

Suicide Risk Assessment and Management Protocols

Mental Health In-Patient Unit



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Related documents

Framework for Suicide Risk Assessment and Management for NSW Health Staff – SHPN (MH) 040184

Suicide Risk Assessment and Management: Emergency Department – SHPN (MH) 040186

Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185

Suicide Risk Assessment and Management Protocols: General Community Health Service – SHPN (MH) 040187

Suicide Risk Assessment and Management Protocols: Community Mental Health Service – SHPN (MH) 040182

Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital – SHPN (MH) 040188

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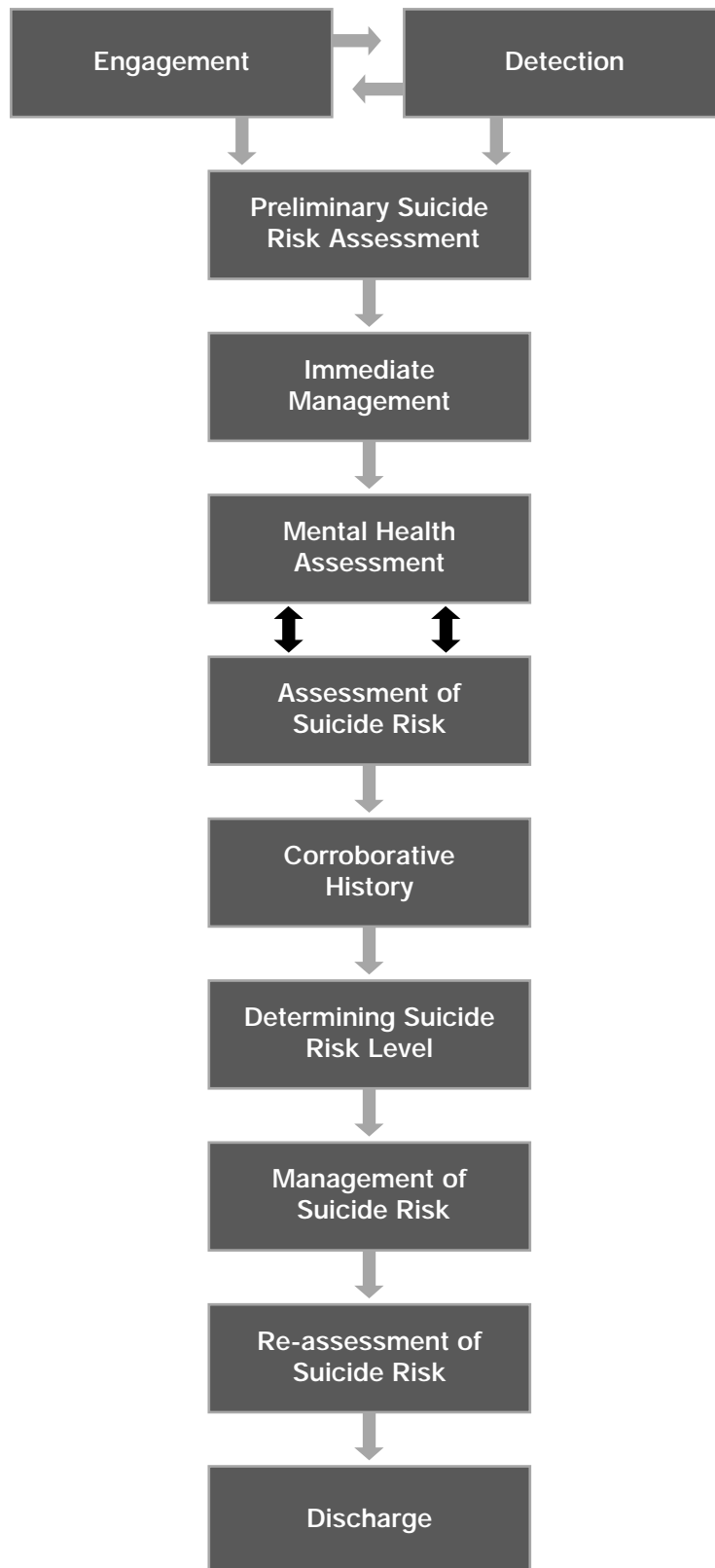
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Introduction

Psychiatric in-patient facilities have a central role in the care of patients presenting with suicide risk. Good therapeutic relationships with patients and their families are key components for the reduction of suicide risk in in-patient facilities.

Admission to an in-patient facility provides the opportunity for a safer and containing environment, supervision commensurate with the degree of risk, direct observation, regular monitoring of mental state and continuous therapeutic support.

An in-patient unit strives for an appropriate balance between the need to manage the person at risk within a safe and containing environment and the need to promote autonomy through therapeutic relationships and an empowering milieu.

These suicide risk assessment and management protocols are to be read in conjunction with the NSW Health circular, *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities*¹ and the *Framework for Suicide Risk Assessment and Management for NSW Health Staff*.²

Assessment of suicide risk

Principles of suicide risk assessment in an in-patient unit

- Suicide risk assessment must be conducted on admission.
- Re-assessment of suicide risk is regularly conducted throughout the admission.
- Observation levels are re-assessed according to current level of risk.
- There is participation of the patient and, where appropriate, involvement of family/partner in the management plan.
- Other service providers involved with the patient (eg general practitioner, community case manager) are included in the development of the management plan.
- Good communication, both verbal and written, is essential for consistent and coordinated care.

Consultant psychiatrist

Every patient admitted to a psychiatric in-patient unit is under the care of a consultant psychiatrist. The consultant psychiatrist must:

- see and assess all patients as soon as practicable following admission
- document the assessment and their findings as well as management recommendations
- review face-to-face each patient under their care at least weekly
- be informed about and approve the patient's discharge.

Assessment

Patients admitted to acute psychiatric units require comprehensive psychiatric and medical assessment on admission. Suicide risk assessment is also performed on admission. The patient's mental state and suicide risk status is re-assessed regularly throughout the admission.

Psychiatric assessment

- Suicidal behaviours are frequently symptoms of underlying mental health problems or disorders. Therefore, a suicide risk assessment cannot be undertaken in isolation from an overall mental health assessment.
- The clinician needs to assess for depression, schizophrenia, other psychotic illness, bi-polar disorder, anxiety disorders, the patient's personality style, current and previous drug and alcohol use and organic and physical conditions.
- Exploration of these areas will provide further important information on the changeability of risk status. For example, a person with a history of impulsivity under stress would be assessed as having a high level of changeability. How plausible is the denial of suicidal ideation in the context of a patient's recent psychotic experiences or with the current severity of their depression?
- Assess whether the person has the capacity and willingness to enter into a therapeutic alliance. For example, a person who is distressed and deluded, such as believing that they are responsible for the AIDS epidemic, cannot give a meaningful reassurance they have no intention of harming themselves.
- A complete psychiatric assessment requires a medical assessment and physical examination and may require investigations to detect or rule out organic illnesses.

Detection

A broad view of all of the risk factors associated with suicidal behaviour is important for the clinician to consider during the assessment. However, the **most important risk factors** for estimating the **current and immediate risk** are the **personal risk factors**, including the current mental state, that are impacting on the individual's life at the present time.

The most important suicide risk factors are how depressed an individual is and whether they have made suicidal plans (as opposed to having passive suicidal thoughts). It is also important to note that a person might not reveal their plans and might try to hide their suicidal intent. Other personal risk factors include:

- recent major life events especially involving loss or humiliation
- 'at risk' mental states especially hopelessness, despair, agitation, shame, guilt, anger, psychosis
- recent suicide attempt
- personality/vulnerability, eg challenges to dependency, impulsivity.

The assessment of suicide risk of a person admitted to an in-patient unit must include consideration of a number of factors external to the patient's mental state. These factors include consideration of the events and persons on the unit and the patient's relationships and events impacting on their life outside the unit.

Table 1 is an illustrative, but not exhaustive, framework.

Protective factors have also been identified that may protect a person from suicide.

These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem-solving skills
- positive values and beliefs
- ability to seek and access help.

A comprehensive suicide risk assessment should explore:

Distress, psychic pain

- What is the nature and level of the person's inner distress and pain?
- What are the main sources of this person's distress?

Meaning/motivation

- What is the person's understanding of their predicament? What is the meaning of recent events for them?
 - What is motivating this person to harm himself or herself? Has the person lost his or her main reason for living?
 - Does the person believe that it may be possible for their predicament to change and that they may be able to bring this about?
 - Explore cultural aspects of meaning and motivation with clients from culturally and linguistically diverse backgrounds.

Table 1: Factors to consider in assessment of suicide risk for patients in an in-patient unit

Patient factors	Environmental factors	Situational factors
<ul style="list-style-type: none"> ■ schizophrenia, depression, borderline personality disorder ■ history of self-harm ■ history of suicide attempts on unit ■ drug and/or alcohol misuse ■ history of absconding ■ negative life experience 	<ul style="list-style-type: none"> ■ unit design ■ staffing levels ■ 'busy times' ■ observation procedures ■ access to means ■ interpersonal dynamics on the unit 	<ul style="list-style-type: none"> ■ impending major stressor, eg court appearance, loss of child custody ■ shaming experiences ■ visit by hostile, critical family member ■ no visit or contact from family ■ drug and/or alcohol misuse

'At risk' mental status

- The presence of certain 'at risk' mental states including hopelessness, despair, agitation, shame, anger, guilt or psychosis, escalate the level of suicide risk. These emotions may be associated with specific body language and specific cues exhibited in the assessment interaction. Clinicians should observe for and directly inquire about such feelings.

History of suicidal behaviour

- Has the person felt like this before?
- Has the person harmed himself or herself before?
- What were the details and circumstances of the previous attempt/s?
- Are there similarities in the current circumstances?
- Is there a history of suicide of a family member or friend?

A history of suicide attempt or self-harm greatly elevates a person's risk of suicide. This elevated risk is independent of the apparent level of intent of previous attempts. Suicide often follows an initial 'suicidal gesture'.

Current suicidal thoughts

- Are suicidal thoughts and feelings present?
- What are these thoughts (determine the content, eg guilt, delusions or thoughts of reunion)?
- When did these thoughts begin?
- How frequent are they?
- How persistent are they?
- What has happened since these thoughts commenced?
- Can the person control them?
- What has stopped the person from acting on their thoughts so far?

Lethality/intent

- What is the person's degree of suicidal intent? How determined were/are they?
- Was their attempt carefully planned or impulsive?
- Was 'rescue' anticipated or likely? Were there elaborate preparations and measures taken to ensure death was likely?
- Did the person believe they would die? (Objectively question the person's perception of lethality.)

- Has the person finalised personal business, eg made out a will, given away their possessions, including pets, settled their debts and said their goodbyes?*

Intent and lethality are very important to explore with the person. Sometimes they may be obvious from his or her account. However, they might be more complex; for example, it is possible that a person who attempts to overdose using paracetamol may assume it is a safe drug on the basis that it can be purchased without prescription. Such an attempt would be assessed as low intent, but high lethality.

Intent and lethality may also be more complex with people from culturally and linguistically diverse backgrounds. For example, planning might not be part of a culture's 'scripts', or culturally influenced methods of lower lethality in an extended family (due to likelihood of discovery) may be very lethal to an isolated refugee.

Presence of a suicide plan

- How far has the suicide planning process proceeded?
- Has the person made any plans?
- Specific method, place, time?
- How long has the person had the plans?
- How often does the person think about them?
- How realistic are the plans?

A suicide plan, or preparation for death, such as saying goodbyes, making arrangements for pets or settling debts indicates serious suicidal intent.

Access to means and knowledge

- Does the person have access to lethal means? Is there a firearm available? (If a person at long-term high risk of suicide has access to a firearm, the police should be contacted before the person is discharged to discuss the possibility of removing the firearm.³) Are there poisons in the house or shed? Are there lethal medications such as insulin, cardiovascular medications or tricyclic antidepressants available to the person? Ensure these questions are also asked of a reliable corroborative source.

* Questions need to be asked in the past tense when assessing a person following a suicide attempt, but some questions should be in the present and future tense when assessing a person contemplating suicide.

- Is the chosen method irreversible; for example, shooting, jumping?
- Has the person made a special effort to find out information about methods of suicide or do they have particular knowledge about using lethal means?
- Is there any item or aspect of the in-patient environment that may be used as a means to self-harm?
- Have visitors been made aware of items brought into the in-patient unit that may be used as a means to self-harm?
- Type of occupation? For example, police officer (access to gun), health worker (access to drugs).

In most cases, if a person has developed a potentially fatal or effective plan and has the means and knowledge to carry it out, the chances of dying from a suicide attempt are greatly increased.⁴ It is important to assess the level of intention and the person's understanding of the level of lethality of their suicide attempt or plan.

Research has indicated the most preventable suicides are those which occur in hospital settings.⁵ The **Access to Means of Suicide and Deliberate Self-harm Facility Checklist** included with these protocols (pp 19-20) provides a guide to assist with the reduction of self-harm behaviours within mental health in-patient units through the conduct of regular environmental safety audits.

Safety of others

- Have the person's thoughts ever included harming someone else as well as himself or herself?
- Has the person harmed anyone else?
- What is the person's rationale for harming another person?
- Is there a risk of murder-suicide? Consideration should be given to the mental state of the person. Is he/she psychotic, or been through a recent and traumatic separation. Are there current issues with custody of children or financial issues?
- Is there evidence of postnatal depression?

Coping potential or capacity

- Does the person possess the capacity to enter into a therapeutic alliance/partnership?
- Does the person recognise any personal strengths or effective coping strategies? How have they managed previous life events and stressors? What problem-solving strategies are they open to?
- Are there social or community supports (eg family, friends, church, general practitioner)? Can the person use these?
- Is the person willing to comply with the treatment plan?
- Can the person acknowledge self-destructive behaviours? Can the person agree to abstain or limit alcohol or drug consumption? Can they see how substance abuse can make them more at risk?
- Does the person have a history of aggression or impulsive behaviour? (Aggression and/or impulsivity make risk status less predictable.)
- Can the clinician assist the person to manage the risk of impulsive behaviour?

Self-harming behaviour

- Self-harming behaviour usually occurs in one of two contexts: the person with a vulnerable personality who is acting out inner distress or the person who is psychotic.
- A person who is acting out inner distress in this manner often feels he/she is not able to communicate distress in less harmful ways.
- Although the vulnerable person's self-harming is frequently acting out inner turmoil or an act of self-soothing rather than an attempt to die, people who self-mutilate do sometimes attempt suicide.
- The self-harming by the person who is psychotic (or the underlying rationale) is frequently bizarre.

Distinguishing between 'self-harm without suicidal intent' and 'attempted suicide' can at times be difficult. Regardless of motivation or intention, both are dangerous behaviours associated with a heightened risk of dying. Self-harm is a maladaptive behaviour that reflects severe internal distress (which may not always be evident in the external demeanor) and a limited ability to develop effective coping strategies to deal with difficulties.

Assessment confidence

It is reasonable for a clinician to conclude in some situations that, on the available evidence, their assessment is tentative and thus of low confidence. Rating assessment confidence is a way a clinician can reflect on the assessment in order to flag the need for further review and psychiatric consultation.

The person's account of the events leading to their contemplation of or attempt to suicide will need to be considered by the clinician in terms of its logic and plausibility. This is best achieved by asking the person for a chronological account of events commencing from before the onset of the suicidal thoughts.

It is important that the clinician gently probes apparent gaps in the person's account and listens not only for what is actually said, but what is implied and what is omitted. The clinician needs to feel confident that the person is providing an accurate and plausible account of their suicide-related problems.

Other factors that might indicate a level of uncertainty in the assessment include the lack of corroborative information or conflicting information between corroborative sources and the person at risk. Reflecting on the quality of their engagement and rapport with the person will also assist the clinician in determining their confidence in the assessment.

Care also needs to be taken when a person responds that suicide is not an issue following a limited number of questions asked by the clinician. The clinician must feel confident with the person's response. Premature closure (concluding there is not suicide risk) should be avoided when the background and facts of the presentation or corroborative history suggest a real suicide risk is probable. When in doubt, the clinician should continue to explore the suicide risk with the person and corroborative sources.

Staff need to be alert to an 'apparent improvement' in which a person's affect may suddenly appear calmer. This may be as a result of a decision by the person to carry out suicide plans. This can be misinterpreted by clinicians as a real improvement and lead to a 'lowering of the guard'.

Another situation requiring caution may occur early in the response to treatment of depression. A person might improve in activity level before his/her mood and ideation improves, leading to an increased ability to carry out suicide plans.

Corroborative history

- All means for accessing further information to assist with the risk assessment should be actively sought. The purpose of a corroborative history is to confirm the clinician's assessment, confirm the level of support and promote collaboration with the person and his/her support person/s.
- Corroboration helps to: provide accuracy around the changeability of risk; enhance the clinician's confidence in their assessment of risk; provide opportunities to assess family members; and provide opportunities for helpful collaboration around management and discharge planning.
- Sources of information include:
 - interview or phone contact with other relevant people, with the permission of the person, eg family members, close friends, significant others, case managers, general practitioner, private psychiatrist, therapists, school counsellors and other relevant health and welfare service providers who know the person
 - where possible, access to previous files.
- There is a need to be aware that due to stigma and shame, some families and support persons may not reveal the extent of the person's problems. Some cultures may fear repercussions, for example, an unwell mother might fear having her children taken away.
- There should be careful consideration of the person's privacy prior to obtaining corroborative history.

Determination of risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.^{6, 7, 8} A thorough assessment of the individual remains the only valid method of determining risk.

Assessments are based on a combination of the background conditions and the current factors in a person's life and the way in which they are interacting.

Suicide risk assessment generates a clinician rating of the risk of the person attempting suicide in the immediate period. The person's suicide risk in the immediate to short-term period can be assigned to one of the four broad risk categories: high risk, medium risk, low risk, no (foreseeable) risk.

Refer to the Suicide Risk Assessment Guide (p 8) to assist in estimating the current level of suicide risk. It is a guide only, however, and is not intended to replace clinical decision-making and practice.

Changeability

Changeability of risk status, especially in the immediate period, should be assessed and high changeability should be identified.

While risk status is by nature dynamic and requires re-assessment, highly changeable risk status is worth identifying, as it will guide clinicians as to the safe interval between risk assessments.

High Changeability: The clinician recognises the need for careful re-assessment and gives consideration as to when the re-assessment should occur, eg within 24 hours. A more vigilant management is adopted with respect to the safety of the person in the light of the identified risk of high changeability.

Assessment confidence

The clinician should consider the confidence he/she has in this risk assessment. A number of factors may indicate low assessment confidence. These include:

- factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage
- factors in the social environment, such as impending court case, isolation
- factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

Low Assessment Confidence: The clinician recognises the need for careful re-assessment, eg within 24 hours. A more vigilant management is adopted with respect to the safety of the person in the light of the gaps in information or rapport.

- High Changeability Flag
- Low Assessment Confidence Flag

Suicide Risk Assessment Guide²

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High risk	Medium risk	Low risk
'At risk' Mental State <ul style="list-style-type: none"> – depressed – psychotic – <u>hopelessness</u>, despair – guilt, shame, anger, agitation – impulsivity 	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts <ul style="list-style-type: none"> – intentionality – lethality – access to means – previous suicide attempt/s 	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder <ul style="list-style-type: none"> – current misuse of alcohol and other drugs 	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History <ul style="list-style-type: none"> – family, carers – medical records – other service providers/sources 	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) <ul style="list-style-type: none"> – expressed communication – availability of supports – willingness / capacity of support person/s – safety of person & others 	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice <ul style="list-style-type: none"> – level & quality of engagement – changeability of risk level – assessment confidence in risk level. 	Low assessment confidence or high changeability or no rapport, poor engagement.		<ul style="list-style-type: none"> – High assessment confidence / low changeability; – Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable?

Highly Changeable Yes No

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information.

Low Assessment Confidence Yes No

Management

The aim of managing a person at risk of suicide in hospital is to ensure their safety in a supportive and therapeutic environment until the suicide risk reduces significantly to a level where a trial of continuing care and treatment in the community setting can commence.

Maximising a safe environment

- The environment of the in-patient unit should be made as physically safe as possible, with potential hazards identified and controlled if they are unable to be removed.
- In-patient units must have clearly stated procedures and protocols for searching the belongings of patients at risk and removing potential means of self-harm, including dressing gown cords, shoelaces, headbands and belts.
- Patient and property checks should occur on admission to the facility. Personal items, particularly those that could be potentially used in a harmful way, should be locked away for safekeeping and returned to the patient on discharge.
- It may be necessary to conduct further searches during an admission if staff have strong suspicions that a patient is engaging or planning to engage in risk behaviour. Searches should be carried out, as far as is possible, with the cooperation of the patient. The patient's consent should be sought prior to the search. When a search is indicated despite the lack of the patient's consent, a clear explanation of what is being searched and why must be provided to the patient. This must always be documented in the patient's record noting the patient's response, including whether consent was obtained.
- A brochure should be provided to families and carers advising of the restrictions on giving items to patients that are potentially dangerous.
- Supervision of the patient's activities which have a potential for self-harm may be necessary, such as the using of sharp implements or lighters, and the kitchen, bathroom and occupational therapy activities. Similarly, it may be necessary to restrict the movements of the patient to safe areas of the unit.

- An environmental safety audit should be conducted at least annually in each in-patient unit as per the **Access to Means of Suicide and Deliberate Self-harm Facility Checklist** (pp 19-20).
- Periods that are particularly dangerous for a person who is at risk of suicide include times of transition, such as staff hand-over, busy times when staff may be distracted and during the quiet hours of the night.⁹

Management plan

Patients who are assessed to be at risk of suicide must have detailed management plans developed, and whenever possible, this should be done in collaboration with the patient. The plan should be documented in the medical record and include the following:

- level of assessed suicide risk
- nature of associated risk, for example, absconding, self-harm, sexual exploitation
- steps to be taken to ensure their safety, for example:
 - level and frequency of observations (refer to *Nursing observation levels*, p 10)
 - requirement for a 'special' nurse
 - frequency of re-assessment and documentation of each suicide risk assessment, including a reviewed rating as high, medium or low

HIGH RISK:	conduct re-assessment at least twice daily
MEDIUM RISK:	conduct re-assessment at least daily
LOW RISK:	conduct re-assessment at least weekly

- the patient's status as voluntary (informal) or involuntary under the *Mental Health Act 1990* (NSW)
- diagnosis and treatment (interventions and their goals) including provision of appropriate treatment therapy or support to reduce the patient's level of distress and to promote hope and recovery

Management

- consideration of appropriate night sedation to assist the patient's rest and sleep
- information regarding family and friends and details of significant relationships
- appropriate exploration of the patient's difficulties, stressors, their responses and coping strategies. These may include:
 - identification of potential triggers or stressors
 - identification of adaptive coping responses
 - identification of support person/s
 - recognition of significant events, especially those which involve loss, death of a significant person or anniversary of divorce or death
 - individual importance of various factors to the patient including anticipation of likely circumstances that may escalate the patient's risk
- promotion of recovery through supportive or other psychotherapy including documentation of the patient's developing understanding of their recovery pathway
- active community team involvement during hospitalisation and on discharge as appropriate
- ongoing liaison with the family/carers and friends to assist in assessment of ongoing risk in the patient as well as providing support and education to them.

Coordination and communication

- Details of all suicide risk assessments, management plans, and observations are to be clearly documented in the patient's medical record. The Suicide Risk Assessment section of the Mental Health Outcomes and Assessment Tools (MH-OAT) Clinical Modules should be used.
- All staff on the unit must be made aware, both verbally at hand-over and in the daily unit reviews, of the patient's current status, including level of suicide risk, and the current management plan.
- The patient's level of risk is to be indicated in a place that is easily identified by staff, eg the unit whiteboard, bed list (in addition to being fully documented in the medical record).

- The patient's management plan should be regularly discussed with senior staff at hand-over and ward round meetings.
- Families should be made aware of the suicide risk and the actions being taken to minimise the risk. Family and (where appropriate) friends should be consulted in the assessment and development of the management plan.
- The community case manager or care coordinator should be included in the formulation of the management plan and the ongoing plan for in-patient treatment and discharge.
- The patient's general progress and revision of the suicide risk should be discussed by the full treating team at least weekly.

Nursing observation levels

All in-patient units are to have a policy in place for nursing observation care levels, clinical indicators for each level and the management requirements for each level, including frequency of observations. Refer to Table 2 for a recommended framework.

- On admission, the admitting doctor, in consultation with the senior nurse, is to determine the category of nursing observation required based on the assessment of the present risk of harm.
- The appropriate level needs to be applied in a way that is responsive to changes in the patient's clinical condition to minimise the level of unnecessary restriction to the patient's rights and liberties.
- A clear explanation is to be given to the patient (and family/carer where appropriate) about the reason for the particular observation level.
- Levels are to be reviewed as an ongoing process throughout each shift by the treating team.
- If at any time the patient's clinical condition requires a higher level of nursing observation the Nursing Unit Manager or delegate may raise the level and discuss with medical staff as soon as practical.
- In exceptional circumstances a voluntary patient may need to be placed on a higher level of observation. Such a situation requires immediate consultation with the medical staff.

Table 2: Framework for Observation Care Levels

Level	Clinical indicators	Description
1	<ul style="list-style-type: none"> ■ Patient is assessed as a high level of immediate risk to themselves. ■ Patient cannot be safely managed in a less restrictive fashion. ■ Environmental limitations preclude other levels of care. ■ The patient presents a high risk to others (aggression/violence). ■ Patient requires daily review. ■ Medical Officer to review on a daily basis, Monday to Friday in consultation with nursing staff. 	<ul style="list-style-type: none"> ■ Patient is to be contained in a locked facility. ■ Patient is to be nursed on a 1:1 basis (specialled). ■ Nurse is to be in close proximity to patient and have direct line of sight at all times. ■ Patient is to be checked for signs of life (eg respiration) each 10 minute interval throughout the night and these are to be documented. ■ There is no leave to be granted. ■ Individual observations chart kept as part of patient's medical record.
2	<ul style="list-style-type: none"> ■ Patient is assessed as a medium risk of suicide or self-harm. ■ Patient cannot be safely managed in a less restrictive fashion. ■ Patient is at risk of absconding. ■ There is a significant risk to the patient's personal reputation, financial affairs or sexual safety. ■ Patient to be reviewed by a medical officer daily (Monday to Friday) in consultation with nursing staff. 	<ul style="list-style-type: none"> ■ Patient is to be contained in a locked facility and checked every 15 minutes. ■ Patient to be checked for signs of life (eg respiration) each 15 minute interval throughout the night. ■ Patient must be escorted by a Registered Nurse when out of the ward. An Enrolled Nurse could be used at the discretion of the Nursing Unit Manager. ■ Individual observations chart kept as part of patient's medical record.
3	<ul style="list-style-type: none"> ■ Patient is assessed as a lower level of risk of suicide or self-harm. ■ Patient cannot be safely managed in a less restrictive manner. ■ Patient has compromised ability to maintain appropriate or acceptable behaviour. 	<ul style="list-style-type: none"> ■ Patient is checked every 30 minutes throughout the day and every 30 minutes at night. ■ Patient is confined to the ward. ■ Patient must be escorted by a member of staff when out of the unit. ■ Individual observations chart kept as part of patient's medical record.
4	<ul style="list-style-type: none"> ■ Patient is not currently a foreseeable suicide or self-harm risk. ■ Minimum level of patient observation. ■ Patient is not actively suicidal or self-harming. ■ Patient does not pose a threat to others. 	<ul style="list-style-type: none"> ■ Patient is checked every 2 hours and at change of shift. ■ If the patient is not on the ward there is a reason documented in the patient's file to include where he or she is and when return is expected. ■ If a patient is on unrestricted ground leave, this must be documented in the patient's medical record. ■ Observations may be recorded on a group observation sheet.

Note: Not all of the clinical indicators need to be present to determine an appropriate level of observation.

Management

- The treating medical officer, in consultation with the senior nurse, authorises the lowering of an observation level (which for some units may mean a transfer from a secured unit to an open unit).
- The level and frequency of observations and all reviews, including the evaluation of effectiveness of the care level, are to be documented in the patient record.
- An individual observations chart must be kept as part of the patient's medical record for Levels 1, 2 and 3 (see Table 2). Observations for Level 4 may be recorded on a group observation sheet.
- The allocation of observation care levels must be clearly communicated to all staff on every shift. Often this is achieved by means of a whiteboard in the nurses' station.

Managing a suicide attempt

- Do not leave the patient. Obtain assistance from other staff.
- Remove the patient from danger without placing staff or other patients and visitors at risk. If there is a risk to others, obtain assistance from security staff.
- Ensure immediate emergency medical care.
- Assess the patient's current suicide risk.
An attempted suicide usually indicates the person is at high risk in the immediate and short-term period.
- Provide support to other people present who may be acutely distressed, including other patients, staff and visitors.
- Follow all related procedures in regard to incident reporting, management and review.⁹

Managing a suicide death

Refer to *Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities*.¹⁰

Leave from an in-patient unit

Leave procedures

- The Mental Health Acute Care Team (and other mental health staff if applicable, eg case manager or care coordinator) should be informed of the patient's overnight leave from the unit prior to the commencement of leave. They should be given information on current risk status and duration of leave.
- Patients at medium or low risk may be allocated leave if family or friends understand the type and level of risk involved, agree to continue the management plan and agree to contact the unit if the patient's suicidal feelings increase.
- Patients allocated leave must receive written contact details and written procedures including the unit phone number. The contact procedures should be explained to the patient and family or friends.
- The responsibilities of patient leave should be explained to family or friends in person, with adequate time for discussion of the issues.
- Patients on leave contacting the unit (or Acute Care Service/Mental Health Emergency Team) with an increase in suicidal behaviour should be assessed over the phone by the staff and advised to return as soon as possible for reassessment.
- Patients on leave who are at increased risk but cannot return should be immediately discussed with senior staff or Mental Health Emergency Team and an appropriate response should be determined according to the level of risk.
- An assessment of how the leave went should be made on the patient's return and this assessment should be documented in the medical record. Information from family or carers may be very helpful in assessing the outcome of a patient's leave.

Approved leave

Recovery for a person at risk of suicide will involve a graduated return to full autonomy. Leave from the in-patient unit can be an important treatment strategy because it provides the patient with manageable

exposure to the home environment. Leave can also provide the person and the treating clinicians with important information about the patient's readiness for discharge.

The purpose of granting leave includes:

- to offer a patient and his/her carer the opportunity to return to their usual environment for a trial period
- to monitor the patient's progress
- to be part of an ongoing assessment process
- to allow the patient to carry out important activities or business
- to ascertain suitability for longer leave
- to prepare for discharge.

An assessment should be made of the patient's current risk prior to each leave and documented. The patient's level of functioning may appear to be better than it really is, due to the support provided by the in-patient environment. Therefore, leave arrangements should in general be graduated to minimise the risk. This graduation includes accompanied leave (by staff or reliable family members or friend) or unaccompanied leave. The duration can also be granted from very short periods to overnight or longer. Depending on the circumstances it is usually best to start with small periods of accompanied leave to 'test the waters' and then to review the situation after each leave.

Patients are usually not given leave when they are assessed to be at high risk. However, in circumstances where such leave is considered advisable (leave can be an important part of therapy), the medical staff should personally inform families of the degree of risk and advise on precautions to be taken to prevent suicidal behaviour. Instructions on what families should do in the event of attempted suicidal actions should be clearly set out. Such discussions with families can occur by telephone or face-to-face and should be documented in the medical record. It is important to ensure adequate time is allowed for families to discuss any issues they may be concerned about.

Trial leave

Trial leave can be a valuable part of the assessment and recovery processes and assists with facilitating discharge planning. Trial leave may proceed to discharge where through assessment, agreement and consultation with the person, community care providers and the person's family, it is believed that discharge whilst on trial leave will enhance the person's recovery and wellbeing.

- The family of a person who is on trial leave and who is at risk of suicide may offer unique insights into the person's progress and the current level of risk. However, conflict with a family member may also be a cause of increased suicide risk.
 - Protocols must be in place setting out the specific criteria for granting patients leave from the in-patient unit. They must include provision for the comprehensive reassessment of suicide risk before the proposed leave and prior to the granting of the leave.
 - There should be clear arrangements negotiated with a responsible person (usually a family member) on:
 - time of return
 - notification if return will be delayed
 - 'handover' of the person to in-patient staff
 - verbal advice on how the leave went and if there were any incidents of concern.
 - An assessment of the leave is to be documented in the medical record.
- notification to the police by the relevant senior medical or nursing personnel, if deemed appropriate on clinical grounds or if there is concern for the safety of the person or others
 - completion of relevant documentation for the reporting of an incident
 - re-assessment on arrival back to the unit or referral to the specialist mental health team for re-assessment, particularly for those considered to be medium to high risk
 - re-assessment of observation/supervision category
 - on return to the unit, the person should be interviewed to ascertain any factors that contributed to his or her absconding
 - people who abscond may be discharged at the judgment of the treating team
 - careful consideration of the duty to warn 'at risk' third parties if there is a grave concern for their safety.

Absent without leave

Absconding from a mental health in-patient facility is recognised as an indicator of high suicide risk in some people.¹¹ All reasonable attempts must be made to locate a person who has absconded.

Protocols must be available for the management of people who abscond. They should include:

- notification to relevant senior medical and nursing personnel
- notification to relatives or significant others of the person
- information from relatives or other relevant persons about favoured places the person might visit

Discharge and follow-up

The decision to discharge a person is based on the treating team's decision that further observation, care and treatment are no longer required in the in-patient setting.

Patients who have been at risk of suicide require close follow-up when discharged from hospital. The **first 28 days following discharge** from a mental health in-patient unit or hospital is recognised as a period of elevated suicide risk.³

The key management principles for this period are:

- assertive follow-up
- safety
- dealing with precipitators or other predisposing or related factors contributing to risk status
- regular face-to-face reassessment of risk
- contingency and relapse prevention planning
- continuity of service provision
- working with the person and, as appropriate, their family
- immediate re-entry to acute care if the risk of suicide escalates.

Discharge process

- Discharge planning should commence on admission to the unit.
- Patients due to be discharged from a mental health in-patient unit or hospital should, wherever possible, be allocated to a community mental health key worker (eg care coordinator, acute care service, emergency service team) prior to the discharge.
- A discharge plan must be documented for patients at risk of suicide. It must include the rationale for discharge. The discharge plan must be filed in the medical record.
- Discharge plans should be developed with the involvement of the patient, the family and the community care coordinator or case manager.

High Risk

Patients assessed to be at **long-term high risk** of suicide when discharged must have a follow-up appointment with the relevant health provider (for example, community care coordinator or case manager, general practitioner, private psychiatrist) **within 24 hours of discharge**.

The rationale and reasons for the decision to discharge the person for continued management in the community and the management plan to support the decision should be clearly documented.

If the person has access to a firearm, the police should be contacted before the person is discharged to discuss the possibility of removing the firearm.³

Medium Risk

Patients assessed to be at **medium risk** of suicide when discharged from a mental health in-patient unit must have a follow-up appointment with the relevant health provider **within one week** of discharge **and contingency plans in place**.

Low Risk

Patients assessed to be at **low risk** of suicide when discharged must have a follow-up appointment with the relevant health provider **within one week of discharge** and accessibility to appropriate health service if required prior to appointment. The person at risk should be provided with written information on 24-hour access to suitable clinical care.

- Consent should be sought to involve the patient's partner or carers and other service providers, such as the general practitioner, in the development of the discharge plan.
- Details of contingencies should the patient not attend follow-up appointments must be included.

Discharge and follow-up

- For patients under 16 years, the parents, family or guardian must be notified of the pending discharge. If the carer is not available, a suitable advocate must be contacted.

The **management plan** for these people should be documented on the MH-OAT Clinical Module D1 (Discharge/Transfer Summary). It should include:

- **re-assessment within the required timeframe based on the current level of risk at discharge**
- a booked appointment with a nominated clinician who has responsibility for the patient's community management. Preferably, this person should have had contact with the patient before discharge
- confirmation that the patient and his/her family or support person(s) have been provided with contact details for rapid response re-assessment
- liaison with the general practitioner.

The management plan is a record of interventions and contingency plans. The management plan should clearly articulate roles, responsibilities and timeframes for the period between assessments. The management plan should also include explicit plans for responding to non-compliance and missed contact by the client. The management plan is to be documented in the MH-OAT Comprehensive Assessment for Adults Module A1.

- All discharge plans should include contingency and relapse planning through a collaborative identification of early warning signs of relapse, eg withdrawal, rumination, poor appetite, poor sleep pattern, irrational thoughts, re-emergence of suicidal or self-harm ideation or behaviour. There should be explicit strategies agreed upon for relapse prevention.
- Local protocols must be available for discharge and follow-up of people at long-term high risk, such as those with depression or those who have had previous suicide attempts.

Contingency planning requires the clinician and the person at risk and/or their family or carer to anticipate likely escalations of risk such as:

- deterioration of family relationships
- increase in symptoms (depression, insomnia, hallucinations, suicidal feelings)
- initial difficulty accessing the acute care service.

Contingency planning is framed, communicated and documented in the following manner:

1. If....., then the person will....., the family will....., the service will.....
2. If....., then the person will....., the family will....., the service will.....etc.

Relapse plan

A relapse plan is a specific contingency plan that includes identification of early warning signs of relapse, for example, withdrawal, rumination, poor appetite, poor sleep patterns, irrational thoughts, re-emergence of suicidal or self-harm ideation or behaviour, or any other known warning signs that are relevant to an individual person. The plan sets out explicit strategies agreed upon for relapse prevention if the person becomes ill again. Warning signs are highly individual and need to be collaboratively identified by the person and family or carers.

As a minimum all persons should know whom to contact in a crisis.

The relapse plan may include:

- early warning signs and relapse indicators
- who the person is more responsive to
- how to contact that support person
- previous strategies that have been successful in improving the situation or getting agreement for changes in treatment, for example, involving a trusted friend, providing 'space'.¹²

Communication on discharge

- The follow-up service provider is to receive a verbal report on discharge of the patient.
- A written interim summary must be forwarded to the follow-up service provider on the day of discharge. The MH-OAT D1 module may be used for this purpose.
- A detailed written discharge summary is also to be forwarded to the follow-up service provider within seven days of discharge.

- A treatment plan must be given to the patient on discharge. This is to include:
 - written information about follow-up appointments
 - the 24-hour contact number for mental health emergencies
 - when to get help
 - appropriate community resources to assist in self-care
 - the discharging clinician (or alternative contact person) and phone number so that the patient can clarify details after discharge.
- A discharge summary should be sent to the patient's general practitioner.

Subject to the patient's consent, the treatment plan must also be provided to the patient's family member, carer or nominated friend.

Self-discharge

There may be times when an informal patient seeks discharge out of business hours or against medical advice. To ensure the facility's 'duty of care obligation' is fulfilled, while maintaining the rights of the person, the following should occur:

- Ascertain why the person wishes to leave prior to formal discharge.
- Request that the person discusses reasons and follow up management with the Medical Officer.
- Inform the person that the hospital advises against discharge at that particular time or for other relevant reasons.
- Inform relevant senior nursing and medical staff.
- The Medical Officer should conduct a mental health assessment including a risk assessment and a review of the medical record.
- All action taken by staff is to be documented in the medical record.
- Where there is a concern for the person if discharged, a change of legal status from informal to formal may be required if the medical officer, after assessment of the person, decides such a change is necessary in accordance with the *Mental Health Act 1990* (NSW). The person must be informed of the change in legal status.

- If there is no clinical reason for the person to remain in hospital and the person still wishes to leave, it is important that staff discuss with the person appropriate care arrangements.

Follow-up

- Follow-up should be targeted towards suicide risk reduction, including management of the person's underlying condition or problems and reducing current risk factors.
- Beyond the first week of discharge, the person's risk status should be comprehensively reviewed at least weekly until the risk status is assessed as no foreseeable risk.
- Measures which will facilitate risk reduction include support, collaboration with the person and all parties concerned, regular review including specialist reviews by a psychiatrist, problem solving and supporting and encouraging the person to see a general practitioner.
- Psycho-education should be provided to the person and, if appropriate, their family. Strategies should be put in place to target the broader psychosocial needs of the person – housing, income maintenance, food, employment and social skills development. Psycho-educational themes which may be helpful to explore include: relapse prevention; information about the seriousness of persistent suicidal ideation and deliberate self-harm behaviour; education about depression management and treatment; and information about the link between mental illnesses (schizophrenia, depression and bipolar disorder) and suicide.
- If the person at ongoing risk does not attend the initial post-discharge appointment, outreach contact and assessment should occur immediately, preferably by the person with whom the appointment was made.

Re-entry pathway

When a person is discharged from a particular setting within a mental health service the following precautions should be in place and documented in the discharge plan:

- The person and their family or support person know how to re-enter the previous level of care through a re-assessment process.
- The person and their family or support person have confidence that there are no barriers to re-assessment and if appropriate, re-entry to the required and appropriate level of care.
- A clinician who knows the person is nominated as the preferred point of contact.

Access to Means of Suicide and Deliberate Self-harm Facility Checklist

All services should review the physical structure of mental health in-patient units to identify:

1. any obstructions to the observation of high risk patients
2. structures that could be used in suicide by hanging.

In-patient units should remove (or make inaccessible) all likely ligature points.

Facility Name: _____ Review Date: _____

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action
Hanging points			
Non-collapsible curtain rails			
Non-collapsible bed frames			
Non-collapsible shower frames			
Internal piping			
Shower fittings			
Clothes rod in room wardrobes			
Shower curtains			
Light fittings			
Ceiling fan			
Door knobs			
Blind spots			
Corners			
Alcoves			
Under stairways			
Power-board rooms			
Other			
Access to facility			
Exit points			
Location of unit			
Busy road			
Railway line			
River, ocean			
Cliffs			
Other			

Discharge and follow-up

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action
Poisonous substances kept in locked cupboard or storeroom			
Medication			
Reagents			
Cleaning fluids			
Any other hazardous material			
Windows – structure and design			
Are windows in the facility made of full glass, meshed glass or small panes?			
Safety policy and procedures			
Routine search of patient on admission			
Further search of patient when there are grounds for suspicion			
Access to areas of particular risk – bathrooms, kitchens, toilets			
Careful observation of cutlery, power cords, tools, plastic bags and any other potentially dangerous implements			
Incident reporting, investigating and reviewing			
Monitoring of items conveyed from relatives, friends and family to patients and information provided on the safety of items bought in to the unit.			

Actions required to reduce risk:

Implementation procedure:

Completed by: _____ Name: _____

Signature: _____ Next Review Date: _____

References

- ¹ NSW Department of Health. Circular 98/31 Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities, May 1998. Note: The policy was being revised at the time of preparation of this framework.
- ² NSW Department of Health. Framework for Suicide Risk Assessment and Management for NSW Health Staff. Sydney: NSW Department of Health, 2004 (in press).
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- ⁴ White TW. How to identify suicidal people: A systematic approach to risk assessment. Philadelphia: The Charles Press Publishers, 1999.
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- ¹¹ NSW Department of Health. Postvention guidelines surrounding a suicide death for NSW health staff and staff in private hospital facilities. Sydney: NSW Department of Health, 2004 (in development).
- ¹² WA Department of Health, Office of Mental Health. Framework for clinical risk assessment and management of harm, January 2003.

