing specific paperwork/information required (e.g., suicide screens, client history, client information). A template version of a *Memorandum of Understanding* is presented in the supporting documents at the end of this section. Links and referral procedure should be established with key external services such as:

- Hospital and community-based mental health services
- Mental health crisis teams
- The local police force
- Local counselling and psychology services
- General practitioners
- Emergency departments
- Specific population groups (e.g., Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, young people, lesbian, gay, bisexual and transgender people)

An up-to-date database/manual containing a listing of emergency and longer term support services available for clients who are at risk of suicide should be made available for staff. This database/manual should also contain bereavement/debriefing resources for staff and volunteers.

Where referral takes place, the process for maintaining high levels of communication with mental health services following a client transfer should be clearly outlined, in order to facilitate re-entry of the client where appropriate.

The referral guidance sub-section in the supporting documents section that follows, contains templates of a *Letter of Referral* and *Client Identification Information Sheet* to further assist services in successfully communicating and liaising with external services.

c. Acute crisis care

As a component of the procedural documentation, services should compile a telephone listing of up to date referral services for staff. A key component of this listing is acute crisis/mental health teams/services. Due to differing state-specific procedures services are advised to contact their specific state government mental health office. Furthermore, due to the potential for these numbers to change, services must review the list they create every six months to ensure it remains up to date.

d. Discharge and re-entry

Important considerations at the time of discharge include current mental state, accommodation, employment and financial situation. Follow-up or re-entry arrangements should also be assessed. Liaison with other professionals involved in client treatment should occur prior to discharge (e.g., general practitioners, psychologists, psychiatrists, other mental health professionals). Clients who have been at risk of suicide require close follow-up when discharged from hospital as the first 28 days after discharge from hospital has been identified as a period of elevated risk of suicide ²⁵. Upon discharge, the client and their family/support person must be provided with contact details for crisis support and rapid re-assessment/re-entry to treatment. Any foreseeable barriers to re-assessment and re-entry to the appropriate level of care should be anticipated, discussed and circumvented.

When establishing discharge procedures, services should consider pragmatic issues such as whether it is appropriate to return all medications (a client arrived with) to the client upon discharge. It may be safer for the client if the amount of medication returned to them is limited to two or three days use. This is not appropriate for all medications, but should be considered for those with high abuse potential/lethality (e.g. hypno-sedatives and pain medication). Services also need to document what circumstances, if any, might prevent a client from being discharged home.

Some services may have exclusion criteria in place for clients whose assessment indicates a high risk of suicide (e.g., ideation, recent attempts). In such services this section may still be relevant in client transfer between services and re-entry upon the successful management of this risk.

v. Professional Development, Supervision and Support

It is important to consider what development and training opportunities the agency will provide concerning suicide assessment and intervention. Services should also ensure both existing and all new staff are adequately trained in the skills of suicide assessment and intervention. It may also be worth evaluating if there is sufficient support and supervision provided to staff and volunteers. This may include the following:

- All current and new staff will be expected to familiarise themselves with the policy document and will be trained in the procedures by management and/or supervisors.
- Administrative staff and volunteers will receive mandatory introductory training to assist them in identifying warning signs and referring clients to appropriate staff members for support.
- All staff and volunteers will receive training in suicide risk identification, assessment and intervention appropriate to their role in supporting clients who are suicidal.
- Counsellors and support workers will receive mandatory introductory and advanced level training in suicide risk assessment and intervention.
- Further training programs delivered by providers with an appropriate level of expertise will be promoted by management where appropriate.
- Staff must attend refresher training as personally required (or every 24 months).
- Supporting clients who are at risk of suicide is a challenging and emotionally demanding process, therefore monitoring and investment in supportive networks and resources for staff and volunteers are a commitment of the agency.
- Staff and volunteers are encouraged to remain aware of their own emotional reactions and seek support from their supervisor and colleagues as required.
- The agency recognises that supervision, collaboration and debriefing are essential to the assessment and intervention process.
- Following an emergency incident involving a client who is suicidal or self-harming, staff and volunteers will be offered access to immediate debriefing support.

vi. Review and evaluation

The policies and procedures developed by your agency should include an inbuilt review and evaluation process whereby at fixed points in time these policies and procedures are evaluated, reviewed and updated where necessary. For instance:

- Six months after the implementation of the suicide policy and procedures. All staff will be surveyed as to the usefulness, relevance and operation of the document. All new staff will be surveyed regarding their awareness of, training in and usefulness of the document. Any limitations or suggestions should be noted and incorporated.
- An annual review of the policies and procedures should occur with an update process after a period of five years.
- Review should be based on feedback from staff and volunteers, results of any service evaluations and new or emerging evidence in the suicide and self-harm prevention field.

vii. Appendices

Appendix A: Onsite incident procedure

If a suicide/self-harm incident occurs onsite, procedure should be in place for how to appropriately handle such an incident, both during and after business hours. This may include the following:

- Ensuring the immediate safety of other clients, staff and volunteers
- Remaining with the client.
- Activating duress alarm if immediate assistance is required (if your service does not have this facility, 000 or the crisis support team should be called)
- Removing where possible, any means of self-harm or potential suicide.
- Providing first aid, initiating lock down procedures and contact emergency services where appropriate.
- Convening emergency response team and plan the following steps.
- Contacting client's family/carer/support.
- Contacting relevant mental health agency if necessary.
- Write critical incident report.

Appendix B: Bereavement

A client's suicide may impact on other clients, staff, volunteers, the client's family and friends and the wider community. Agencies should offer debriefing and relevant referral to local mental health services to anyone who might require it and encourage staff to seek support as needed. The availability of these services needs to be outlined in the policies and procedures document.

Appendix C: Special Populations

Certain population groups may require tailored services to better meet the requirements of suicide assessment and intervention. This is due to increased risk factors, additional stressors and culturally differing indicator patterns. Agencies should be aware of and consider the following:

- Current trends regarding high risk groups (e.g., Aboriginal and Torres Strait Islander people, young people, lesbian, gay, bisexual and transgender people, older people, homeless people, people with a mental illness, people in custody, people from culturally and linguistically diverse backgrounds, and people from rural and remote communities).
- Specific stress issues relating to these groups that should be considered during the course of assessment, management and treatment (e.g., the impact of colonisation, migration and refugee experiences, family dislocation, trauma, homophobia, stigma and marginalisation, geographical isolation and challenges associated with ageing).
- Standard assessment tools and frameworks are not necessarily valid and reliable across all social and cultural groups, and culturally specific tools and practices should be available to staff and implemented where appropriate.
- Organisations representing these specific population groups should be consulted where appropriate, to ensure assessments and interventions are appropriate, effective and inclusive. A list of relevant local services should be made available in the policies and procedures document.

4. Supporting Documents

For managers

The following documents are some additional resources which managers may find useful when drafting and implementing policy and procedures relating to suicide risk assessment.

4.1 SAK integration checklist

Step 1: Read the Manager section of the SAK

Step 2: Identify additional resources that may be useful in informing the development of policies and procedures

Step 3: Review existing policies and procedures using the following table to identify strengths and gaps.

	Present	Absent	Comments/Action plan
1. Definitions section included.			
2. Overarching principles stated.			
3. Roles & responsibilities of staff clearly outlined.			
4. Issues of: a. Confidentiality, and b. Limits to confidentiality in upholding duty of care, are clearly discussed.			
5. Expectations regarding documentation of risk assessments and intervention outcomes are clearly stated.			
6. The consultation and referral process for assessment and management of suicide risk is obvious. This should include arrangements for weekends and after hours.			
7. Contact details for acute crisis care teams/services are readily accessible.			

	Present	Absent	Comments/Action plan
8. Expectations regarding when risk assessments should occur are clearly outlined.			
9. The assessment procedures used by the service are clearly documented. The cultural needs of clients are taken into consideration.			
10. Maintaining the safety of others is addressed			
11. The need for planning the re-assessment of suicide risk is openly addressed			
12. Discharge: Considerations at time of discharge are discussed – <ul style="list-style-type: none"> • Mental state • Accommodation • Financial support • Aftercare • Circumstances, if any that would prevent client being discharged home. • The re-assessment and re-admission process should be clearly outlined 			
13. Outline what professional development and training opportunities the agency will provide re: suicide assessment and intervention.			

14. Acknowledgement of the need for supervision, collaboration and debriefing as part of the assessment and intervention process is evident.			
15. Policies & procedures have an inbuilt review & evaluation process whereby at fixed time points they are reviewed and updated where necessary			
16. The procedure to follow when there is an onsite incident (eg. suicide attempt) is clearly specified.			

Step 4: Engage service staff and management to develop service-specific guidelines to ensure relevance, based on gaps identified in the above table.

Step 5: Draft policies and procedures and seek feedback from staff and management and any external sources of expertise (e.g., local mental health professionals).

Step 6: Incorporate this feedback into your draft document, finalise and distribute where appropriate.

Step 7: Ensure existing staff familiarise themselves with the policies and procedures and ensure the document is easily accessible. Check that organisational resources are in place to support the standards set out in your policies and procedures.

Step 8: Conduct any necessary training with the workforce and ensure appropriate induction for new staff to be educated and trained in the issues pertaining to suicide risk and the policies and procedures set out by your service.

Step 9: Ensure policies and procedures regarding suicide risk assessment and intervention are consistent with the standards set out in any other relevant organisational policies where appropriate.

Step 10: Monitor and evaluate the practical application of the policies and procedures.

Step 11: Identify a date to review and update your policies and procedures.

Feedback from a Service Director on implementation of the SAK

First we reviewed the SAK, and then reviewed our policies relating to suicide and suicide assessment (assessment policy, discharge policy and suicide assessment procedure). This identified the key points where we assess for suicide (ICF, F2F, intake, discharge and any points of crisis) and our current practice for suicide assessment.

We had questions to ask about suicide at each of these points, so all that was needed was to merge to suicide screen into our existing paperwork, which made our assessments more comprehensive. We also had suggested courses of action based on risk level, so we only had to merge this with the recommendations in the SAK. We didn't have much on how to determine the clients risk level, so the SAK was helpful here, in particular the suicide screen, as it gives clear guidelines on determining a risk category.

We didn't have any formal suicide risk formulation aside from our screening questions, so the suicide risk formulation from the SAK was introduced, to be completed during the F2F/intake process. This provides a much more thorough assessment of both the stable and dynamic risk factors for suicide than we were doing.

We had self protection contracts, but we replaced these in favour of the safety plans from the SAK. We didn't have any formal safety plan for clients leaving, so we could use the safety plan on exit, although this is pretty much a relapse prevention plan, which we do with our clients.

The main thing that wasn't included in the SAK, or wasn't as comprehensive as our existing policies was the clinical management of suicidal behavior (i.e. problem solving and symptom management).

At the moment we are in draft stage, with a few more areas to be developed within the Policy. The Policy and new SAK based assessments will be presented to the board of directors at the end of February. Once ratified, staff training will commence in March.

Overall, staff involved were impressed by the SAK, found implementing the SAK into current practices to be relatively easy and believed the SAK would enhance our current Policies and Procedures.

Fiona Craig

Service Director

Kedesh

09.02.13

4.2 Memorandum of Understanding

Instructions

A Memorandum of Understanding is a document describing a framework of co-operation and establishing an agreement between two parties. It expresses an arrangement between the parties, indicating an intended common line of action, and the roles played by each party in achieving the mutual goals.

This can be a useful document for establishing links with outside services (e.g., mental health) and agreeing on roles and responsibilities. Some services may, however, be reluctant to sign such a contract. In such cases managers should still attempt to meet with these external agencies and discuss informal referral processes.

Memorandum of Understanding

Template

MEMORANDUM OF UNDERSTANDING

Between

Name of agency.....

Address.....

.....

.....

and

Name of agency.....

Address.....

.....

.....

This Memorandum of Understanding is dated: _____

1. BACKGROUND

[A background to the partnership. For example: When and why it commenced, information on both organisations, etc.]

*..., have endorsed the development of formal linkages between **XXX** alcohol and drug and **XXXX** mental health service to assist coordination and shared care practices for the management of clients with alcohol and drug and mental health comorbidities.*

2. PURPOSE

[The reasons for setting up this agreement.]

For example, the purpose of this Memorandum of Understanding is to support liaison, communication, consultation and shared care practices between local alcohol and drug and mental health agencies.

Expected outcomes

For example,

- *Improved referral processes for clients of our service...*
- *Increased communication and information sharing between organisations...*

3. PRINCIPLES

[Guiding philosophies and standards of the Memorandum of Understanding.]

For example,

- *Provide optimal continuity of care for people accessing the services...*
- *Service interactions and operations should be guided by the client's needs...*
- *Issues arising as a result of the Memorandum of Understanding development and implementation will be approached and resolved for the good of the client...*

4. TERMS OF THE AGREEMENT

Term

[Information regarding the period of operation of the Memorandum of Understanding and a specified review period.]

For example,

- *This Agreement is effective from the date of signature by both parties and remains so for a period of **XX**, unless earlier terminated in accordance with this Memorandum of Understanding. At the completion of the agreed term a review on continued partnership shall be undertaken...*

Dispute resolution

[Information regarding dispute resolution of the Agreement.]

For example,

- *If a question, difference or dispute arises at any time between the two parties concerning this Memorandum of Understanding or the rights, duties or liabilities of any Party under this Memorandum of Understanding then the relevant **XXX** manager & **XXXX** manager will negotiate in good faith to resolve the dispute. Where issues are not resolved at this level, either party shall refer to their organisations' external dispute management processes...*

Termination

[Length of notice required to leave the partnership.]

For example,

- *Either Party may terminate this Memorandum of Understanding by giving 30 days written notice to the other Party...*

5. BASIS OF PARTNERSHIP

[A clear statement of the nature of the partnership and that both agencies consent to the partnership's existence.]

Governance

[Who in each organisation holds authority in relation to this Agreement? How are activities going to be undertaken and monitored? Etc.]

6. DESCRIPTION OF SERVICES AND AGREED ACTIVITIES

[Specific activities that will be undertaken to achieve the expected outcomes of this Agreement]

For example, this may include details about:

- *Priority groups...*
- *Inclusion/exclusion criteria...*

- *Type of staff and their availability. For instance, Doctor may only be made available for referred clients one day a week...*
- *Ability to assess and manage risk issues...*

7. LIAISON AND CONSULTATION

[Information pertaining to contact and other consultation.]

For example, this may include details about:

- *Mechanisms for ongoing liaison (e.g. key workers, their agreed activities/position descriptions and their contact details, shared learning activities, team meetings and strategic planning).*
- *Procedures for secondary consultation (advice from one service to the other regarding client management)*

8. REFERRAL AND INTEGRATED CARE PROTOCOL

[Identify pathways that clients can be referred between the agencies.]

For example, this may include:

- *Agreed referral forms and information provided (e.g., what information a local mental health requires about a drug and alcohol client)...*
- *Guidelines for referral that will ensure that referrals are appropriate...*
- *Key workers/positions that will provide liaison...*
- *Consent forms for the exchange of information signed by the client...*
- *Timelines for the forwarding of relevant background information...*
- *Agreed case management model to be employed*
- *Agreed procedure for informing referring party of:*
 - *The outcome of the referral;*
 - *Discharge from treatment;*
 - *Other significant events.*

9. CONFIDENTIALITY AND PRIVACY

[Clause outlining confidential and privacy requirements]

For example, for the purposes of this Memorandum of Understanding:

- *'Confidential Information' means all information which is not in the public domain and which is reasonably regarded by a Party as confidential;*

- *'Party' means a party to this Memorandum of Understanding; and*
- *'Parties' means XXX and XXXX*

Both XXX and XXXX agree to hold all confidential information in confidence for each other and will not directly or indirectly at any time during this Memorandum of Understanding or after the termination or expiry of this Memorandum of Understanding use any confidential information or disclose any confidential information to any third party except if the use or disclosure:

- a) relates to information already within the public domain, other than by virtue of a breach of this Clause by the disclosing Party;
- b) is required by law or by any competent authority having jurisdiction over a Party; or
- c) is made with the prior written consent of the other party.

Both XXX and XXXX hereby acknowledge that where they are bound by the provisions of the Privacy Act 1988 and they handle any Personal Information under this agreement, they shall comply with their obligations under that act including, without limitation, how they collect, use and disclose the Personal Information. Further, where either Party is not an Organisation (as defined in the Privacy Act 1988) that Party hereby agrees to comply with the provisions of the Privacy Act 1988 as if it was such an Organisation.

10. MAINTENANCE OF DATA/EVALUATION

[May or may not be necessary.]

For example, this may include:

- *What data will be collected and by whom...*
- *Responsibility for the collation of data and any report preparation...*
- *Clarify how the joint activities will be evaluated...*

11. LEGAL RESPONSIBILITIES

[Information pertaining to any relevant legal responsibilities of the organisations. Generally, the Memorandum of Understanding does not create legally enforceable obligations on the parties. The parties note that all staff remain the employees of their employing agencies at all times. Neither party will be liable to the other in respect to any loss or damage or injury suffered by their staff while on each other's premises except where such loss, damage or injury is as a result of negligence. All parties will remain responsible for their own insurance.]

12. COSTS

[Information of any additional financial costs for either party.]

Executed as a Memorandum of Understanding

SIGNED ON BEHALF OF XXXXXX

SIGNED ON BEHALF OF XXXXXXXX

Signatures to this Agreement

Signed: _____

Signed: _____

Dated: _____

Dated: _____

Name: _____

Name: _____

Position: _____

Position: _____

Organisation: _____

Organisation: _____

4.3 Referral Guidance

Instructions

The following is template of a Letter of Referral and Client Identification Information Sheet. Services may find these two collaborative resources useful when referring clients to external services. The authors acknowledge and thank the staff and management of Kedesh Rehabilitation Services for their input. These two resources have been adapted from Kedesh documents.

The Letter of Referral serves as a template to facilitate the assistance of an external treatment service. It details the basic information required by an external service in order for a client to transfer successfully between agencies. Staff must fill out the blanks as required. The attached/faxed additional information list can be modified to be service specific, depending on the originating AOD service's policies and procedures and the requirements of the external service.

The Client Identification Information Sheet provides a comprehensive file of a client's basic information. It should be completed as accurately and detailed as possible by client and staff member. In the 'shared care' section staff should list all services that information might need to be shared amongst. This list might include other AOD services, pharmacies, pathology services, medical centres and hospitals, mental health services (e.g., counsellors, psychologists, psychiatrists) and emergency services. The client must then authorise and sign the bottom of the form to consent to this sharing of information.

Letter of Referral

Date: ____/____/____

Dear Consulting Doctor,

Thank you for seeing _____ DOB: ____/____/____

☐ Please find attached: ☐ Due to safety concerns, the following will be faxed:

- ☐ Medication profile
- ☐ Psychiatric assessment
- ☐ Client identification information sheet
- ☐ Suicide Risk Assessment Screen
- ☐ Suicide Risk Formulation Template
- ☐ Other: _____

☐ The client has reported the following: ☐ Staff have observed the following:

To continue medication after his/her assessment with you, we require any changes to medication to be updated on the medication profile attached and brought back to our service with any prescriptions.

Our service (_____) will hold the above client's bed and facilitate his/her return to the service on any working day upon receipt of psychiatric and medical reviews from the hospital, and clinical discussion between our staff. Please also note that our service is only able to facilitate re-admission between the hours of _____ and _____.

Currently, this client had been discharged from the service. In order to facilitate re-admission it is essential that the above stated paperwork be faxed to this service and a clinical staff member is contacted between _____ and _____ in regards to the status of this client before re-admission to the program can be considered.

Staff are available at our service between the hours of _____ and _____, if you have any queries please do not hesitate to contact me on _____.

Yours sincerely,

Name: _____ Position: _____

Signature: _____ Ph: _____ Fax: _____

Client Identification Information Sheet

Title: _____

Surname: _____ [PHOTO]

Given name(s): _____

Date of Birth: ____/____/____ Gender: _____

Country of birth: _____

Address: _____

Telephone: (Home) _____ (Mobile) _____ (Work) _____

Concession #: _____ Expiry date: _____ Card type: _____

Name of Medicare: _____ Medicare #: _____

Position #: _____ Valid to: _____

Name of GP: _____ GP Phone #: _____

Allergies: _____

Marital status: _____ Occupation: _____

Employment status: _____ Employer name: _____

Employer address: _____

Dept of Housing? YES/NO/NA Rent reduction application required? YES/NO

SHARED CARE (list services):

I, _____, authorise the exchange of information between these services. I also consent to providing supervised urine samples when requested by medical centre or treatment service staff. Failure to provide a sample may lead to discharge from the service.

Date: from: _____ to: _____

Client signature: _____

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