



Director of Forensic Disability POLICY

Title: Management of Self-harm and
Suicide Ideation and Behaviour

1. Policy Statement

Staff at the Forensic Disability Service (FDS) must support forensic disability clients in a manner that minimises the client's risk of engaging in self-harm and suicidal ideation and behaviour. The management of self-harm and suicide ideation and behaviour policy reflects the state and national guidelines and frameworks on suicide prevention and management of suicide risk.

2. Purpose

This policy outlines the relevant provisions of the *Forensic Disability Act 2011* (the Act), and the Director of Forensic Disability Policy, regarding the management of self-harm and suicidal behaviour of forensic disability clients.

The purpose of this policy is to support prevention, intervention and postvention for forensic disability clients who present with self-harming and suicidal ideation and behaviour.

3. Scope

This policy applies to staff at the FDS. The Administrator, Senior Practitioners, Authorised Practitioners, or other persons, performing a function or exercising a power under the Act must comply with this policy.

This policy must be implemented in a way that is consistent with the purpose and principles of the Act.

4. Authorising Legislation

Section 91 of the Act.

5. Policy

This policy emphasises a planned approach to the care of clients that includes prevention, intervention and postvention activities. The FDS must plan all client activities in a safe environment and provide individualised interventions that enhance the capacities of clients to cope with environmental or emotional stressors. This may be achieved by utilising the client's individual coping skills, assisting clients to acquire new coping skills and encouraging family and staff support.

Where staff are unclear about any aspect of client care and support in terms of self-harm or suicide risk, they should contact the Senior Practitioner and/or Principal Clinician. The Administrator should ensure appropriate resources are available to support prevention, intervention and postvention for clients at the FDS.

5.1 Prevention

Rates of suicide remains high in the general population in Australia, with over 3,000 people completing suicide each year i.e. approximately 8.6 per day (Australian Bureau of Statistics (ABS), 2022). Seventy-five percent (75%) of those who take their own life are male (ABS, 2022). The incidence of suicide in Aboriginal and Torres Strait Islander communities is estimated to be twice the rate of the general Australian population (ABS 2022).

Compared to the general population, adults with intellectual disability may have significant exposure to risk factors such as, interpersonal stressors, depression, substance abuse, serious financial and legal issues, loss and bereavement, employment and housing problems, trauma, abuse and social isolation. Furthermore, these risk factors may be compounded by a lack of protective factors such as emotional resilience and the ability to adequately problem solve or seek help when dealing with stressful or distressing situations.

The client's Individual Development Plan (IDP) must be in place to promote rehabilitation, habilitation, quality of life and informed by appropriate and evidence-based assessment. The IDP should include supports and approaches that will meet clients individualised needs pertaining to health and wellbeing, including management of suicide or self harm risk (where relevant) and proactive strategies that promote emotional resilience and coping strategies.

It is important to note that whilst self harm may be used by a person as a coping strategy or as a means to get their needs met without any intent to die, the risk of accidental death through self harm is very real and can signify feelings of hopelessness and possible suicidal thoughts.

General risk factors for suicidal behaviour include:

- previous self-harm or suicide attempt, or exposure to suicide behaviour in others;
- depression;
- mental illness diagnosis;
- co-existing mental illness and substance use problems;
- chronic pain or physical disability;
- experience of a sense of hopelessness or isolation; and
- experience of stressful or negative life events (e.g. conflict, loss of a close relationship, rejection, failure, humiliation, abuse, financial crisis).

It is important for clinicians to understand that the risks of suicide or self-harm for Aboriginal and Torres Strait Islander clients should consider social and cultural risk factors, such as social cohesion, spirituality, impacts of trauma (including abuse, family violence, racism, intergenerational) and lack of connection to country.

All staff have a role in minimising harm and prevention of loss of life. Where elevated risks are identified, staff should ensure these are reported and immediate action is taken.

Non-verbal indicators may include:

- social withdrawal
- a persistent drop in mood
- disinterest in maintaining personal hygiene or appearance
- uncharacteristically reckless behaviour
- poor diet changes, rapid weight changes
- being distracted
- anger
- insomnia
- alcohol or drug abuse
- giving away sentimental or expensive possessions

Indirect verbal expressions may include:

- hopelessness
- failing to see a future
- believing they are a burden to others
- saying they feel worthless or alone
- talking about their death or wanting to die.

It is important to note that suicide risk may exist and may even be imminent without communicated suicidal thoughts, intent or plans.

Prevention includes, but is not limited to:

- Referrals to mental health specialists where early warning signs are present and ensuring assessment and intervention occur in a timely manner;
- Assessing risk of suicide and self-harm on a regular basis and using this to inform risk management plans;
- Ensuring risk management plans are developed and implemented, where required (see 5.2 intervention);
- Access to supports, programs and evidence-based interventions aimed at reducing self-harm and suicidal behaviour; and
- Consideration of cultural issues as part of the assessment and care planning processes including:
 - being aware of gender-sensitivity issues;
 - gaining an understanding of cultural belief systems concerning suicide or mental illness;
 - linking Aboriginal and Torres Strait Islander clients and clients from different cultural backgrounds with their community support networks and involving them in assessment processes; and
 - use of apps/resources developed for targeted groups such as the AIMhi Stay Strong App (a tool that addresses the mental health and wellbeing concerns of First Nations Australians using a cross-cultural approach).

5.2 Intervention

Intervention refers to strategies implemented by staff to respond to a client's suicidal ideation or threats to engage in self-harming or suicidal behaviour. Identifying suicide risk requires sensitive

interviewing and attention to suicidal behaviour as many persons who die by suicide deny suicidal intent.

5.2.1 Risk assessment

Suicide risk is generally assessed through identifying the presence of:

- Static risk factors - fixed historical factors that may have a predisposing influence on a person's risk of suicide, including: history of self-harm, seriousness of previous suicide attempts, previous psychiatric hospitalisation, history of mental disorder, history of substance use disorder, personality disorder/traits, childhood physical or sexual abuse, family history of suicide, age and gender;
- Dynamic risk factors - changing factors that are having a current impact on the person's current distress and are modifiable, including: suicidal ideation, communication and intent, hopelessness, active psychological symptoms, treatment adherence, substance use, psychosocial stress, problem-solving deficits, engagement with support and services and physical pain;
- Protective factors - factors that are available, accessible and valued by the person that they can turn to in a crisis;
- Warning signs - these are likely to be unique to each individual and may involve an uncharacteristic change in behaviour, withdrawing from staff, co-tenants, family or community;
- Future risks - upcoming events that might destabilise the person and increase risk of suicide;
- Tipping points - these are likely to be unique to each individual and may involve the client being confronted by a significant negative life event, such as a relationship ending, the death or suicide of a relative or friend, being bullied or abused or loss of status or respect; and
- Unknown risks - consideration should be given to factors that are unable to be assessed and may have significant bearing on the person's assessment and care.

The analysis of risk should consider any factors potentially affecting or driving an individual's risk so that safety strategies can be targeted towards mitigating or managing sources of risk or harm.

Assessment of elevated risk of suicide or self harm may require immediate intervention such as further assessment of the client by a mental health service, psychologist or psychiatrist. It may require transport to the closest hospital for further assessment and consideration of admission.

5.2.2 Risk management plans

Where risk of self-harm or suicidal behaviour has been identified or assessed as elevated a client's risk management plans should outline risks and the strategies to prevent and manage this behaviour (refer *Director of Forensic Disability Policy and Procedure – Clinical Risk Assessment and Management* and *Director of Forensic Disability Policy and Procedure - Individual Development Plans*).

Safety planning is a key component of risk management plans. The goal of safety planning is to support the client to identify how they can manage their suicidal thoughts while also reducing access to lethal means. Planning should assist the client to identify their individual warning signs and available resources and strategies they can use to manage thoughts, emotions and circumstances that cause distress. Strategies should be based on individual assessment with consideration of environmental, therapeutic and social supports, as well as security measures that will mitigate the risk of self harm or suicidal behaviour.

Actions in the event of a crisis or escalation in suicide risk should be clearly documented. Where possible, staff should attempt to communicate to the client risk mitigation strategies before they are implemented. This will assist the client to have an understanding of why actions are being undertaken and their purpose. Examples may include, removal of client's items, change of client's environment or increase in observation levels.

In the event that staff are uncertain as to how to proceed in relation to a client, staff should consult the Senior Practitioner and/or Principal Clinician.

5.2.3 Emergency responses to self-harm and actual or attempted suicide

Staff should use first aid and/or cardiopulmonary resuscitation (CPR) if required and ensure the Queensland Ambulance Service is contacted. A Senior Practitioner must be notified, and staff should stay with the client until management of care has been reviewed. Inpatient treatment may be necessary and should be facilitated where required.

5.2.4 Review of incident

Staff must record and report incidents where a client has threatened or attempted to self-harm or suicide. The Senior Practitioner should review the incident and the support, care and risk management strategies in place prior to the incident. The Director of Forensic Disability must also be notified in accordance with *Director of Forensic Disability Policy – Notification of Incidents to Director of Forensic Disability*.

The Senior Practitioner should work with the staffing team to identify the best approach to supporting the client and, where relevant, new strategies should be included in the risk management plan.

5.3 Postvention

Postvention refers to activities and strategies undertaken after an incident of self-harm, attempted or completed suicide, therefore reducing further trauma and harm.

Postvention responses aim to:

- Respond to the needs of individuals, families, groups, communities and service providers by linking those at risk of experiencing trauma (including witnesses to incidents of self-harm or suicide attempts) and those close to the client (such as support staff, friends and family) to appropriate counselling responses.
- Prevent further self-harm incidents, suicide attempts or completed suicide events by:
 - Facilitating the early identification of other individuals who may be at risk of harming themselves;
 - Ensuring appropriate support and continuing care is provided to people who have attempted suicide or who have sought assistance for suicidal ideation;
 - Engaging in close consultation with experts in the suicide prevention and postvention field (e.g. psychiatrists and psychologists) to continue to develop and implement postvention responses; and
 - Providing staff with additional training as required.

5.4 References

Australian Government - Department of Health and Ageing (2008). Living is for Everyone (LIFE) framework.

Beyond Blue (downloaded 2022). Suicide. <https://www.beyondblue.org.au/the-facts/suicide-prevention>

Menzies School of Health Research. (Downloaded 2022). The AIMhi Stay Strong App https://www.menzies.edu.au/page/Research/Projects/Mental_Health_and_wellbeing/Development_of_the_Stay_Strong_iPad_App/

Queensland Health (2021). Suicide Prevention Practice Queensland Health Guideline. https://www.health.qld.gov.au/_data/assets/pdf_file/0027/1125864/gh-gdl-967.pdf

Queensland Mental Health Commission (2019). Every Life: The Queensland suicide prevention Plan 2019-2029.

Salvatore, T., Brown, J., Huntley, D., Kivisalu, T., Arndt, C., & Wiley, C. (2016). Intellectual disability and suicide risk: An exploratory discussion. *The Journal of Special Populations*, 1(1), 1-19.

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