in-patient setting

suicide **qu**estions **a**nswers **re**sources

square **s**uicide **qu**estions **a**nswers **re**sources

in-patient setting
ISBN 0 9752419 2 3

Jointly funded by the Australian Government and the Government of South Australia

An education resource for primary health care, specialist and community settings

Most people who die by suicide have sought help in the weeks before death. Therefore the nature and quality of response offered by workers in primary health care is crucial.

Even a simple interaction like listening can be significant.

Everyone can make a difference.

note

This Booklet is designed to be used with the rest of the **square** resources, not alone or as a substitute for an informed professional response. Its main focus is on adults although much of it is also relevant to young people. Those seeking specific guidance about working with young people should source relevant Australian, state government and local information.

You will find information in the service setting books that will be helpful in your own practice. This will be particularly relevant where referrals are made or received from these services or there is a shared care arrangement in place.

Your service will also have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this Booklet.

In addition it may be useful to consult the South Australian Emergency Demand Management policies, which cover best practice and specific procedures on matters such as admission, care and discharge, contingency planning, restraint and seclusion, emergency transport, assessment and crisis intervention service.

The experience of consumers and carers has been incorporated into these training materials. This reflects the priority placed on consumer and carer participation in decision and policy making. The contribution of these consumers and carers is gratefully acknowledged.

Note: All names used in quotes from consumers are pseudonyms to ensure anonymity and protect confidentiality.

contents

how to use this resource

This booklet is part of an integrated resource – **square s**uicide **qu**estions **a**nswers **re**sources developed for South Australia as part of the National Suicide Prevention Strategy (NSPS). **square** consists of 3 layers, each progressively providing more detailed information about suicide prevention.

A The first layer is the **Desk Guide**, a quick reference providing key information, tools, guidelines and questions.

B The second layer is a series of **9 booklets**

1. **Foundations for effective practice**
2. **Community setting**
3. **Primary health care setting**
4. **In-patient setting**
5. **Emergency department setting**
6. **Community mental health setting**
7. **Forensic setting**
8. **Mental health in-patient setting**
9. **Suicide postvention counselling.**

This booklet, **In-patient setting**, is aimed at health workers in general hospital ward settings who may encounter people at risk of suicide in their professional roles. It is designed to be used in conjunction with the **Foundations booklet** which has been written for a broad audience and provides the foundations which underpin the 8 other booklets addressing specific settings and audiences.

C The third layer is the **square** CD-ROM/Website **www.square.org.au**. It is intended for those readers who want a more in-depth discussion and application of the key topics covered in the Desk Guide and the booklets. It contains discussion papers, video clips, resource lists, some downloadable forms and plans, and pdf files of all the **square** print materials – the 9 booklets and the Desk Guide.

introduction

This Booklet is designed to be used by health workers in both public and private hospital settings, whose work may involve them working with in-patients who have been, or may be, at risk of self harm or suicide. This includes nurses, allied health workers, and medical practitioners, including psychiatric consultants and other specialists. It is also of relevance to general practitioners who could be admitting patients to community and country hospitals (This group should also consult the Primary Health Care Setting booklet).

Its focus on the hospital ward setting highlights the following points:

- Health workers in general wards are very likely to encounter patients who have deliberately harmed themselves or attempted suicide, at some stage. For example, it is estimated that up to 5% of all medical admissions to general hospitals are for deliberate self poisoning (RANZCP, 2004, p.868).
- Being in a hospital ward does not necessarily protect a patient against suicidal behaviour. In fact, some individuals may be at particular risk of suicide when hospitalised. Factors which may exacerbate an existing suicide risk include:
  - worry about symptoms and prognosis
  - being in a stressful environment where there may be noise, little privacy, and close proximity to other patients and their visitors
  - anxiety, depression or distress due to effects of illness or injury or side effects of medications.
- General medical illnesses can predispose patients to suicidality.
- Mental health issues may not be a primary focus in general hospital wards. However, attending to these issues may be crucial for the patient's recovery and future wellbeing.
- For some patients at certain times (e.g. during the night, or over weekends, or at changes of shifts), when there are lower levels of interaction and observation, there may be particular safety issues requiring increased vigilance and management.
- There are many reasons why patients who have deliberately harmed themselves may be admitted to a general hospital. These include:
  - to provide a clear line of clinical responsibility for care
  - to provide co-ordination of care between medical specialities
  - to provide containment where there is risk of self-harm, suicide or harm to others
  - to provide a safe environment until intoxication with alcohol, drugs or toxins is resolved
  - to enhance engagement and decrease hopelessness
  - to facilitate psychiatric assessment
  - to obtain collateral information and enlist support from relatives or others
  - to co-ordinate follow-up services, and
  - to improve the quality of information derived from hospital records (RANZCP, 2004, p.873).
- Hospital staff may also have a role to play in assisting family and friends who are bereaved by the suicide of a loved one or experiencing strong emotions after an attempted suicide.

Key facts

- While there has been a decline of 18% in suicide rates since a peak in 1997, suicide is still a major public health problem in South Australia and nationally. Approximately 2100 Australians were reported as taking their own lives in 2005 (ABS, 2007). This is more than the number of deaths from road accidents, industrial accidents and homicides together.

- People of all ages and from all walks of life may suicide.

- Many more people attempt suicide or deliberately harm themselves. While figures are difficult to estimate, it is thought that attempted suicide may be 30-50 times more common than death by suicide (Martin et al., 1997). Admissions to hospital for intentional self injury are about 10 times as common as deaths due to suicide. While men kill themselves more often than women, there is a higher level of attempted suicide and self harm among women.

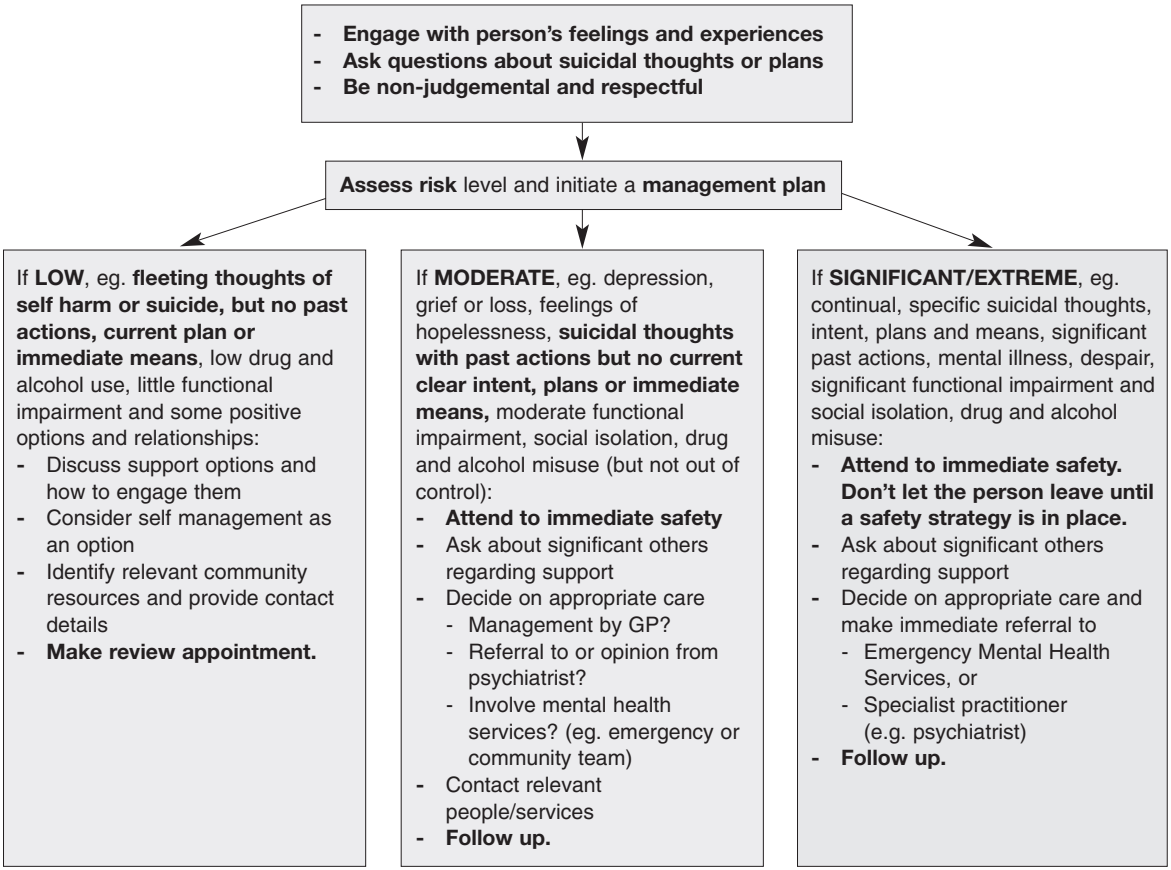
- It is believed that only a small proportion of suicide attempts are actually made in hospital settings (Gair & Camilleri, 2000). However, a large proportion of people who attempt suicide are subsequently hospitalised. A NSW study (Sayer et al., 1996) reported that of 4463 suicide attempts resulting in death or hospitalisation in NSW in 1992, there was a hospitalisation rate of 85% (p.59).

- Prevailing stigma surrounding mental illness and suicide may produce feelings of shame and guilt in those who attempt suicide and are subsequently hospitalised, and they may be reluctant to talk about how they are feeling emotionally. This stigma may also be encountered within hospital settings. In addition, some health workers may be afraid of asking about suicidal thoughts or plans. This may be because they are fearful that by enquiring they will precipitate another attempt, or simply because they feel inadequate about how to respond.

- It is vital, therefore, that hospital staff dealing with in-patients who have been, or may be, suicidal, are well informed about suicide and appropriate ways of engaging with those at risk. There is helpful information in the **square Foundation booklet**, including a section on myths and facts about suicide, advice for ways of engaging with patients, and appropriate questions to ask to assess risk of suicide and self harm.

Assessment and management of suicide risk

The following diagram represents some general principles and options for assessing and managing suicide risk. Some of the care and referral pathways will need to be adapted for the in-patient setting.



Active, connected referral and follow up are essential for ongoing care.
Ensure a seamless, supported transition to the next stage in the person's care. Do not leave gaps in follow up.

The role of hospital staff in suicide prevention

Suicide prevention is a whole of community responsibility and the best interventions will be collaborative ones. Health workers in hospital settings have crucial roles and responsibilities in this collaborative enterprise. While they may not be involved in all stages of the assessment and management process, it is important that they are aware of the overall 'landscape' of care in which their involvement is located. Competent management of suicidal ideation in the hospital setting is part of their duty of care and will have a significant influence on both morbidity and mortality outcomes.

As with health workers in other settings there are some key requirements for managing patients who are potentially suicidal. These include:

- the importance of engaging effectively with patients
- the priority of ensuring safety for all in the hospital setting
- knowledge of the risk factors for suicide
- familiarity with the processes involved in assessing risk of suicide
- appropriate interventions to minimise risk and maximise safety
- awareness of the circumstances in which specialist services need to be involved
- familiarity with discharge and follow up arrangements to ensure continuity of care
- awareness of community support options and therapeutic interventions.

Engaging well with patients

- In a general hospital ward setting it is possible that a patient has thoughts or plans of suicide even though this may not be apparent in the presenting problem. Hospital staff in both general and psychiatric wards therefore need a high index of awareness about suicide and self harm.
- Mental health problems, especially depression and anxiety, are common, but professional help is often not sought. Anyone can be at risk of suicide at certain times of their life.
- Many distressed people do not talk, simply because they are not given the opportunity. An appropriate question asked in the right way, at the right time, could save a life.
- Many people do not disclose suicidal thoughts or desires because of the stigma that is attached to 'not being able to cope' or to being diagnosed as having a mental illness. It is vital that hospital staff do not perpetuate such stigmatising of patients with mental health problems.
- Responding appropriately to someone who may be at risk of suicidal behaviour is vital in determining whether or not that person receives appropriate support – or even whether they disclose their thoughts and feelings at all. Listening attentively and non-judgementally, and providing opportunities for the person to describe their feelings and experiences, is the first step of appropriate engagement.
- If a person does have underlying mental health issues it is quite possible that a hospital admission will exacerbate the problems.
- Do not panic or be afraid of the issue of suicide. Raising it in an appropriate way will not escalate its likelihood. If you think that someone may be at risk, do not avoid the issue or assume that someone else must be dealing with it. Ask a question like: *Do you wish you didn't have to go on living?* (For further appropriate questions see the **Foundations booklet** or the **Risk Assessment Paper** on the **square** CD-ROM/Website **www.square.org.au**).
- Remember that support is available to you (e.g. from your colleagues or senior clinicians) as well as to the person in question. Country people may also seek assistance from the Emergency Triage Liaison Service, a team of mental health nurses, a social worker and sessional psychiatrists providing telephone support and guidance to GPs and other health care professionals, consumers and the community.

Sarah, a young woman interviewed for **square**, who was hospitalised following a suicide attempt, described the engagement of the hospital staff in these words:

> Some of the staff stayed distant you know, doing this professionalism thing. But for me when they stepped out of that and showed me some care and some trust I found it much easier to communicate with them. Like, you know, I'm not going to tell my deepest secrets to anyone [Sarah, Adelaide, 2005].

Managing safety

Safety in the hospital setting is a priority requiring immediate and ongoing management.

Immediate management (crisis intervention) will involve ensuring the safety of the suicidal person and any others at risk, including hospital staff.

All in-patients with possible suicidal behaviour must receive a **preliminary screening for suicide risk**. This will necessarily involve a quick initial judgement of risk, before a more formal risk assessment process is undertaken. Depending on the risk level ascertained it could mean ensuring **back-up assistance** is available and the **removal of lethal means** (including belts, ties etc, and any other dangerous items).

It will also involve ensuring **an appropriate level of observation and supervision**, e.g. making sure that a person at immediate or high risk of self harm or suicide is not left alone. If possible, a person who is calming and reassuring should stay with the person at risk.

If a person who may be at risk of suicide absconds from the hospital, appropriate staff should be immediately notified and the police should be contacted. The use of provisions in the Mental Health Act 1993 (SA) may be required in some circumstances to detain a patient, in the interests of his or her own health and safety and/or for the protection of others, if they do not consent to voluntary admission. This intervention may be necessary in the event of serious self harming, persistent and intense suicidal thoughts or threats when there is a serious mental disorder or illness.

In-patients suffering from depression or with possible suicidal thoughts or behaviour may be at particular risk at certain times, including late at night through to dawn, at changes of shift and over weekends. During these times there may be lower levels of observation and interaction by staff.

Risk assessment

Immediate management will be followed by a more comprehensive **Risk Assessment** process which may include a mental health assessment to diagnose/confirm underlying mental health problems and/or identify associated problems such as drug and alcohol misuse, and may incorporate immediate treatment of these issues, e.g. medication. Particular vigilance may be necessary while a person is waiting to be assessed and immediately afterwards while consultation or referral arrangements are being made.

For detailed discussion of risk factors and Risk Assessment see the **Foundations booklet** and also the **Risk Assessment** paper on the **square** CD-ROM/Website **www.square.org.au**. On the following pages you will find part of a Risk Assessment Form that is used by state mental health services. It also forms part of a form developed for practitioners referring to mental health services.

Risk assessment guide

This risk assessment is from the Mental Health in South Australia Emergency Demand Management Policy and Procedure Series (2002) that is used by staff in mental health services. It forms part of the risk assessment, referral and follow up form developed for private practitioners. The form and the accompanying guidelines can be downloaded from the management section of the **square** CD-ROM/Website **www.square.org.au.**

Please note form continues over the following pages.

risk of harm to: ☐ **self** ☐ **others** ☐ **both**

☐ none	☐ low	☐ moderate	☐ significant	☐ extreme
No thoughts or action of harm.	Fleeting thoughts of harming themselves or harming others but no plans, current low alcohol or drug use.	Current thoughts/distress, past actions without intent or plans, moderate alcohol or drug use.	Current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed. Increased alcohol or drug use.	Current thoughts with expressed intentions/past history/plans. Unstable mental illness. High alcohol or drug use, intoxicated, violent to self/others, means at hand for harm to self/others.

level of problem with functioning

☐ none/mild	☐ moderate	☐ significant impairment in one area	☐ serious impairment in several areas	☐ extreme impairment
No more than everyday problems/slight impairment when distressed.	Moderate difficulty in social, occupational or school functioning. Reduced ability to cope unassisted.	Significant impairment in either social, occupational or school functioning.	Serious impairment in several areas such as social, occupational or school functioning	Inability to function in almost all areas.

Risk assessment guide

level of support available

☐ no problems/ highly supportive	☐ moderately supportive	☐ limited support	☐ minimal	☐ no support in all areas
Most aspects are highly supportive. Effective involvement of self, family or professional.	Variety of support available and able to help in times of need.	Few sources of help, support system has incomplete ability to participate in treatment.	Few sources of support and not motivated.	No support available.

history of response to treatment

☐ no problem/ minimal difficulties	☐ moderate response	☐ poor response	☐ minimal response	☐ no response
Most forms of treatment have been successful, or new client.	Some responses in the medium term to highly structured interventions.	Responds only in the short term with highly structured interventions.	Minimal response even in highly structured interventions.	No response to any treatment in the past.

Risk assessment guide

attitude and engagement to treatment

☐ no problem/ very constructive	☐ moderate response	☐ poor engagement	☐ minimal response	☐ no response
Accepts illness and agrees with treatment, or new client.	Variable/ ambivalent response to treatment.	Rarely accepts diagnosis.	Client never cooperates willingly.	Client has only been able to be treated in an involuntary capacity.

Is the person's risk level changeable?	**Highly Changeable**	☐ yes	☐ no
Are there factors that indicate a level of uncertainty in this risk assessment? (e.g: poor engagement, gaps or conflicting information)	**Low Assessment Confidence**	☐ yes	☐ no

overall assessment of risk

☐ none	☐ low	☐ medium	☐ high	☐ extreme

Note Risk assessment is not a precise 'science'. A form such as the one above is a valuable guide, but your professional judgement and experience are also crucial. Remember too, that a person's risk of suicide may be highly changeable, fluctuating at different times and in response to certain events.

You will find an explanation and discussion of these questions in Dr Long's **Risk Assessment** paper on the **square** CD-ROM/Website **www.square.org.au**.

Nursing observation

It is important that nursing staff implement the appropriate nursing observation categories for patients' management and safety in accordance with a risk assessment plan. More detail can be found in the document *Nursing Observation*, which will be available in your hospital.

There are four nursing observation categories that can be assigned to a patient. These categories identify presenting behaviours and provide a guide to assigning the appropriate nursing category. A patient is assigned to one of these categories on the basis of risk to self and to others. The four categories used are:

Observation Category	Behaviour examples	Notes
Specialling (continuous) observation **(S)**	Intent to self harm. Suicide plans. Mental state that puts self/others at risk. Poor impulse control. Sexually inappropriate - risk to self and others high.	Most restrictive category. Continual observation.
Close observation **(C)**	Detained with evidence of risk. Anger at hospitalisation. Absconding attempts. Confusion and/or wandering.	Regular sighting recorded in client record. In open ward risk assessment 24 hourly. Observations at least every 15 minutes.
Regular observation **(R)**	Some evidence of risk. Moderate risk of absconding. Ambiguous about assurance of personal safety. Conversation/behaviour indicates some risk of harm to self/others.	At least hourly observations.
General observation **(G)**	Voluntary status, minimal risk to self/others. Able to give assurance of personal safety Impairment related to dementia.	At least 2 hourly sightings by assigned nurse.

Ongoing management

A person who assesses an individual as being at risk for suicide should always take action. Depending on the context this may mean continuing to treat the person in the general ward with specialist mental health input or it may mean transfer to a psychiatric ward or a carefully planned discharge with appropriate support from GP/family/friends/specialist mental health services.

People who are to be managed in a general hospital ward must have a **Management Plan**. Ideally this plan should be developed in consultation with the person, their nominated significant person/s (e.g. family and/or friends) and a mental health provider. The person must be encouraged to engage with the treatment plan and to agree to follow-up attendance. It is especially important to avoid treatments that might increase the risk of self-harm (RANZCP, 2004, p.873).

The plan will record:
- steps that will be in place to ensure safety including specific instructions on the frequency of ongoing risk assessment
- medication
- factors or triggers that are upsetting
- protective factors that can be drawn on
- follow up arrangements on discharge.

Part of a management plan in a hospital setting could include referral on discharge to appropriate support services dealing with the issues which may have precipitated the suicide attempt. For example, there might be referral to services designated to assist with domestic violence, childhood sexual abuse or drug and alcohol issues, if these risk factors have been involved.

Guidelines for developing a management plan

- ☐ Have you ensured safety (i.e. considered supervision, removal of lethal means, backup assistance, security/police, if necessary)?
- ☐ Has the appropriate nursing observation protocol been set in place?
- ☐ Is the person able and willing to engage with treatment and support options?
- ☐ What protective factors are evident (e.g. support networks)?
- ☐ When reviewing risk assessment, consider if it is appropriate for the person to:
  - ☐ be self managed in the community on discharge.
  - ☐ be managed as an out-patient, or by a GP, or in a shared care arrangement
  - ☐ be discharged and managed elsewhere and if so where?
  - ☐ be managed in a less restrictive environment.
- ☐ Are antidepressant, antipsychotic or other medications indicated?
- ☐ What other therapeutic interventions (such as psychotherapy) are appropriate and available?
- ☐ Is there a contingency plan to address any potential escalations of risk, and does it clearly identify appropriate and feasible roles and responsibilities?
- ☐ Is there a contingency plan to cover events such as adequate care following discharge?
- ☐ What community support services can be utilised (alone or to supplement other interventions)?
- ☐ Has a comprehensive discharge/transfer plan been devised and thoroughly documented?
- ☐ What aftercare/longer term care arrangements can be set in place?
- ☐ Who will provide follow up and review the plan?
- ☐ Who will be responsible for ensuring that the relevant documentation is relayed to others involved in a timely manner?

A Collaborative Management Plan has been developed for private practitioners as part of this suicide prevention initiative. It is useful as a guide, referral document and record. The management plan can be downloaded from the management section of the square CD-ROM/Website www.square.org.au.

best practice in the hospital setting

- Firstly, **engage** empathically and non-judgementally with the person at risk.
- Ensure that the hospital setting has a culture and ethos that encourages patients to **feel comfortable in disclosing their feelings and fears**.
- If necessary **work on your confidence in talking about suicide** with patients.
- In determining the most appropriate management of their situation, **consider any features of the hospital environment that the patient finds upsetting** and whether these can be addressed.
- Consider the **protective factors** (eg. family/friends/interests/personality traits) that can be drawn upon. Actively involve the patient's wishes and needs, where possible.
- Key considerations are:
  - The **immediate safety** of the patient (and others involved)
  - Ongoing treatment to **address the underlying issues**
  - **Continuity of care**.
- Any **decision to continue hospitalisation** should be made on clinical grounds with the involvement of the patient and someone (family/friend/colleague) in a supportive role.
- If referral to a specialist service is desirable, but not available as soon as you would like, maintain **close observation and ongoing engagement in the general ward setting**.
- If a person is, or has been, at risk of suicide, they need **ongoing review**. Levels of risk can change at different times and will require different levels of support.
- **Coordination of care** and appropriate reassessments are vital. If referral is only 'one way', a person may receive crisis intervention but little or no follow up.
- Recognise the client's own resources and **encourage self management** and use of community resources and services on discharge, if appropriate.
- A knowledge of **community services** and **relevant state mental health policies, procedures and protocols** are important components of good hospital care of mental illness and suicidal ideation.
- Remember that **hospitals are also communities**, with a range of staff with different roles and interests, but shared concerns. Capitalise on the resources of the hospital community and keep the lines of communication open between patients, visitors, nurses, doctors and allied health workers.
- **Reflection on one's own practices** and decisions is vital for dealing with the psychological and emotional stress and uncertainty which may be involved in some decisions regarding suicidal persons.

Referral principles

- Referral options are likely to be most appropriate when they are based on comprehensive information about the person.

- General hospital wards will either have in-hospital consultation liaison psychiatric services or an external service available to the hospital. Protocols should be in place about the circumstances in which these services should be contacted.

- When in doubt about a person's wellbeing and possible risk, consult with senior staff e.g. attending MO.

- People who are assessed as at risk in a general ward must have a full assessment by appropriate mental health professionals.

- Referral to relevant psychiatric services should occur if people present after a suicide attempt or an episode of self harm, or if they convey that they are thinking of, or preparing for suicide, or if they have a mental illness.

- A mental health condition could be indicated by a range of behaviours such as impulsivity, agitation, superficial self harm, 'accidental' overdoses. Consultation should occur when general ward staff have reason for concern.

- Rural hospitals will probably rely on general practitioners as primary mental health practitioners, with the backup of the statewide Rural and Remote Mental Health Service.

- The decision to continue hospitalisation should be made on clinical grounds. If the decision is made not to hospitalise, appropriate referral should be made where appropriate.

- People are especially vulnerable during transfers of care, i.e. when transferring out of a particular context of care.

- Ensure that referrals are acted upon and documented.

support and self care for hospital staff

Self care is typically not given much emphasis in health worker training. Because of notions of 'professionalism' and 'objectivity' within the health professions, practitioners may hide their feelings or not take sufficient time out to deal with loss and grief. Yet there are proactive ways in which health workers can engage in self care which may prevent burnout or other long term negative effects.

Common stressors within the health care professions, which may lead to burnout, are:
- Understaffing/high client load/inadequate mental health resources
- Constantly having to make critical decisions
- High levels of emotional interactions with clients
- The litigious context within which health care operates (Gundersen, 2001).

Working constantly with clients in crisis can also contribute to negativity and cynicism, high levels of drug and alcohol use, relationship problems and mental health problems.

> People who self-harm may reject help from health professionals and many do not keep appointments. Others may be rejected by health professionals and may not find health services helpful. Dysfunctional coping styles and chaotic ways of seeking help can induce negative attitudes in clinicians. Those who regularly work with [self harming] patients need appropriate strategies for their own support, including supervision, peer discussion and specific training to manage patients. Inexperienced clinicians need to discuss and understand their own reactions… Health services should consider training their staff in the management of [self harming] patients (RANZCP, 2004, p.873).

Some reminders

- Remember that while you can assess the risk of suicide, you cannot always prevent it. Don't blame yourself if you have taken every reasonable precaution.
- It's OK to admit you don't know. Seek assistance from others with specific knowledge and experience.
- De-brief with a skilled colleague after a critical incident or seek trauma support.
- While maximising safety in the hospital must always be a short term priority, in the longer term supporting patients to develop their own skills may be the best strategy.
- Reflective thinking is integral to self care.
- Review your own needs with the same seriousness as you review client needs, and seek help if necessary.

consumer issues

Diane, interviewed for this resource, described her hospital experience after a suicide attempt in this way:

> Just being in hospital…you felt powerless and you didn't have a sense of control over what you were doing. And I think when you take that away from people, you actually demean them and you actually make them act in ways which are powerless…I sometimes felt that [it] was a gross inconvenience on the medical system that they had to look after me…..I think … we want people to behave in certain ways in hospitals and that's to sit quietly and be compliant.
> [Diane, Adelaide 2005]

This comment draws our attention to the ways in which the hospital environment and its routines may have an adverse impact on a patient who is already feeling very vulnerable at the time of admission.

Hospitals play a key role in the care of some people with mental illnesses and those who have attempted suicide and who may be at risk of further attempts.

Consumers being admitted to a hospital ward after a suicide attempt are likely to be suffering from depression and may still be having suicidal thoughts. However, they may feel intimidated and inhibited about disclosing their mental health issues. This problem is compounded if staff in a general ward feel more comfortable dealing with their immediate physical problems and do not adequately address their underlying mental health issues. Because of widespread stigma about mental illness, patients may feel a sense of shame or guilt about 'not coping', and may be reluctant to name feelings of hopelessness or despair. It is therefore very important that the hospital setting is one in which patients feel that it is acceptable to disclose such feelings.

It is also vital that patients feel a sense of optimism about their recovery and that they are made aware of the range of community, medical and psychotherapeutic interventions which are available to help them. Such a climate of acceptance and positive thinking needs to be established in all hospital settings and this needs to be evident to patients.

A holistic response

Throughout the **square** resource it is emphasised that suicidal ideation and behaviour cannot simply be thought of as a medical illness. Effective responses require a holistic approach which addresses complex psychosocial and cultural issues, as well as biomedical issues. With this approach health workers will engage with people about fundamental aspects of who they are, what is important to them and what is distressing them. This is challenging and confronting work for health workers in hospitals, but its significance cannot be underestimated. Health workers should be reassured that the very act of talking and listening to a distressed patient is therapeutic in itself and can make a real difference.

It should also be remembered that hospital wards often provide an excellent environment for respite and supportive care, in which patients can work through a crisis. The time that such a patient may have in a general ward receiving care, for even an unrelated medical issue, may provide an excellent opportunity to address such problems. The empathy, knowledge and skills of hospital health workers to engage with patients about these problems may be hugely significant.

On the other hand, some individuals may be at particular risk of suicide while in-patients in a hospital ward. Depression or anxiety can predispose patients towards suicidal thoughts and the hospital environment itself may be an additional stressor.

The suicide prevention model used in **square** emphasises the significance of consumers having a personal sense of empowerment and control. To achieve optimal health outcomes interventions will be collaborative and where possible, will include self management options. The inclusion of carers and significant others, where consent is given, is therefore recommended in the development of suicide management plans, as are partnerships with community agencies.

references

Australian Bureau of Statistics (2004) *Suicides: Recent Trends Australia, http://www.abs.gov.au/Ausstats/abs@.nsf/0/a61b65ae88ebf976ca256def00724cde?OpenDocument*

Gair, S. & Camilleri, P. (2000) 'Attempted suicide: Listening to and learning from young people' *Queensland Journal of Educational Research*, 16, *http://education.curtin.edu.au/iier/qjer/qjer16/gair.html*

Gundersen, L. (2001) 'Physician burnout', *Annals of Internal Medicine*, 1135: 145-148.

Martin, G., Clark, S., Beckinsdale, P., Stacy, K. & Skene, C. (1997) *Keep yourself alive.* Adelaide: Foundation Studios.

RANZCP (2004) Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Deliberate Self-harm, *Australian and New Zealand Journal of Psychiatry*, 38:868–884 *http://www.ranzcp.org/pdffiles/cpgs/Clinician%20version%20full%20DSH.pdf*

Sayer, G., Stewart, G & Chipps, J. (1996) 'Suicide attempts in NSW: Associated Mortality and Morbidity', *NSW Public Health Bulletin*, 7, 6, June 1996. *http://www.health.nsw.gov.au/public-health/phb/phbjun96.pdf*

for further information
www.square.org.au

square

Australian Government
Department of Health and Ageing

Government of South Australia
Department of Health

Relationships Australia
SOUTH AUSTRALIA

SA Divisions
of General
Practice Inc

SHADIADESIGN