Guidelines for the Psychological Management of Suicide Risk

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INTRODUCTION

This document aims to contribute to our thinking about risk management in suicidal patients from a psychological perspective. It is not intended to be a formal set of procedures with any expectation of uniformity, but could be seen as a supportive resource.

It might be most useful when managing those people with personality disorders or who have chronic states of suicidality which may be related to their personality structure but is also relevant to those with other diagnoses who present as suicidal.

Leicestershire Partnership Trust has adopted the Department of Health approved risk assessment package Working with Risk* by Steve Morgan. There are other valid and convenient formal measures of risk, which individuals may use in addition to the Morgan package in the course of their work with suicidal people and this document can be considered as an adjunct to these. Although it contains a number of psychodynamic ideas, and draws on attachment theory, it will also be applicable to work based on other models.

Effective risk management is not an exact science. It is a task that falls, primarily, to individual clinicians and it is important that they be familiar and comfortable with their own approach to risk management. This document is aimed at adding to this but not replacing it. The most important “tool” available to clinicians is their own clinical “sense”, developed through experience, informed by the use of formalised assessment measures and intuition.

Because of the anxieties that are inherent within risk assessment and management, the ability to think clearly when faced with risk can be compromised. It is hoped that this document may provide some structure and fresh ideas for managing this difficulty.

Much of the material stems from thinking about risk management in longer-term therapeutic relationships but similar overarching principles can be applied to managing risk in one-off and first contacts. It may also be a helpful resource for individual and team supervision, which can be crucial to effective work in this area.

The clinical team is often the best resource available to clinicians when facing testing situations and clinical supervision, team meetings and handovers, are vital to the success of risk management, as is informal and peer support. It is important to encourage the ethos in which all members of the team engage in the consideration of, and responsibility for, risk management and can offer their perspectives and opinions about this.

The Guidelines seek to promote a better psychological understanding of why patients become suicidal and advocates involving the patient as much as possible in the risk management process. The areas covered in this respect include abandonment, depression and anger, anxiety, ambivalence, malignant regression, the body barrier, learned helplessness and the idea of suicide as a contingency plan. It also refers to self-harm and its relationship to suicide. It then elaborates some of the issues surrounding psychological risk assessment before exploring different aspects of risk management. These include managing risk with new patients as well as those having ongoing contact.
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The importance of collaboration is then stressed, as well as the importance of referring to evidence of how risk might be within a particular patient. The problem of escalating risk is addressed, as well as the need to manage the diverse responses that risk arouses within the staff group. The need to work with the aftermath of a suicide is also acknowledged. The Guidelines then propose a system of reviewing patients on acute wards and other areas where the patient is found to be difficult to help but remains at high risk of suicide. The involvement of senior managers and clinicians as a support for high-risk decision-making is advocated as good practice in support of the clinicians involved in the case. A condensed checklist of key issues in risk management appears in Appendix 1.

This document will explore the importance of:

- Regular review in supervision and in teams, such as handovers to ensure that historical or enduring risk is not avoided or denied.

- Considering collaborative working, i.e. asking whether you should be consulting or involving other people in thinking about this risk. This does not mean handing over responsibility but collaborating. Individuals can identify triggers for themselves, e.g. a change in the pattern of a patient’s self-harming, which may indicate that a review of the patient is necessary, whether this is formalised and external or within the team.

- Questioning your capacity and what other resources you may need to help understand your response to patients and the risk they present. This may be particularly important where a patient evokes more or less anxiety than is usual, or where they get a change of clinician or treatment, or move to a different service.

It is acknowledged that there is no certainty in the field of risk; however, clinicians must strive to maintain a thoughtful and open minded response to patients.

SUMMARY

These guidelines aim to offer advice and ideas to clinicians in the Leicestershire Partnership NHS Trust working with patients who are at risk of suicide. They should be read in conjunction with other documents, including the Morgan “Working with Risk”, risk management framework, and any additional service specific risk frameworks. The reader is also advised to consult the Mental Health Act, 1983 (amended 2007), as well as the literature on risk assessment tools.

This document offers ways of thinking about suicide risk in order to support and assist clinical staff in the difficult task of clinical risk management. A checklist appears in the Appendix of this document, but the document is not intended to be a manual of procedures.

While the majority of patients pose no significant risk, occasional serious events do occur in the care and treatment of people with mental health difficulties. At worst these will involve the death, by suicide of patients or, much more rarely, harm to other people. Although (even with the best practice) it will never be possible to prevent these incidents entirely, these guidelines are written with patients who are suicidal in mind, and are intended to support the clinicians who are trying to help them.

Risk in mental health puts a considerable amount of personal pressure on clinicians, and staff understandably feel anxious when faced with the risk of serious incidents. A review of inpatient suicides within the Trust was undertaken by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) in 2012. The review provided a reminder that whilst is it important to assume that in a human system, errors will occur, the Trust must ensure that there are sufficient safety nets to prevent suicides when errors happen, and this requires a comprehensive approach to risk management.

Patient U had become an inpatient following a psychotic episode. He wanted to leave the ward for a cigarette. He was well known to the nursing staff and the senior nurse on duty, who thought that it should be safe to allow this. But because U was on a Section the nurse did not feel he would be supported if anything went wrong. He therefore refused the patient, in spite of his own risk assessment that this would be safe. In response to this refusal the patient became very agitated and ended up in seclusion.

The NCI report also highlighted that errors are often made by the most skilled and experienced staff, and these errors need to be understood if deaths are to be prevented. In recent years, the Trust has worked to develop a culture of learning from adverse events, and this document represents a further attempt to facilitate and promote an atmosphere of thoughtful, reflective practice and intelligent risk-taking. The aim should always be to improve the outcome for the patient.

All actions involve risk, as does inaction. There is a tendency in society to expect mental health clinicians to provide effective treatment and solutions that will alleviate patients’ distress and prevent harm, both to themselves and to others. However, the effectiveness of most treatments depends in significant measure on the ways in which patients engage with these, as well as on their own capacity and willingness to accept control and responsibility for their lives. Clinicians are accountable for the way they practice but outcomes also dependent on the patient’s ability and willingness to engage with them. The outcome of the work can never be guaranteed, whether or not risk is an issue of concern.
A considered and professional approach to risk assessment and management can, nevertheless, save lives. These Guidelines are intended to contribute to this aim by suggesting ways of thinking about risk that can be of help to practitioners.

THE ASSESSMENT OF SUICIDE RISK

1. Some Factors in the Aetiology of Suicidal States

Although each patient is unique and can only be properly understood within their own subjective terms, there are a number of emotional factors that frequently contribute to suicidal states and it is helpful for clinicians to have an awareness of these when working with patients in severe distress.

General Risk Factors

Statistics can provide one kind of picture of people who take their own lives and this has resulted in an understanding of the background risk factors. These include previous incidents of self-harm, social isolation and alienation, substance abuse and unemployment. While people falling into these categories are often not suicidal, they may well experience a sense of personal isolation, alienation and abandonment that is common to suicide. Familiarity with risk assessment tools can be of help in assessing suicide risk.

Abandonment

Many mental health patients experience a long-standing sense of abandonment that stems from insecure and unstable attachments in early life. Abandonment can induce a powerful sense of despair and the ending of important relationships - perhaps through bereavement or divorce - can significantly increase this feeling and its associated risk of suicide. Similarly, the ending of a significant and close clinical relationship can also induce the despair of abandonment. For this reason, patients who are discharged from lengthy periods of in-patient and other forms of care may be at particular risk, and attention needs to be given to the necessity of helping patients to mourn the loss both of this care and the attachments with staff and other patients that have developed as a result of it.

During a long stay on an acute ward patient V developed a strong attachment to the staff. Eventually, she was transferred to a mental health hostel. She felt upset about the loss of her relationships on the ward and started self-harming and threatening suicide when moved to the hostel. Unfortunately, the strength of her attachment to the ward was not fully appreciated. The change had been abrupt and its impact was not fully discussed with her. She was not encouraged to have further contact with the ward staff. Nor was there any acknowledgement of the feelings aroused in her by finding herself in a new and unfamiliar setting in which she now knew nobody. The patient took her life shortly after arriving at the hostel.
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Depression and Anger

Depression involves difficult feelings such as guilt, helplessness and despair. Depending on the degree of these feelings and how overwhelming they are, depression is often a factor in suicide. Many people who are depressed have considered suicide, although this is not the same as intending it.

Suicide can be thought of as the murder of the self. It has a devastating effect on the families, friends, relatives, colleagues and clinicians of the person taking their life and may be an aggressive act on the part of the patient. It is not uncommon for the suicidal person to be harbouring an acute sense of rage that cannot find safe external expression and so is suppressed and consequently becomes turned inward in the form of a destructive attack on the self. Anger is often an underlying and unconscious feature of depression and can result in suicide in cases where patients turn this on themselves. In more extreme cases the suicide threat can have a sadistic quality, appearing to be an attack on the clinician by arousing intense feelings of guilt, anxiety and inadequacy within them. These may be the very feelings that the patient is struggling with and which underlie their own difficulties and distress.

Anger is also a common emotional response of clinicians when patients are suicidal or have attempted suicide. This is also suggestive of the same angry feelings within the patient that cannot find a more positive form of expression. It is important that the clinician be aware of their anger in these circumstances without acting it out in the way that they talk to or behave towards the patient.

Anxiety

Anxiety is a characteristic feature of mental health difficulties. This may be experienced by the patient in a number of different ways and may be observed and even experienced directly and personally by people around them (including clinicians). High levels of anxiety in the clinician may, therefore, indicate areas of difficulty and potential risk for the patient. Patients may feel anxious about the prospect of carrying on living but may be equally afraid of the thought of dying. Clinicians are equally likely to experience high levels of anxiety when they feel that their patients are suicidal and this is one indication of the present degree of risk.

Excessive anxiety in the clinician may be an indication that the patient is not feeling safe or psychologically contained and that further measures need to be considered to try to ensure the patient’s safety. At the very least it should prompt a serious discussion of the situation with a clinical supervisor.

Equally, the absence of anxiety in the clinician can also be a danger sign and should also be noted when the clinician is feeling unmoved whilst patients are talking about serious difficulties, or when they seem to be minimising their problems.

Ambivalence

All human behaviour is in some degree conflicted. This can be particularly true of suicidal behaviour and impulses, which are, themselves, the subject of social taboos. Patients who wish to die also tend to fear death and may often be seeking the relief of pain rather than death itself. Regrettably, it is not always possible to keep someone alive when they are determined to die themselves. Even relatively extreme measures such as compulsory detention are no guarantee that suicide can be prevented and such strong measures may even increase the suicide risk.
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It is important in these circumstances that the patient retains their own sense of responsibility for their life and death. Where the clinician feels responsible for keeping the patient alive this can split and weaken the patient’s own ambivalence, leaving them more free to act suicidally while the clinician carries their sense of fear, inhibition and responsibility that would otherwise provide an inner restraint on their behaviour. Paradoxically, allowing the patient to express their suicidal ideas and wishes more fully, without seeking to stop them in this, can enable the patient also to remain in touch with their counterbalancing wish to carry on living. It is the latter that will most often help the patient to stay alive.

**Malignant Regression**

For some people the offer of help can undermine their own capacity to cope and make use of their own resources. In these circumstances patients may come to rely with increasing urgency on the clinician, to whom they look to solve their difficulties. In more extreme cases they become more and more dependent and demanding in ways that can leave clinicians feeling that they are now solely responsible for the recovery and even the survival of the patient.

This involves an addictive state known as malignant regression that manifests as an escalating degree of regressive dependency on the part of the patient. In these circumstances, whatever the clinician tries to provide it is never quite enough and the patient’s condition continues to deteriorate. This can result in acute feelings of anxiety in clinicians, who are likely to feel increasingly out of their depth. The threat and fear of suicide is often a feature of these malignant spirals but the more the clinician tries to change the patient’s behaviour, the more the patient’s condition seems to worsen.

In these circumstances it is important that clinicians accept and acknowledge, with the patient, that their approach has failed and that there are limitations to their ability to help. This may be the only way of establishing a more collaborative approach in which the patient’s own resources can be better mobilised in their own service.

**The Body Barrier**

It is very difficult for people to take their own lives. The patient's own fears and inhibitions will generally act as a restraint to the act of suicide. One way of accounting for this is the idea of the ‘body barrier’. This suggests that people have an embodied sense of inhibition about extreme actions (such as suicide and murder) that pose a threat to the integrity and survival of the person and the species. Suicide is a taboo and taboos are difficult to break. However, once the body barrier has been breached – for instance in a previous and serious suicide attempt – its strength is weakened and it becomes easier to transgress this again. It needs to be borne in mind, therefore, that a person who has made a serious suicide attempt in the past may be at greater risk of succeeding in taking their own life in the future.

The suicide of another person in the patient's life, including a fellow patient on a ward, represents the crossing of a boundary that was previously felt to be inviolate. This may also have the effect of weakening the patient’s own ‘body barrier’, which may also partly account for the phenomenon of an increase in suicide attempts by patients who are known to each other.

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Suicide as a Contingency Plan

The thought of suicide can be a contingency plan when all else fails. This is an important means of coping for some patients, reminding them that they still have some control and sense of agency over their lives. For some of these patients the thought that they can always kill themselves is one of the things that enable them to stay alive and it is important that the clinician can understand and appreciate the value of this perspective.

Learned Helplessness

In many patients depressed mood can be an indication of suicidal risk. It is very common for people who are depressed in mood to experience suicidal thoughts and plans and whilst the presence of these can increase risk, it does not follow that suicidal thoughts lead to suicidal acts. However, in patients who have experienced numerous traumas or negative life events this can damage their sense of volition and feeling they can control their own destiny. In some patients this can lead to an inability to find solutions to the problems they face and a belief that suicide is the only viable option. This ‘learned helplessness’ is often accompanied by a marked flattening of mood and a calm resignation to fatalism and should be taken as an indication of increased risk when accompanied by suicidal ideation.

Patient W had a long history of self-harming behaviour and had made several suicide attempts in the past. It was felt that she had developed a dependent relationship with the CMHT that was undermining her capacity to take responsibility for her actions. She often placed demands on the team and made threats of self-harm or suicide if the demands were not met. In the past the team had met her demands so as to reduce the risk of her carrying out her threats. On learning that her key worker would be unavailable for two weeks she informed the team that she was in crisis and requested a referral to the crisis service, threatening to kill herself if she was not referred.

Whilst taking the threat seriously, the team felt that if they referred her to crisis resolution they would be increasing her dependence on services and complicating the demanding nature of the relationship for the future, which would be to the detriment of her care in the long-term. This was explained to patient X and she was not referred. Although there was an increase in the number of threats over the following two-week period, she did not act on them.

Self-Harm and its Relationship to Suicide

Although many patients who self-harm have no intention of taking their own life it is important not to be lulled into complacency. Some patients who lead chaotic life styles and chronically self-harm, increasingly lose touch with the risk involved, and may accidentally die, without particularly meaning to, through increasing carelessness.

Others, who regularly self-harm, also make serious suicide attempts. The patient is usually able to distinguish between the two and focusing on the particular circumstances where suicide has been attempted may reveal information that is

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pertinent to the risk of suicide in the future.

For some patients regular self-harming behaviour (particularly self-laceration) is an important coping mechanism. Such patients may describe the behaviour as putting them in touch with their feelings, allowing them to be in touch with their pain, releasing the tension, letting out the bad, distracting from a feeling of emptiness and deadness inside etc. Where self-harming has become an entrenched coping mechanism and way of life, stopping the self-harm may expose the patient to an overwhelming sense of vulnerability and the risk of suicide in the short term may increase significantly.

Patient X had been in the therapeutic community for 6 months. She seemed to be progressing well, engaging in community life, helping other residents and significantly reducing her medication and incidents of self-harm. Prior to this she had spent 3 years in another Trust revolving between the locked ward and Rehabilitation Unit, seriously cutting and burning herself two or three times each week. It was now put to her that she was doing really well and the next stage was to stop cutting completely. A rather fierce community insisted that she hand in all her razors, which for years she had secreted in various secret pockets in her clothing. Two days later she made a serious suicide attempt and was lucky to survive. Later she talked about how the hidden razors felt a fundamental part of her, that giving them in had left her feeling stripped naked with no sense of who she was “completely helpless and jelly like and evil”
2. Assessing the Suicide Risk

Risk Factors

Certain risk factors, such as previous incidents of self-harm, social isolation, a history of anti-social behaviour and violence to the self, substance abuse and unemployment, can often be associated with high-risk behaviour. While these factors do not, in themselves, indicate that the patient will be suicidal, they should be borne in mind so as to alert the clinician to possible risk. Demographic information about age, gender and ethnic group will also affect the risk of suicide and the ways in which suicidal feelings are expressed.

The factors in the aetiology of suicidal states outlined above should also be kept in mind when the risk of suicide is being assessed.

The Clinician’s Anxiety and Intuition - Facing the Possibility

Although they are subjective, the clinician’s own feelings and intuition are amongst the best guides for establishing the patient’s mental state and the degree of suicide risk. The emotional intensity of the clinical relationship in mental health practice is such that the clinician will often experience a wide range of emotional reactions in response to the patient and their disclosures. An important element in the work is the clinician’s capacity to face and experience these reactions within themselves and subject them to scrutiny for the purpose of increasing their understanding of the patient and the issues and conflicts that are currently troubling them. The clinician's assessment and identification of risk should take into account these “countertransference” feelings, particularly issues such as intense feelings of anxiety or a sense of emotional deadness and detachment in the face of disturbing disclosures by the patient. These feelings should be taken to indicate the possible presence of serious risk.

Suicidal intent can be overlooked because it is hard for clinicians to face the severe degree of distress and disturbance that that some patients are experiencing. One research study scrutinized videotapes of clinicians’ facial expressions while they were assessing patients known to be at risk. The clinicians were asked to predict further suicide attempts but did this with only 23% accuracy. However, researchers’ predictions, judged solely from the clinician’s facial expressions, predicted this with 82% accuracy. The implication of this discrepancy was that clinicians were registering the extent of risk in a bodily way, without being consciously in touch with this. The clinicians’ facial expressions conveyed that they knew more than they were aware of knowing (Archinard et al 20004).

In order to assess the real risk of suicide in any particular situation the clinician must be able to face the possibility that the patient could kill themselves and not allow themselves to be falsely reassured when their own underlying feelings, even if somewhat intangible, suggest that all is not well.

Hearing the Patient

The best way of assessing whether a patient is at risk is to talk to them and, in particular, to listen to what they have to say, not just the story but also the meaning they ascribe to it.

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Two patients took serious overdoses after their flats were burgled. One of them had been severely sexually abused as a child and felt intruded upon by the experience; whereas for the other, it was the theft of her mother's jewellery that brought back the feelings of loss and grief associated with the sudden death of her mother as a child.

The clinician needs to listen for meaning. Simply identifying the burglary as the trigger would have missed vital information in both cases.

Listening to people is a difficult skill to acquire, particularly when they are saying things that we do not want to hear. Perhaps the most difficult challenge of working with suicidal patients is to allow them to talk about their wish to kill themselves without interrupting them, ignoring what they are saying or simply trying to get them to stop feeling as they feel. Suicidal patients often feel abandoned. Not being properly heard by a clinician risks further reinforcing this feeling and undermining the hope that remains.

It may be important to challenge the patient's wish to die but this should be informed by the patient's own ambivalence about this rather than the clinician's need to prevent it.

**Holding on to Risk Information**

Whilst the evaluation of risk should be an integral part of a patient's initial assessment, it is important to realise that risk assessment should be ongoing and part of every interaction. Risk does not remain static.

One phenomenon that is well described in enquiry reports occurs where initial assessment suggests a high risk, but, as time passes, this information drifts from consciousness and fails to be passed on to new staff involved with the patient. Although involving a murder, one prominent example of this was the Falling Shadow Enquiry (Blom-Cooper 19955). It was known that the patient had threatened a woman he was infatuated with using a shotgun but this information became watered down as successive team members took over his care. It was lost completely by the time Georgina Robinson (no relation) became his occupational therapist and he eventually murdered her.

Serious risk information gets lost because of psychological conflict within the clinician. It is difficult to continue facing the reality of the wish to die, or the potential dangerousness of patients with whom we are developing a close relationship. For this reason it is important to have up to date summaries that clearly capture important information and also for team leaders and supervisors to ensure that previous high risk behaviours are retained within their own and their staff's consciousness. The tendency for risk information to “drift” underlines the need for good communication and CPA processes, particularly for those patients who require a complex care package.

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MANAGING RISK

1. Patients Who Are Not Known to the Clinician

The assessment and management of risk in patients who are not known to the clinician is a more complex task, involving greater uncertainty, than with known patients. Clinicians face the unknown when a patient is new to them. They are not in a position to fully assess the nature of risk that the patient might pose and must fall back on general, often theoretically based, knowledge as to how the patient might respond to different approaches. Particular note of referral information and general risk factors should be taken into account. An escalating pattern of self-harm, e.g. mild to moderate self-laceration progressing to more violent actions over a few months is a particularly clear risk factor for continuing escalation and severe risk. Risk assessment tools may be particularly helpful in assessing patients who are not known. In all cases, however, discussion with the patient forms the primary means of establishing the degree of risk present.

It is likely that the patient will experience considerable levels of anxiety when faced with a clinician whom they do not know. Age, gender, class, ethnic group and culture are all likely to affect the anxiety a new patient experiences talking to a mental health professional. Cultural norms and religious beliefs may also help or hinder patients in acknowledging and talking about suicidal feelings. They may be very reluctant to disclose the kinds of personal information that can help the clinician to evaluate risk more effectively. It is therefore important to establish a degree of trust and rapport with the patient as quickly as possible so that self-disclosure is encouraged.

It is important, however, to ask specific and direct questions about suicidal ideation, intent and planning as part of the initial mental health assessment, particularly with people who are not known, where there is a history of risk or where there is some other indication that the patient may be at risk. This can be a great relief to the suicidal patient. Acknowledging this area can validate the patient's distress and give permission to them to open up this area for fuller thinking.

2. Ongoing Work with Known Patients

Key to the effective management of risk with most patients is the quality of the ongoing clinical relationship. This provides the context within which risk becomes apparent and offers the best hope that it can be effectively contained.

The following factors need to be taken into account in the evolution of this relationship:

- The patient must be involved and participate in the risk assessment. Although there are a number of factors typical of suicide, the wish to die is a subjective state within the patient and each person's feelings and impulses can only be understood by reference to what these mean to the patient themselves. The degree of risk needs to be more fully assessed in collaboration with the patient and cannot simply be understood from the "outside".

- It is vital that the patient's sense of self-control is not dismissed or overridden in the management of risk. Even in those circumstances in which the invocation of the Mental Health Act is felt to be necessary the patient should be treated with respect and consulted as much as their mental
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state permits. When patients’ wishes are being overridden this should be acknowledged and, where practicable, an explanation given. Responsibility for their own lives should be given back to patients as soon as possible after the crisis.

- Fundamental to the assessment and management of risk is the management of the patient’s anxiety through providing reliable and predictable contact with them, talking openly and honestly with them about their difficulties and supporting their own adaptive strategies and capacities for coping. Where the degree of anxiety cannot be contained by these means, other forms of intervention may be indicated.

- Consultation with other clinicians is valuable and important, but is better undertaken with the patient’s prior knowledge and managed in a way that does not further disempower the patient. There may be emergencies or other circumstances where this is not possible but the patient should be informed about this as soon as possible and an explanation given.

- Conveying the clinician’s understanding of the underlying issues should be done with respect and sensitivity. For example, telling a patient what they are feeling (that they are angry, for instance) can be counterproductive. The patient may simply not be aware of what they are feeling. They may experience such comments as criticisms and this can add to their sense of isolation and alienation - even though being in touch with and able to express feelings such as anger can also help people to stay alive.

- It is important that clinicians try to remain calm under pressure. This means acknowledging the possibility of tragedy occurring and also appreciating that anxiety and risk are not directly correlated.

3. Collaborative Risk Management

Risk assessment and management is most effectively undertaken within the context of an ongoing clinical relationship. The most effective forms of clinical risk management are collaborative in nature and, first and foremost, this requires working together with the patient. The patient is the person who can most effectively influence the level of risk, and risk management that does not involve the patient only increases the danger of the situation.

Where a collaborative approach to risk management is not possible, the clinician may need to invoke the powers of the Mental Health Act. This, however, should be a last resort, indicating that a more collaborative approach is no longer feasible or effective.

It is difficult for any clinician to manage risk in isolation and where concern arises about a patient, the support of a colleague or clinical supervisor should always be sought. Where necessary the support and involvement of other colleagues and carers should also be sought, particularly where these have access to other resources not otherwise available to the clinician and patient.

Individual clinicians may carry the burden of ‘high risk’ individuals in relative isolation, particularly when the patient is not ready for, or is unable to engage with, specialist services. The generalist clinician may feel left to manage the most difficult patients with too few resources and with little or no support. The solution to
this is collaborative working across service boundaries. This should provide the clinician with access to the advice, supervision and support necessary for working with such patients.

New Ways of Working for Psychiatrists\(^6\) challenges existing hierarchical structures and emphasises the importance of team working. The clinical team is often the best resource available to clinicians when facing testing situations and clinical supervision, team meetings and handovers, are vital to the success of risk management, as is informal and peer support. It is important to encourage the ethos in which all members of the team engage in the consideration, of and responsibility for, risk management and can offer their perspectives and opinions about this.

Some patients are so damaged by early experiences that there is a limited amount services can offer. Such patients may be kept safe for prolonged periods by frequent contact with a known and dependable clinician who can acknowledge and manage the reality of their dependency. This can put a heavy burden on the clinician(s) involved, particularly around periods of leave or coming up to leaving the service and it is recommended that clinicians access ongoing support and supervision in relation to these patients as described above, both to share the load and to help to minimise major deterioration at these times.

4. **Evidence-based Risk Management**

- The suicide of a patient is not, in itself, evidence that clinical practice has been deficient and the effectiveness of risk management cannot be determined simply by the outcome of a clinical decision. Risk assessment and management are always matters of clinical judgement and cannot be undertaken with any degree of certainty about the outcome. The clinician must be able to demonstrate that a thoughtful and professional approach to risk has been undertaken, even where the situation has ended in tragedy, and that this has been done in collaboration with the patient and colleagues.

- Previous experience with the patient needs to be taken into account. Where risk management measures have been effective in the past, this is some indication that the patient may again be helped through the use of a similar approach. However, it must not be assumed that what has worked in the past will necessarily be effective in the future. Present circumstances may be different and each new threat requires a new evaluation - both of the degree of the risk present and of what measures might be the most helpful in the current circumstances.

- Statistically established risk factors should be borne in mind but must not, on their own, determine the clinical evaluation of the degree of risk present or how best to manage this. The complexity of the individual patients’ emotional circumstances should always be taken into account and risk properly evaluated in conjunction with the patient. The views of other people in the patient’s lives should also be taken into account, as relevant to the particular circumstances and as long as this remains compatible with the treatment approach being used. It should be borne in mind, however, that there are circumstances in which friends and families of patients form part

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\(^6\) New Ways of Working for Psychiatrists: Enhancing effective person-centred services through new ways of working in multidisciplinary and multi-agency contexts (2005). Department of Health
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of the emotional matrix within which the patients’ difficulties are being generated and that consultation with them is not always indicated.

- The clinician’s intuition, based upon their relationship with the patient, and their knowledge of the patient’s history and characteristic patterns of behaviour are often the best guides to the most appropriate course of action.

5. Escalating Risk

The “safe” option for the clinician may not be the most effective way of managing risk. For example, a short period of intensive community support, or arranging a hospital admission of a community based patient, may help to reassure the clinician but can prove more dangerous to the patient if this undermines their own coping mechanisms. Such approaches will not necessarily prevent people from committing suicide and in some cases they may even be counterproductive.

It is not uncommon for risk behaviour to escalate when patients engage with caring services, particularly on admission to acute psychiatric wards. This behaviour is often related to chaotic attachment patterns, triggered by high levels of anxiety and the fear of and craving for dependency that can be associated with the patient role (see Malignant Regression – page 6).

Distress can lead to self-destructive behaviour which in turn engenders anxiety in the staff group who may then attempt to control the behaviour, amplifying the power relationship which in turn increases the patient’s anxiety and dependency and increases the high risk behaviour. These mutual interactions and projections feed into a vicious circle. The patient may end up acting in a violent or self-destructive manner as a way of trying to re-establish a sense of control.

It is particularly important to avoid inducing a sense of humiliation, which may be associated with feelings of impotence and disempowerment. In this context, it is important to be aware of issues around disability, special needs, race and cultural sensitivities. Physical and emotional impingement may also arouse claustrophobic anxieties often associated with the threat of exposure and humiliation. Treating patients with proper respect is the most effective way of avoiding or de-escalating the sort of scenario described above. Keeping in touch with the underlying anxiety and desperation may help the clinician to manage these sorts of situations more effectively.

6. Managing the Staff Group Response

When certain patients are particularly disturbed this can be reflected in a splitting of feelings and attitudes within the staff team that make assessment of the situation very difficult.

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Patient Y was admitted to an acute ward because of suicidal thoughts and plans. She had a 6-year history of depression and had one previous short admission following an overdose. She had always been dependent upon her husband but her husband left her and she was now staying with her sister. As a result of binge drinking, her relationship with her sister had deteriorated

On the ward she formed close relationships with two members of staff and selectively confided in them. Others saw a different side of her, finding her cold and rejecting and, at times, contemptuous and sarcastic. The staff group had become increasingly preoccupied by her and split in their feelings and views about her.
If splitting within a team does occur in this way, the patient and staff become predisposed to the process of “malignant alienation”. This is usually focused around particular patients who do not show the “required response” to the efforts being made to help them (Morgan, 1979)\(^7\). At worst this involves a progressive deterioration in the patient’s relationships with the staff group. Sympathy for them is lost and they come to be seen as “manipulative” or “over dependent”. This process can gather momentum rapidly.

One of the dangers of this development is the team’s habituation to risk and dismissal of it. This can culminate in an inability to consider risk in a meaningful way and, therefore, an increasing insensitivity to the indications of risk.

A series of antidepressants had little impact on Y’s mood. She isolated herself from other patients but became increasingly demanding of staff. She was referred to a psychologist whom she saw weekly but who had little contact with the ward. Twenty weeks into her admission, there had been little progress and an attempt at home leave had resulted in a small overdose.

Her psychologist and her two preferred nurses had become demoralised, while most other ward staff had stopped bothering with her altogether, feeling that she was manipulative and attention seeking. They were unimpressed with her small overdose and suicidal talk was met with a mechanical response. Her diagnosis was changed to that of personality disorder and there was a general wish that she be discharged.

Although she had been accustomed to finding support and relief when she spoke of her suicidal thoughts, Y now experienced disdain from most staff and avoidance by those that she had felt close to. Her psychologist suggested referral elsewhere.

Y then suggested a period of leave, which was seized upon by the staff group. Whilst on leave, she was visited by her CPN. He was unable to gain access and she was found dead, having taken a large overdose.

Several features of patients have been identified as contributing to the development of “malignant alienation” within clinicians. These include “withdrawn psychoticism, severe character pathology (personality disorder), suicidal depressed behaviour and violence / agitation”, in short those characteristics which make patients likely to be experienced as difficult or hard to treat.

Furthermore, this group of patients are more likely to infringe the “sick-role code” by not co-operating with efforts to return to health. This tends to provoke ambivalent responses within clinicians and, ultimately, a failure of the therapeutic alliance can result.

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Paradoxically, when such patients remain locked in conflict with staff, they are often at less risk, as they remain in a state of attachment with their clinicians. But these difficulties can lead to staff avoiding patients. This can be concretely expressed through ignoring the patient, prematurely discharging them and transferring their care to others “better equipped to treat them.” It is at this point that the patients, experiencing a sense of abandonment, are at the highest risk of suicide.

Clinicians should be alert to these difficulties, particularly when arguments and ill feeling develops about different treatments and courses of action. An appropriate forum can bring together members of the staff team and allow them to discuss their different perspectives. It is an advantage for a staff team to be able to step back in the face of such difficulties and consider whether these disagreements and negative feelings towards the patient are in some measure the consequence of the inner conflicts and turmoil within the patient. This can sometimes be easier when an external person who is not caught up in this dynamic is available to help the staff group to understand the situation.

Additionally, the capacity to identify patients who may evoke these responses and monitoring of the therapeutic alliance with all parts of the unit or service can help teams pre-empt the acceleration of this process.

7. Managing Risk within a Team after a Suicide

Suicides and near misses are a reality for those working in mental health an invariably have an effect on staff involved. It is common for staff to suffer from symptoms of post-traumatic stress and depression. This is bound to affect their capacity to work - particularly their capacity to contain anxiety and affects the decision making process. Although there has been some evidence accruing that traumatised members of the public do not necessarily benefit from post trauma counselling, it may well be different for staff whose day-to-day work involves similar situations and triggers. Often a whole team can be left traumatised by an incident and the group dynamic may amplify feelings of fear, guilt and helplessness, which is likely to affect other situations and patients.

Where individual staff members are affected by a suicide or other serious incident, the team leader and service manager are responsible for making sure they get appropriate therapeutic help: where a whole team is involved, this should be the responsibility of the lead clinician in conjunction with the service director. This should happen automatically and should not be left to team leaders or consultants of the team involved as they may be adversely affected themselves.
REVIEWING PATIENTS WHO ARE AT RISK

1. Informal Review

Where situations arouse serious levels of concern a review of the case involving the clinical supervisor and / or colleagues is indicated. In these cases the clinician should be in a position to ask for support by involving others in the decision-making process and, consequently, sharing the risk. In the most difficult circumstances this could involve clinicians who are outside the service and can provide an external opinion regarding the appropriateness of the course of action being followed. This includes the clinician facing their own inability to help, and being prepared to acknowledge this with the patient.

Patient Z was admitted to an acute ward following an overdose. She suffered from serious, long-standing depression with suicidal impulses. She remained on the ward for 11 months. Successive psychiatric and psychological treatments were tried but none of these had more than a temporary benefit.

During the course of her stay in hospital a second opinion was sought. Eventually, and reluctantly, it was decided that none of the treatment options available would be of help to Z. In fact, her condition was somewhat worse than when she was first admitted.

This was discussed with her and she was told that the clinical team felt unable to help her. She was offered outpatient appointments in which she could have time to consider the implications of her situation. In spite of the fact that she was felt to be at risk of suicide, she was then discharged back to the community. Z’s condition subsequently improved spontaneously. In this case the willingness of members of the clinical team to acknowledge their own limitations and inability to help had the paradoxical effect of empowering the patient, whose condition then improved.

2. Formal Review

In certain circumstances and, in particular, when a patient remains on an acute ward for longer than six months, an automatic and more formal review should be signalled. In some circumstances, the clinical team may want to request a formal review at an earlier stage. The first purpose of this should be to assist the clinicians responsible for managing the case, helping them to step back from their day-to-day involvement in order to review the patient’s overall progress. Such a review should not be seen as critical of the clinicians concerned but as a means of sharing the anxiety in difficult circumstances when the risks are high.

The aim of the review is to allow very high-risk decisions to be taken with the full backing of relevant senior clinicians and managers that would otherwise place an undue burden of responsibility on the shoulders of the individual practitioner. Such a review should, therefore, involve senior staff, including a consultant psychiatrist, a specialist in a psychological therapy and a Trust Director. It is important that such reviews are conducted jointly with the clinician(s) responsible.
for managing the patient and who know the patient best; also, that any decisions made are explicitly joint decisions, with joint ownership of risk. This should avoid the danger of clinicians feeling that they are left holding full responsibility for decisions with which they do not fully concur.

There is a danger that the staff group may feel criticised and undermined by the involvement of outsiders in situations that are already particularly likely to arouse strong and difficult feelings. It should be acknowledged, therefore, that it is inevitable that all clinicians and teams experience these types of difficulties from time to time, regardless of their levels of experience and expertise. The introduction of an automatic review process is a reflection of the intense difficulty of managing some very disturbed patients, often with serious personality disorders, and this is not a criticism of the clinicians concerned.

CONCLUSION: THE BALANCE OF RISK

Risk of suicide cannot be eliminated and safety can never be guaranteed. Effective risk management involves the known, the unknown and the unknowable. It cannot, therefore, aspire to become an exact science. Consequently, well-considered decisions about risk may not always prevent tragedies from occurring. It is important that this is accepted at all levels of the organisation and by all concerned with the processes of risk assessment and management. Where tragedies do occur clinicians need to be able to demonstrate that they have made a thoughtful decision based on balancing the risk of different interventions, including that of taking no action. 'Inaction' may often be the safest way of dealing with a situation, if what this means is the continuation in its present form of a treatment relationship in which the clinician and patient are continuing to work together to do what they can to improve the patient’s circumstances and wellbeing. Actions that disrupt a working relationship with a patient are generally more likely to increase the risk than to contain it.

In the last resort, there are no right answers in the field of risk, just balanced judgments. It is enough that the clinician has approached situations of risk in a thoughtful and open-minded manner, in the best interests of the patient, and has done his or her best in the circumstances.
APPENDIX 1

Risk Management Checklist

1. Make sure you are familiar with the risk factors that are common in people who kill themselves.
2. Be aware of cultural, religious and other factors that may make it difficult for patients to talk about openly about suicidal feelings.
3. Formulate an interpersonal understanding of a particular patient’s risk behaviour. This may include sensitivity to abandonment and rejection, intrusion, humiliation, learned helplessness, and suppressed anger.
4. Identify particular situations that may trigger these feelings.
5. Try to predict how you or your team may get drawn into these particular dynamics and listen out for this in ongoing conversations.
6. Respect the patient’s need for physical and emotional space.
7. Be aware of the possibility of malignant regression and try to avoid taking responsibility away from the patient.
8. Monitor your own feelings, particularly your anxiety levels. Learn how to read your feelings.
9. Make sure you are well supported in terms of supervision, reflective time etc.
10. It is not usually helpful to try to cheer the patient up as this leaves him or her isolated with their despair.
11. Be aware of the effect of changes in the inter-personal environment on a potentially suicidal patient.
12. Work together as a team, particularly when you don’t feel like it. Splitting is inevitable and needs to be addressed openly.
13. If there is a suicide in your team, make sure that staff receive appropriate emotional support and have time to work through their feelings. If there is a suicide in a group forum or on the ward, other patients may well be affected and may be at increased risk themselves.
14. In situations that feel very stuck there may be others in the Trust who can help by offering a fresh perspective and support.
APPENDIX 2

Useful Trust Policies

Safe and Therapeutic Observation of Inpatients Policy, August 2012

Guidelines for the Provision of Staff Welfare and Support following an Incident of Violence and Aggression, January 2013
http://www.leicspart.nhs.uk/Library/LPTGuidelinesfortheProvisionofStaffWelfareandSupportfollowinganIncidentofViolenceandAggression.pdf

Handover Policy for Adult Mental Health, FYPC Adult Eating Disorders and Learning Disabilities, March 2013
http://www.leicspart.nhs.uk/Library/HandoverPolicyAMH.pdf

Clinical Risk Assessment Policy, August 2012
Guidelines for the Psychological Management of Suicide Risk

APPENDIX 3

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Community Mental Health Teams
Consultant Psychiatrists
Crisis Resolution Service
Dynamic Psychotherapy Service
Forensic Mental Health Service
Liaison Psychiatry
Managed Clinical Network for Personality Disorders
Psychological Therapies Strategic and Advisory Committee
Psychotherapies Clinical Governance Committee
Senior Management Team
Specialist Mental Health Services Directorate
Treatment and Recovery Service

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