

Suicide Risk Assessment and Management Protocols

Justice Health Long Bay Hospital



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Contents

Framework for Suicide Risk Assessment and Management for NSW Health Staffii

Introduction.....1

Assessment of suicide risk2

Principles of suicide risk assessment in an in-patient unit.....2

– Consultant psychiatrist2

Assessment.....2

– Psychiatric assessment2

Detection.....3

Assessment confidence.....6

Corroborative history6

Determination of risk level.....7

– Changeability7

– Assessment confidence7

Suicide Risk Assessment Guide8

Management9

Maximising a safe environment.....9

Management plan.....9

Coordination and communication.....10

Nursing observation levels10

Managing a suicide attempt11

Managing a suicide death.....11

Discharge and follow-up12

Discharge process.....12

Communication on discharge.....12

Access to Means of Suicide and Deliberate Self-Harm Facility Checklist.....13

References15

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

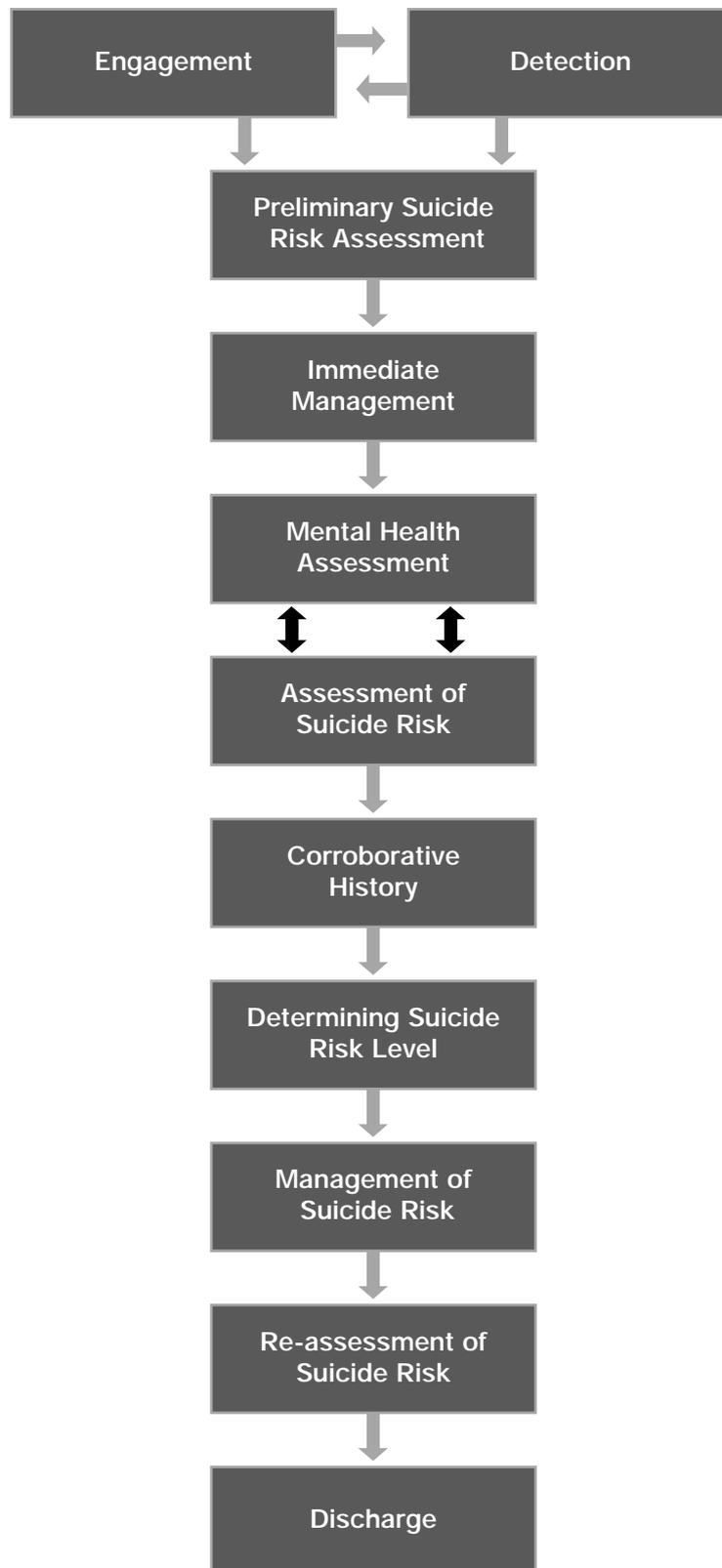
Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185

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: Mental Health In-Patient Unit – SHPN (MH) 040183

Framework for Suicide Risk Assessment and Management for NSW Health Staff



Introduction

Long Bay Hospital has a central role in the care of patients presenting with suicide risk. Good therapeutic relationships with patients and where possible, their families, are key components for the reduction of suicide risk.

Admission to Long Bay Hospital provides the opportunity for a safe and containing environment, supervision commensurate with the degree of risk, direct observation, regular monitoring of mental state and continuous therapeutic support.

Long Bay Hospital aims for an appropriate balance between the need to control 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 should be conducted on admission.
- Re-assessment of suicide risk should be regularly conducted throughout the admission.
- Observation levels should be re-assessed according to current level of risk.
- There should be participation by the patient.
- Other service providers involved with the patient (eg welfare, psychologist) should be included in the development of the management plan.
- Good communication, verbal and written, is essential for consistent and coordinated care.

Consultant psychiatrist

Every patient admitted to Long Bay Hospital 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 are re-assessed regularly throughout the admission.

Psychiatric assessment

- Most frequently, suicidal behaviours are 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, the patient's personality style and current and previous drug and alcohol use.
- 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 a 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 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.

Examples include:

- 'at risk mental status', for example, depression, hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes
- recent interpersonal crisis, especially rejection, humiliation
- recent suicide attempt
- recent major loss or trauma or anniversary
- alcohol intoxication
- drug withdrawal state
- financial difficulties or unemployment
- impending legal prosecution or child custody issues
- cultural or religious conflicts
- lack of social support network
- unwillingness to accept help
- difficulty accessing help due to language barriers, lack of information or support or negative experiences with mental health services prior to immigration.

Hopelessness is one of the main factors mediating the relationship between depression and suicidal intent.³ Some people experiencing hopelessness may conclude that death is a better alternative than living a life in which they believe there is no hope for a positive future. Hopelessness can be determined by exploring how a person feels about his/her future. Lack of positive expectancies and a negative view on life are important factors in suicidal behaviour.

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.

The assessment of suicide risk of a person admitted to Long Bay Hospital must include consideration of a number of factors external to the patient's mental state. These factors include consideration of the events and people on the unit and the patient's relationships and events impacting on their life outside prison. Table 1 is an illustrative, but not exhaustive, framework.

Table 1: Factors to consider in assessment of suicide risk for patients in Long Bay Hospital

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 ■ negative life experience 	<ul style="list-style-type: none"> ■ prison environment ■ staffing levels ■ 'busy times' ■ observation procedures ■ interpersonal dynamics on the ward 	<ul style="list-style-type: none"> ■ impending major stressor, eg court appearance, loss of child custody ■ shaming experiences ■ visit or phone call from hostile, critical family ■ no visit or contact from family

Assessment of suicide risk

A comprehensive suicide risk assessment should explore:

Distress, psychic pain

- What is the nature and level of the person's inner distress, anger 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 themselves? Has the person lost his/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.

'At risk' mental status

- The presence of negative emotions – hopelessness, despair, agitation, helplessness, withdrawing, 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?
- 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 delusions or rational thoughts)?
- 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 person's perception of lethality.)
- Has the person finalised personal business, for example, made out a will, given away their possessions, 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 may 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.

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

Presence of a suicide plan

- How far has the suicide planning process proceeded?
- Has the person made any plans?
- Is there a 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 access to sharp instruments?
- 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?
- Are there lethal medications such as insulin, cardiovascular medications or tricyclic antidepressants available to the person?
- Is there any item or aspect of the environment that may be used as a means to self-harm?
- Have visitors been made aware of items brought into the environment that may be used as a means to self-harm?

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 actions involved in a suicide attempt or plan.

Safety of others

- Have the person's thoughts ever included harming someone else as well as themselves?
- 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? Has he/she been through a recent and traumatic separation? Are there current issues with custody of children or financial issues?

Coping potential or capacity

- Does the person have the capacity to enter into a therapeutic alliance? (Is a partnership possible?)
- 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 other supports (family, friends, church, welfare)? 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 impulsivity make risk status less predictable.)
- Can the clinician assist the person to manage the risk of impulsive behaviour? For example, for suggestions relating to impulsive behaviour (anger, sarcastic remarks, seductive actions), guide the person to learn to recognise the early signs and plan for a pause: 'Count to 10', 'Stop the insults and think of a compliment', or 'Stick to business'. Important rules for restraint are:
 - wait 10 minutes
 - think about the consequences
 - use distraction (think about something else).

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 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 no 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 and provide opportunities for assessing family members and for helpful collaboration about management and discharge planning.

- Sources of information include:
 - interview or phone contact with other relevant people, with the person's permission, eg family members, close friends, significant others, case managers, GP, private psychiatrist, therapists, school counsellors and other relevant health and welfare service providers who know the person
 - where possible, access to previous files.
- There should be careful consideration to the issues 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.^{5, 6, 7} 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. 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. 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 may 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 an 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 enough to allow continuing care and treatment in prison with a mental health nurse.

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 and shoelaces.
- 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. Such a search should be conducted by one staff member with a second staff member in attendance. In most cases these searches will be carried out by the Department of Corrective Services (DCS). A member of the nursing staff is to be present during these searches.
- Supervision of the patient's activities that have potential for self-harm may be necessary, such as using sharps, showering, cigarettes and checking utensils after eating. Similarly it may be necessary to restrict the movements of the patient to safe areas of the ward.
- An environmental safety audit should be conducted at least annually in each in-patient unit. The NSW Health **Access to Means of Suicide and Deliberate Self-harm Facility Checklist** included with these protocols (pp 13-14) 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.

- 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.

Management plan

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

- level of assessed suicide risk of the patient
- nature of associated risks, for example, self-harm, sexual exploitation
- steps to be taken to ensure the patient's 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

- 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
- consideration of appropriate night sedation to assist the patient's rest and sleep

Management

- information regarding triggers, stressors, precursors, methods, plans and the individual importance of various factors to the patient including anticipation of likely circumstances that may escalate the patient's risk
- 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 stressors
 - identification of adaptive coping responses
 - identification of support person/s
 - recognition of significant events, especially those that involve loss, death of a significant person or anniversary of divorce or death
- promotion of recovery through supportive or other psychotherapy, including documentation of the patient's developing an understanding of their recovery pathway
- details of ongoing liaison with the family and friends to assist in assessment of ongoing risk in the patient as well as providing support, and education to the family and friends.

Coordination and communication

- All details of all suicide risk assessments, management plans and observations are to be clearly documented in the patient's medical record.
- All staff on the ward must be made aware, both verbally at hand-over and in the daily ward 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 or bed list.
- The patient's management plan should be regularly discussed with senior staff at hand-over and ward round meetings.
- 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 levels, clinical indicators for each level and the management requirements, including frequency of observations, for each level. Table 2 opposite provides a suggested framework for observation care levels.

- 5-minute nursing observations are to occur for any patient who is locked in their cell.
- When a patient is assessed as being low or medium risk of suicide, the patient is placed on 15-minute nursing observation.
- A patient who is assessed as at high risk of suicide must be given a 'Special' nurse for close 1:1 nursing observation.
- 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 nurse in charge may raise the level upon discussion with medical staff or on-call registrar.
- The Nursing Unit Manager or nurse in charge can authorise to lower the level of nursing observation following consultation with the medical staff.
- The allocation of observation care levels must be clearly communicated to all on every shift. This is often achieved by means of a whiteboard in the nursing station.
- The level and frequency of observations and all reviews, including the evaluation of effectiveness of the care level, are to be documented in the management plan.

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 presents a high risk to others (aggression/violence). ■ Patient cannot be safely managed in a less restrictive manner. ■ Environmental limitations preclude other levels of care. 	<ul style="list-style-type: none"> ■ Patient is placed in safe cell. ■ Patient is in direct line of staff sight at all times. ■ Staff are to be in close proximity to patient unless otherwise directed in writing by medical staff. ■ Patient is nursed on a one-to-one basis, in direct line of sight. ■ Patient is to be checked for signs of life each five minute interval and this must be documented.
2	<ul style="list-style-type: none"> ■ Patient is assessed as a medium risk for suicide or self-harm. ■ Medium risk of harm to others. ■ Patient cannot be safely managed in a less restrictive manner. 	<ul style="list-style-type: none"> ■ Patient is to be checked for signs of life at each fifteen minute interval and this must be documented.
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 to be checked at each fifteen minute interval and this must be documented.
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 cooperative/participating with clinical management. ■ Patient does not pose a threat to others. 	<ul style="list-style-type: none"> ■ Frequent assessment of patient, monitoring level of risk for suicide.

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

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 at risk. If there is a risk to others, obtain assistance from DCS.
- Ensure immediate emergency medical care.
- Assess the patient's current suicide risk. An attempt at 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 inmates and staff.
- Follow all related procedures in regard to incident reporting, management and incident review.⁸

Managing a suicide death

Refer to *Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities*.⁹

Discharge and follow-up

The decision to discharge a person is based on the treating team's decision that further observation, care and treatment is no longer required in Long Bay Hospital.

Patients who have been at risk of suicide require follow-up when discharged from hospital.

The **first 28 days following discharge** from a mental health in-patient unit or hospital are recognised as a period of elevated suicide risk.

The key management principles for this period are:

- comprehensive discharge summary given to the mental health nurse
- assertive follow-up of discharge by the mental health nurse in prison
- ensuring 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
- re-entry to appropriate level of care.

The management plan for these patients should be documented on the NSW Health Mental Health – Outcomes Assessment Tool (MH-OAT) Clinical Assessment Module D1 (Discharge/Transfer Summary).

It should include:

- re-assessment within the first week following discharge from Long Bay Hospital
- liaison with the relevant psychiatrist and mental health nurse.

All discharge plans should include relapse and contingency planning through collaborative identification of early warning signs of relapse, for example, withdrawal, rumination, poor appetite, poor sleep pattern, irrational thoughts or re-emergence of suicidal or self-harm ideation or behaviour. Explicit strategies should be agreed upon for relapse prevention.

Local protocols must be available for discharge and follow up of people at high risk, such as those with depression or those who have made previous suicide attempts.

Discharge process

- Discharge planning should commence on admission to the unit.
- Patients due to be discharged from Long Bay Hospital should be discharged to a prison with a mental health nurse.
- 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.

Communication on discharge

- The follow-up mental health nurse is to receive a verbal report on discharge of the patient.
- A written interim summary must be forwarded to the 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 provider within seven days of discharge.
- A treatment plan must be given to the patient on discharge. This is to include:
 - the 24-hour contact number for the mental health emergency help line
 - when to get help
 - where to get help.

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

Inpatient 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).
- ³ Rudd MD, Rajab MH, Dahm PF. Problem solving appraisal in suicide ideators and attempters. *American Journal of Orthopsychiatry*, 1994;64: 136-149. Cited in: H Hawton, K van Heeringen K, eds. *The international handbook of suicide and attempted suicide*. Chichester: Wiley & Sons Publishers, 2000.
- ⁴ White TW. *How to identify suicidal people: A systematic approach to risk assessment*. Philadelphia: The Charles Press Publishers, 1999.
- ⁵ Pokorny AD. Prediction of suicide in psychiatric patients: report of a prospective study. *Archives of General Psychiatry*, 1983; 45:249-257.
- ⁶ Goldstein RB, Black DW, Nasrallah MA, Winokur MD. The prediction of suicide. *Archives of General Psychiatry*, 1991;48:418-422.
- ⁷ Rissmiller DJ, Steer R, Ranieri WF, et al. Factors complicating cost containment in the treatment of suicidal patients. *Hospital and Community Psychiatry*, 1994;45(8):782-788.
- ⁸ Adapted from South East Sydney Health Service. *Managing a patient at risk of suicide on the in-patient unit. Final Draft Policy*, 2001.
- ⁹ 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)

