WORKPLACE OPTIONS

GLOBAL PARTNER NETWORK

Partner Policy: Risk Of Harm To Self

Introduction

This policy is concerned with the EAP's approach to those participants who report either suicidal intent or non-suicidal self-harming behaviour.

The following guidelines present an overview of best practice clinical considerations regarding the assessment, management, and documentation of suicidal risk. The guiding principle dictating practice is that suicide is a multidetermined phenomenon that requires a multidimensional approach. At the present time, mental health professionals cannot predict with certainty which participants are going to attempt suicide. There is currently no scale or clinical assessment instrument that has proven predictive value in the assessment of suicide. A direct and comprehensive assessment of the individual remains the only valid method of determining risk. Therefore, it is imperative that clinicians provide a thorough assessment of suicide risk for all participants. Raising suicidal risk with participants and exploring their experience does not increase their risk of taking action and clinicians should approach the subject openly and without bias. The clinician's aim is to empower the participant to take responsibility for their own safety while at the same time taking the necessary steps to keep the participant safe should this be required. Immediate risk requires immediate action.

The majority of those participants who report self-harming behaviour are not intending a suicidal outcome. Rather the self-harming is a coping strategy adopted to relieve emotional pain. Nevertheless, there is always a risk that the harm being inflicted causes irreparable damage.

Policy

Clinicians will, during their clinical engagements with participants, assess which cases have a probability of suicide risk. This assessment will, wherever possible, constitute part of the 'Good Conversation' the clinician holds with the participant and emerge naturally out of that conversation. The clinician will specifically assess whether the danger appears to be imminent, or if the participant is at high risk of suicide in the short-term. The participant's level of distress will always be acknowledged and respected.

The goal of the suicide risk assessment is to identify factors that may increase or decrease a participant's level of suicide risk, to estimate an overall level of suicide risk, to develop a plan that addresses participant safety, and to modify contributors to the suicide risk. The risk assessment allows for early detection and thus may aid in prevention.

Where imminent, clear, and present danger is judged to exist, the clinician will collaborate with the participant to implement a plan to protect the participant's safety above all else. Under these circumstances, professional standards and the law allow for a breach of confidentiality (as appropriate), as part of an organized safety plan. The EAP will only breach confidentiality, without a participant's consent, when risk is assessed as imminent.

When a participant reports suicidal risk but refuses to confirm whether or not their intent is imminent and refuses to agree a safety plan before disconnecting the call, the clinician will attempt to immediately re-connect. If this reconnection is unsuccessful potentially imminent risk will be assumed and Emergency Services contacted to request a safety check.

Some participants report imminent suicidal risk while remaining anonymous and refusing to provide the demographic information required to keep them safe. In these circumstances, the EAP will use any information available to aid the Emergency Services in identifying and locating the participant even when the details have not been provided directly by the participant (e.g. a phone number displayed on the clinician's phone or the details the participant used to register on IConnectYou).

Participants reporting self-harming behaviour will be thoroughly assessed to establish the frequency, immediacy and gravity of that behaviour. Where the behaviour is driven by underlying suicidal intent or is of such a nature that it is exposing the participant to a risk of immediate or significant physical harm the steps taken to keep them safe will be commensurate with the level of suicidal risk identified. Where the intent is not suicidal, or the behaviour unlikely to cause immediate and significant physical harm, a supportive space will be provided where the participant can gently explore the steps they may need to take to minimise the self-harming behaviour and to no longer rely on the immediate, but generally fleeting, relief it provides. The aim is to agree a safety plan, tuned to the individual participant, which helps to manage the behaviour going forward and to encourage them into the support they require. A referral to short-term solution-focused therapy is unlikely to be appropriate for those participants who are self-harming though Transitional Support may, with the agreement of Partner Clinical Management, be beneficial in providing the support and encouragement required to develop a comprehensive safety plan and to engage in the intervention required to meet their on-going needs.

The EAP will only disclose that a participant is at risk of harming themselves to an Employer on the rare occasion when it is considered that an Employer's intervention is the only option, due to the urgency of the situation or lack of information on which to base a timely response from the Emergency Services. The Employer can then contact Emergency Services (if the Employee is at work or the Employer has contact information not available to the EAP) and/or take the steps they need to take to mitigate the risk as appropriate.

Clinical Practice

- Clinicians must stay mindful that participants in crisis may be communicating strong emotions and may present with feelings of being out of control, angry, overwhelmed, and hopeless. Clinicians will be careful not to be overly drawn into, or impacted by, the participant's distress, but rather attempt to maintain a healthy professional boundary and take control of the situation as appropriate. A professional attitude will be coupled with compassion and sensitivity.

- A consistent approach will be used with all participants who present in crisis, allowing the clinician to stay organised and follow appropriate steps in gathering information and taking necessary action. Providing order for the participant is an important first step to mitigate the chaos or disorder the participant may be experiencing. They may feel hopeless, trapped, or desperate, with no foreseeable way out of their circumstances. They need the clinician to make a difference and take control of the situation.

- Clinicians must remember to take a positive approach, reminding the participant that they are there to assist, that they expect things to improve, and that they will appreciate the participant cooperating with them in the process of getting them the assistance they require. The participant's strengths and steps towards self-help will be acknowledged and a sense of cooperation in the process at hand fostered. Participants expect the clinician to make a difference in the situation. That's the reason they have contacted the service. Clinicians will proceed in the belief that they have unspoken permission to take control of the situation. That permission can be used to contract with the participant, or others who are with the person, to set the direction of events. The clinician acts as if the situation will improve, that there are positive options available, and that they expect the participant to cooperate in obtaining appropriate help. Statements acknowledging the participant's strengths, achievements, positive actions, positive intentions, and capabilities foster a partnership of success. Such statements also support the contracting process as an interactive process of self-help rather than a rescue. Obtaining agreement as early in the contact with the participant as possible increases the likelihood of a collaborative safety plan.

- Identification of Suicidal Risk and Protective Factors

The clinical evaluation is the essential element of the suicide assessment process. The clinician's knowledge of suicide risk and protective factors is used during the assessment process to identify and explore relevant factors that either increase or mitigate risk for the individual participant. In order to accurately assess suicidal risk, the identification of risk and protective factors is essential.

  - Does the participant have a prior history of suicidal intent or self-harming behaviours?
  - Does the participant have a family history of suicide or self-harming behaviours?
  - What is the participant's support system?
  - Has the participant experienced traumatic or stressful life events in the past several months?
  - Does the participant live alone?
  - What is the participant's age?
  - Does the participant have minors in the home?

Risk Factors	Protective Factors
At-risk mental status: depression, hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes, irrational thinking, impulsivity, perfectionism. Also a feeling of having come to a resolution in making the decision to kill themselves and with it a sense of peace or calmness. A sense that their departure will not impact others.	Stable mental status: resilience, independence, capacity to tolerate frustration, effective coping skills, sense of humour, optimism. Willingness to cooperate with a safety plan. An acknowledgement that their departure will impact and affect others.
Being between 18 and 34 years of age	
Being male	

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Being Caucasian	
Being single, divorced, or widowed	Warm, caring family relationships, strong perceived support, feeling valued
Isolation, lack of social support network	Social competence, positive peer relationships, acceptance and support demonstrated through support and encouragement
Alcohol intoxication or drug withdrawal	
Previous suicide attempts	
Access to methods of suicide (e.g., guns, pills, rope)	Restricted access to methods of suicide
Having an organized plan	
Family history of suicide	
Recent interpersonal crisis (e.g., rejection, humiliation)	
Financial difficulties or unemployment	Opportunities to participate in the community
Difficulties at work or school	
Impending legal prosecution or child custody issues	
Recent major loss, trauma, or anniversary	
Medical or physical illness	Affordable access to health and mental health care
Cultural or religious conflicts	Cultural or religious beliefs that discourage suicide and support self-preservation; positive values and beliefs
Unwillingness to accept help (e.g. reluctance to connect with Doctor)	Willingness to accept help
Multiple visits or call outs to Emergency Services	

- Specific Questions About Suicide

  Obtaining accurate information is imperative and best done creatively through learned interviewing techniques, preferably not in a checklist-style interaction. The following questions may be helpful to determine the level of intent:

  - Are you thinking about killing yourself?
  - Do you feel so bad that you wish you were dead?
  - Have things been so bad recently that you have thought you would rather not be here?
  - Have you ever felt that life was not worth living?
  - Did you ever wish you could go to sleep and just not wake up?
  - Is death something you've thought about recently?
  - Have things ever reached the point that you've thought of harming yourself?

- The following questions may be helpful to determine whether the participant has a suicidal plan.

  - How close have you come to acting on those thoughts?
  - How likely do you think it is that you will act on them in the future?
  - If you had to weigh the thought of ending your pain and ending your life, which would be heaviest?
  - Have you ever started to harm or kill yourself but stopped before doing something (i.e. holding the knife or gun, getting the rope, going to the bridge but not jumping)?
  - What do you envision happening if you actually killed yourself (i.e. escape, reunion with others, rebirth, reactions of others)?
  - Have you made a specific plan to harm or kill yourself?
  - How does the future look to you?

- The following questions may be helpful to determine the means/lethality of the suicidal plan:

  - Do you have guns or other weapons available to you?
  - Have you made any particular preparations (i.e. writing a note or a will)?
  - Have you spoken to anyone about your plans?
  - Do you have any intention of acting on the thoughts of suicide?
  - Could you rate your intent on a scale of 1 to 10?

- Managing Self-Harming Behaviours

  Participants who self-harm in most instances employ this as a coping strategy to address anxiety and stress which they have come to experience as intolerable. Although there may be no intent to fatally self-harm, such behaviours may take on a form that can put their lives at risk. The following questions may be useful in establishing whether a participant is, or is at risk of, self-harming and aid in establishing the gravity of the behaviour reported:

  - Have you ever tried to harm yourself? With what intent?
  - Have you ever harmed yourself by cutting, scratching, biting etc without wanting to end your life?
  - Have you ever tried to injure yourself or cause pain on purpose?
  - How frequently?
  - When was the last time? When did it start?
  - Is anyone else aware that you do this?
  - Did you need medical support at any point?
  - What are you hoping to achieve by doing this?

  The Suicidal Risk and Protective Factors listed above may be pertinent in identifying the gravity of the self-harming behaviour reported by a participant. Once it is established that the behaviour is not suicidal in its intent, the clinician should work with the participant to agree a safety plan that includes strategies to reduce active self-harm both in terms of frequency and gravity. This will be adjusted to the participant’s current behaviours and resources and can include, but not be limited by, strategies such as reaching an agreement regarding reducing frequency of self-harm, ensuring wounds are adequately dressed and sanitised, using clean blades, negative replacement behaviours, mindful breathing and visualisation, non-competitive physical exercise or artistic expression.

- Determining Overall Level of Suicidal/Self-Harming Risk and Intervening Accordingly.

  Based upon the answers to the questions above, and taking into account risk factors and protective factors, the clinician will make a determination of Non-existent, Mild, Moderate (Non-imminent), or Severe (Imminent) risk. This determination must be recorded. A safety plan will be created based on this assessment.

  Non-Existent

  Participant reports no current or historical suicidal ideation or self-harming behaviour.

Mild

Participant reports historical suicidal/self-harming ideation/attempt or current thoughts of limited frequency, intensity, and duration. No clear plans, no clear intent, good self-control, fewer risk factors, and identifiable protective factors. Appropriate action with the participant is not limited to, but may include the following:

- Encourage follow-up with existing counselling services
- Offer EAP sessions if focus is short-term
- Discuss/explore ways to counteract suicidal/self-harming thoughts should they return
- Develop plan for safety
- Remind participant of 24-hour availability of service
- A welfare check, to establish whether the participant has taken the steps agreed to keep them safe and has engaged with appropriate services, may be scheduled within an appropriate timeframe (24 to 48 hours generally). Any second or subsequent welfare check can only be actioned with the agreement of partner Clinical Management following a case review.

Moderate (Non-imminent)

Frequent suicidal/self-harming ideation is present with limited intensity and duration, some specific plans, no clear intent. Risk factors are present; identifiable protective factors are also present. Participant reports no immediate intention to act on thoughts but states they may do so in the future. Appropriate action with the participant is not limited to, but may include, the following:

- Obtain verbal contract for safety if possible. Having the participant verbally contract to a safety plan and verbally contract to ‘do no harm to self’ is an important part of a safety plan but should not be the determining factor. For participants who are intoxicated or vacillating between moods and thoughts or present any other high-risk factors contracting may not only be inappropriate but unreliable and Severe (or Imminent) risk actions may need to be taken.
- Facilitate contact with local supports (e.g. GP).
- Assess if participant is willing to go to emergency room of their own volition.
- Conference-call with the participant to relatives or friends and ask for their help. If a conference call is not workable, ask a supervisor or co-worker to make the call.
- Ensure that a follow-up call (welfare check) is initiated at an appropriate interval (sometimes within an hour or hours, sometimes the following day) to establish whether the participant has taken the steps agreed to keep them safe and has engaged with appropriate services. Any second or subsequent welfare check can only be actioned with the agreement of partner Clinical Management following a case review.

  - Transitional Support may occasionally be appropriate to provide the participant with some containment and encouragement to process their options for support going forward. This will only be offered following review/agreement with partner Clinical Management.

Severe (Imminent)

Frequent, intense, and enduring suicidal/self-harming ideation, specific plans, markers of intent (access to lethal methods, some preparatory behaviour), evidence of poor self-control, and severe psychological distress. Multiple risk factors are present, and few protective factors have been identified. In this situation the clinician must follow the 'Partner Calling Emergency Services' Policy.

- Safety Planning

  WPO Clinicians will work with participant's presenting with any level of suicidal/self-harming risk to lower perturbation. The following questions may help the participant to draw on their previous coping mechanisms and aid in the development of a safety plan relevant to this participant's specific needs:

  - Have you felt like this before?
  - What did you do last time you felt like this?
  - What will you do if you continue to feel this way?
  - What will you do if you feel worse?
  - What will you do if the safety plan we are agreeing now doesn't work?

  Clinicians should always be mindful of cultural norms and expectations when agreeing a safety plan with a participant (e.g. wherever possible engaging personal, rather than professional, support in jurisdictions where suicide remains illegal).

- Documenting in Case Record

  As always, accurate documentation in the clinical record is a vital aspect of any counselling service. When ethical and legal liability is in question, decisions are based primarily on the extent to which mental health professionals gathered the necessary information to appropriately assess risk, and then did something about it. Here is a guide on what to document:

  - Evidence that a suicide risk assessment has occurred and recognition of suicide/self-harming risk. The clinician's assessment of the participant's suicidal/self-harming ideation must be recorded.

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  - Evidence that a reasonable intervention plan was formulated to contain, manage, or mitigate the risk. The level of care the participant received must be documented, along with details of the safety plan agreed, and any communications and involvement with family members and friends.
  - Evidence that the plan was implemented competently and adjusted as needed. Contact and follow-up with anyone to whom referrals were made, or from whom additional information was obtained must be documented.
  - Evidence of any follow-up required.

  The clinical rationale behind the decision to classify the risk as non-imminent as opposed to imminent must be documented as this will make clear why Emergency Services were, or were not, contacted.

- Self-Care and Debriefing with Supervisor/Colleagues

  Managing participants at risk of harming themselves can be stressful for clinicians; therefore, it is important that clinicians consult with partner Clinical Management after engaging with these participants. In addition, a review of the details and actions taken is an important aspect of clinical supervision and skill-building.

- Exceptions to this Policy

  Some EAPs may have their own specific requirements with regard to how they wish participants at risk of harm to self to be handled; these are documented in the Case Management system and must be followed where they apply.

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