
Suicide, Self-Harm and Self-Injury Intervention Policy

Turas Training

Approval date:

Revision date:

1. Policy Statement

- 1.1. TURAS acknowledges that suicidal ideation, the action of suicide and the desire to self harm are issues which affect many people. This organisation is committed to responding to these issues in a way which is direct, supportive and informed by good practice.

2. Purpose

- 2.1. The purpose of this policy is to outline how staff should respond to: someone who they suspect may be contemplating suicide; someone who has expressed an intention to complete suicide; an individual who has attempted suicide.
- 2.2. The policy also outlines how the service can respond to a person who is considering or engaging in self harm and self injury behaviours. While self injury and suicide are not mutually inclusive behaviours, responses to both these behaviours are contained within this policy.

3. Scope

- 3.1. The policy outlines the steps to be undertaken by all staff, volunteers and locums.

4. Glossary of Terms and Definitions

- 4.1. STORM and ASIST are suicide first aid training course that is endorsed by the HSE. They provide models for first response to suicide.
- 4.2. Suicide: the act of deliberately or intentionally taking one's own life.
- 4.3. Self harm: Self-harm includes attempted suicide, overdoses, swallowing objects, starvation, or excessive amounts of a substance such as alcohol or drugs.
- 4.4. Self injury: the various methods by which people deliberately harm themselves, including self-cutting and taking overdoses. Varying degrees of suicidal intent can be present; sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with all self injury.
- 4.5. Suicidal ideation: refers to having thoughts of and/or the intent to complete suicide, including planning how it will be done.

5. Principles

- 5.1. It is widely confirmed through research that asking someone directly about suicide will not encourage a person who is not thinking about suicide to consider it. It is always better if you have concerns to raise these directly and empathetically with the person. If a staff member feels ill equipped to do this, they should raise the issue at the earliest possible time with the manager or a senior staff member so that other supports can be put in place.
- 5.2. Turas will aim to have all staff / at least 50% of staff trained in STORM and/or ASIST at all times to ensure that the service can provide effective interventions for services users and also that staff are protected from undertaking work for which they are not equipped.
- 5.3. Concerns that an individual may be contemplating suicide or self reported issues of suicidal thoughts should never be dismissed and must always be dealt with as serious and in the way described in this policy.
- 5.4. Suicide interventions will be undertaken by staff trained in STORM or ASIST, if the issue arises in one-to-one sessions and the individual's key worker is not trained, they will need to explain to the individual why another staff member is being involved and then support the process as required.
- 5.5. All staff who have dealt with a suicide intervention will be offered a de-briefing session to ensure they are able to professionally contextualise the experience.
- 5.6. While this policy refers to service users as the group that may be experiencing suicidal thoughts, it is noted that these experiences can affect all people and it may be the case that the principles and actions in this policy need be applied to a staff member or other individual within the work setting.

6. Roles and Responsibilities

- 6.1. Managers are responsible for ensuring that staff:

- 6.1.1. have appropriate training in relation to risk assessment and management of suicide, self harm and self injury,
 - 6.1.2. have a clear understanding of the processes outlined in this policy,
 - 6.1.3. have formal de-briefing following a suicide intervention,
 - 6.1.4. are aware of the procedures for taking overtime in the event that a service user requires an intervention that runs afterhours.
- 6.2. Staff who have been trained in STORM or ASIST are responsible for:
- 6.2.1. managing suicide first aid intervention in the way described in this policy and in their training.
 - 6.2.2. ensuring that line management is informed of all decisions throughout the course of the suicide intervention.
- 6.3. Staff who have not been trained are responsible in regard to:
- 6.3.1. informing the manager or another staff member trained in STORM or ASIST when they have suspicion that someone maybe experiencing thoughts of suicide.

Part one - Suicide

7. Initial Risk Assessment – Suicide

- 7.1. Risk assessment should be undertaken by trained staff.
- 7.2. As part of the service's initial risk assessment the individual should be asked if they have:
 - 7.2.1. tried suicide before
 - 7.2.2. had or have thoughts of suicide
 - 7.2.3. self harmed/self injured or has had or has thoughts of self injury
- 7.3. In the instance that someone answers yes to either question, the following response is undertaken:
 - 7.3.1. A plan that outlines what will happen should the individual have thoughts of suicide/self injury should be agreed between the staff member and service user. This should be written into the care plan. The ideal agreement is that the individual will contact someone in the organisation as soon as they are able. A plan will also look at what supports are available, such as family and friends, medical and professional. A regular check-in may be agreed by the key worker or as part of a counselling provision.
 - 7.3.2. The relevant team members in contact with the individual should be informed of the outcome of the risk assessment.

8. Procedures – Staff Suspect an Individual of Suicidal Intent

- 8.1. Concerns about an individual in relation to suicide should never be ignored, it is better to ask and for the service user to say no than for a high risk situation not to be responded to. Suicidal indicators could be described as one or more of the factors listed below, although it should be noted that there is no hard and fast rules and circumstances will differ for different people:
 - 8.1.1. Changes in behaviours: crying, emotional outbursts, increased alcohol or drug use, withdrawal from usual networks, friends or interactions, change in appetite/weight, reduced interest in life events and activities, talking about suicide or dying.
 - 8.1.2. Preparation: giving away possessions, putting affairs in order.
 - 8.1.3. Expression of the following feelings/thoughts: hopelessness, no future, loneliness, confusion, overwhelming sadness, desperation, rage, worthlessness, helplessness, guilt, need to escape, thoughts of death or suicide.
 - 8.1.4. A quick and unexplained improvement from a period of sadness, withdrawal or depression that may denote a private decision to undertake suicide.
- 8.2. If staff are not trained in ASIST and have concerns about an individual in relation to suicide they should raise this with their line manager, who will arrange for a staff member trained in ASIST to undertake the following:
- 8.3. If the staff member has concerns, and is trained, then they should directly ask the service user whether they are thinking about suicide. This should be done in an open, non-judgemental and empathetic way - using active listening skills. In some cases the staff member may wish to lead in with questions concerning how the person is feeling, whether they feel hopeless or other

introductory questions. All efforts should be made to ensure that the environment is appropriate for a confidential one-to-one discussion.

- 8.3.1. If the answer is yes, then the staff member should follow the steps outlined in section 9.
- 8.3.2. If the answer is no then this will be respected. It may be useful to explain what observations / occurrences lead to the question being asked. Ideally the discussion will be managed to allow other needs to be identified by the service user and supports to be offered.

9. Procedures – Service User Identifies Suicidal Intention

- 9.1. Suicide interventions should be undertaken by staff members trained in STORM or ASIST. If a service user identifies suicidal thoughts or intentions the following should be observed:
 - 9.1.1. The staff member should remain calm and should address the issue in a confident and empathetic manner.
 - 9.1.2. The service user should be asked to stay on the premises so that they can be supported, if the individual wishes to leave then they must be allowed to, although all efforts should be made to have them remain in the service or have them escorted to another supportive environment.
 - 9.1.3. The service user should not be left alone if at all possible.
 - 9.1.4. If the staff member is trained in STORM or ASIST then they should utilise this suicide intervention model. In general the following steps will be undertaken:
 - 9.1.4.1. The first step is to listen without judgement to the service user. The service user should be encouraged to discuss what is wrong and any plans / thoughts they have. Active listening skills should be employed (paraphrasing, reflecting back, summarising, open ended questions).
 - 9.1.4.2. The worker needs to be aware of the dangers of dissuading the service user from suicide too early in the intervention as this can lead to the service user feeling unheard and may act as a barrier to honest and/or continued communication.
 - 9.1.4.3. The worker should work with feelings of ambiguity, i.e. not caring about living or dying. The purpose of this is to help the individual to agree that they are not one hundred per cent sure about suicide or that they are able to acknowledge some reasons for living. Once the person is able to do this then agreement should be made that the person will not act on the suicidal thoughts/plans for an agreed period of time.
 - 9.1.4.4. A safe plan should be agreed between the service user and staff member. A safe plan would include the following, if relevant:
 - 9.1.4.4.1. A commitment from the person to hold off on undertaking suicide for an agreed period time.
 - 9.1.4.4.2. A disablement of the suicide plan, this may involve handing over the method of suicide (pills, rope, weapons).
 - 9.1.4.4.3. A commitment to make contact through an agreed mechanism if there are further issues or the individual feels that they want to change the plan.
 - 9.1.4.4.4. The immediate and future supports should be explored; this may include the following: doctor, psychiatrist, family members, friends, other relevant professionals (services they are engaged with, other counselling services etc.), and suicide support services.
 - 9.1.4.4.5. An agreement for the next steps in regard to follow up.

10. Onwards Referral

- 10.1. In the following situations the individual should be facilitated to access professional services:
 - 10.1.1. There are no staff members available who are competent to undertake a suicide intervention, therefore necessitating a referral.
 - 10.1.2. The service user is not willing to undertake a safe plan and so poses an immediate risk to themselves. In such cases, staff may phone the Gardai.
 - 10.1.3. The staff member makes an assessment that there are mental health issues which require a specific mental health intervention.

- 10.2. Where possible, consent for a referral should be sought, the staff member should outline to the service user why they think referral is necessary and what supports may be provided. Note that in accordance with the Confidentiality Policy if the individual is at risk to themselves then information may be passed on to relevant professionals without the individuals agreement, although time should always be taken to clearly explain the rationale for the referral and to seek agreement.
- 10.3. Where possible staff should accompany the service user to the referred service, to provide support and ensure appropriate handover.
- 10.4. In cases where there is a referral to medical / mental health services, one of the following referral pathways should be undertaken:
 - 10.4.1. If the individual has a psychiatrist, contact should be made. If this can not be done or the individual does not have a psychiatrist then;
 - 10.4.2. An emergency appointment should be made with the services users GP or prescribing doctor. The doctor will conduct an assessment and if they deem it necessary will write a referral letter to a psychiatric service. If this can not be done;
 - 10.4.3. Referral into a psychiatric service can be managed through A&E, or in some cases through direct contact with the service. To find out what service is most appropriate a call should be made to the psychiatric provider in the catchment area where the service user lives.
- 10.5. In the case of under 18s contact should be made with the under 18 Consultant Psychiatrist, see case management guidebook or www.casemanagementguidebook.ie.

11. Referral Following Overdose

- 11.1. If the individual has taken an overdose of medication then they should either be taken to A&E in an ambulance or if the overdose was taken in the last 24 hours and there is no immediate risk of unconsciousness then all efforts should be made to obtain an emergency GP appointment. See overdose policy for additional information on procedures in the event of an overdose.
- 11.2. In the instance that an individual has taken an overdose within the last 24 hours and requires referral to a psychiatric service, in all cases they will need to be taken to A&E prior to admission into any medical/psychiatric service.

12. Follow up After a Suicide Intervention

- 12.1. Follow-up to a suicide intervention plan should be a priority for the workers involved. Once initial actions have been undertaken the individual should be offered ongoing formal support.
- 12.2. If the service user has a risk assessment the intervention should be recorded with details of the care plan and any follow up.
- 12.3. The team should be informed so that they can provide an appropriate service into the future.

13. Suicide Interventions for the Under 18s

- 13.1. In the case of individual under the age of 18, the same process should be followed. However the following must be noted:
 - 13.1.1. At some point in the intervention the worker must ask whether the individual's parent or guardian can be contacted. If consent is not granted see below:
 - 13.1.2. For individuals under sixteen years where there is a danger to the youth's life or physical safety there is an onus on the organisation to contact the guardian or parent in the case of risk to safety of the child. In the case that this is not possible the HSE child protection services or the Gardaí should be contacted.

14. Staff Supports Following a Suicide Intervention

- 14.1. A staff member who has engaged in a suicide intervention will be debriefed by their line manager. The purpose of a de-brief is to ensure the staff member is able to professionally contextualise the intervention and to offer the chance to talk through what may be been a difficult or stressful experience, as well as highlighting any learning for future interventions of this nature.
- 14.2. If required a further formal supervision session will be arranged as soon as possible to provide an opportunity to address any remaining issues and concerns.

- 14.3. If the worker finds that due to a suicide intervention issues have arisen for them in the course of their work, they should raise this through supervision. If the issue is urgent they should request that the supervision session be brought forward.
- 14.4. Following a supervision session if it is agreed that the supports required fall outside the expertise of the supervisor the organisation will ensure access to a counsellor as soon as possible.

15. Staff and Community Supports Following a Completed Suicide

- 15.1. If a current or ex-service user of the project completes suicide then supports should be made available to staff in line with the interventions detailed in the Death of a Service User Policy.
- 15.2. Appropriate supports should be offered to other service users and /or their family if known to the project. These should be provided based on what is considered appropriate within the context of current service delivery:
 - 15.2.1. Counselling referral or service provision offered immediately after the suicide. The offer should also be re-iterated after a few weeks when individuals may be more aware of their needs and able to avail of services.
 - 15.2.2. Facilitation of group response: memorials, support group etc.
 - 15.2.3. Facilitate attendance at removal, funeral etc.

Part two – Self Harm

16. Self Harm - Overview

- 16.1. Self harm includes: overdoses, swallowing objects, high risk drug and alcohol use and starvation. It should be noted that there is a link between completion of suicide and individuals previous experience of self harm.
- 16.2. Conversely self injury can be an act done to oneself with the intention of helping oneself rather than killing oneself. It is understood that damage is done to the body as an attempt to preserve the integrity of the mind¹. Individuals self injuring may cut themselves, burn their body, bang their head, throw their body against something hard, punch themselves or stick things in their body. Self injury can be occasional events or frequently repetitive
- 16.3. A key feature of self injuring behaviour is the inability of the individual to resist the impulse once the decision has been made, which may have been building for hours or days.

17. Interventions – Overview

- 17.1. Staff intervention when conducted in an appropriately non-judgmental and empathetic way can have a significant impact on an individual's behaviour and ability to make change.
- 17.2. In any case of suspected self harm or self injury the worker should seek to clarify whether the individual is engaged in self injury or whether the individual is having thoughts of suicide.
- 17.3. If there are thoughts of suicide then this should be dealt with as outlined in the earlier sections of this policy, otherwise the issues should be dealt with initially through a one-to-one intervention, with the focus being dependent on the needs and views of the individual. Generally the session's focus will fall into one of two categories:
 - 17.3.1. Supporting the individual to stop self injury/self harm or,
 - 17.3.2. Providing a harm reduction session that facilitates the individual to engage in self injury more safely. It may need to be clarified that the purpose of an intervention is not necessarily to stop the individual from self injuring if they do not want to. The purpose is to support them to make the safest and best choices for themselves.
- 17.4. Through open discussion try to ascertain the method of self injury and whether the individual wishes to continue or stop/reduce self harm /injury. Guidelines for specific interventions are detailed below.

18. Reducing or Stopping Self Injury / Self Harm

- 18.1. Generating alternative behaviors that the sufferer can engage in instead of self injury / self harm is one successful behavioral method that can be employed. The following may be useful:
 - 18.1.1. Help them to think about their self injury / self harm not as a shameful secret, but as a problem that they can be assisted to sort out.
 - 18.1.2. Explore other activities or coping mechanisms not related to self injury / self harm that can be engaged in when the individual feels an urge to do this. These will be particular to each individual but may include:
 - 18.1.2.1. communication such as talking to friend, family or professional;
 - 18.1.2.2. physical activity such as walking or running;
 - 18.1.2.3. creative activity such as writing a diary, dancing or drawing;
 - 18.1.2.4. relaxation activities such as controlled breathing, mediation, focusing on peaceful or positive images or thoughts etc.
 - 18.1.3. It may be possible for the individual to change the self injuring behavior to an activity that is less physically harmful although provides a similar release, such as:
 - 18.1.3.1. using rubber bands that can be pulled and released on the skin,
 - 18.1.3.2. rubbing ice on the area the individual would usually harm or submerging hands into a bowl of ice,
 - 18.1.3.3. using a punching bag or pillows to punch,
 - 18.1.3.4. 'harmless' pain can be engaged in, such as eating a chilli or taking a cold shower,
 - 18.1.3.5. using marker to mark the skin or using plasters or bandages on the area.

¹ Refer to National Institute for Clinical Excellence (NICE) Guidelines, 2004

- 18.1.4. If the worker is appropriately trained then a session may include exploring the underlying issues related to self harm / self injury. If the worker is not a trained counsellor then referral to a trained counsellor should be discussed with the individual.

19. Harm Reduction in Relation to Self Harm / Self Injury

- 19.1. An individual may not wish to stop self injury/self harm; in this case the workers role may be to provide immediate harm reduction support and to keep the door open to further interventions when/if the individual is ready to seek change and support. The session may usefully include:
 - 19.1.1. Supports to use alcohol or drugs in a safer way i.e. to reduce overdose.
 - 19.1.2. Information on what parts of the body are dangerous to cut, i.e. near arteries.
 - 19.1.3. Use of sterile equipment, including information on how to sterilise equipment.
 - 19.1.4. Use sharp or appropriate tools, i.e. in the case of cutting to use clean and sharp blades to ensure clean wounds.
 - 19.1.5. To provide first aid information to enable the individual to appropriately clean and dress any wounds.
- 19.2. In the case that harm reduction is being undertaken the worker should clearly outline their obligations in regard to confidentiality and their duties to protection the individual. The discussion should clarify what actions would mean they would need to extend confidentiality.

20. Referrals in Relation to Self Harm / Self Injury

- 20.1. In the following situations the individual should be facilitated to access professional services:
 - 20.1.1. There are no staff members available who are competent to undertake a self harm /self injury intervention, therefore necessitating a referral.
 - 20.1.2. The staff member makes an assessment that there are mental health issues which require a specific mental health intervention.
- 20.2. Where possible consent for a referral should be sought, although it needs to be noted that in accordance with the Confidentiality Policy, if it is assessed that the individual is at risk to themselves then information may be passed on to relevant professionals without consent. In occasions where there is significant risk of harm to self, staff may contact Gardaí.
- 20.3. Where possible staff should accompany the service user to the referred service, to provide support and ensure appropriate handover.
- 20.4. In cases where there is a referral to medical / mental health services required, one of the following referrals pathways should be undertaken:
 - 20.4.1. If the individual has a psychiatrist, contact should be made. If this can not be done or the individual does not have a psychiatrist then:
 - 20.4.2. An emergency appointment should be made with the services user's GP or prescribing doc. The doctor will conduct an assessment and if they deem it necessary will write a referral letter to a psychiatric service. If this can not be done:
 - 20.4.3. Referral into a psychiatric service can be managed through A&E, or in some cases through direct contact with the service. To find out what service is most appropriate a call should be made to the psychiatric provider in the catchment area where the service user lives.
- 20.5. In the case of under 18s contact should be made with the under 18 Consultant Psychiatrist, see case management guidebook for details.

21. Follow up in Relation to Self Harm

- 21.1. If staff members require support following an intervention in regard to self harm they should inform their supervisor as soon as possible.
- 21.2. Follow up with the service user should take place at least weekly, staff should be direct in dealing with the issue and ensuring the individual is supported and the care plan is followed up with.