Clinical Care of People Who May Be Suicidal

Summary All health staff have a role in the identification of people at risk of suicide and the implementation of effective policy. This policy assists the specialist mental health workforce to provide care across community, inpatient and emergency settings in collaboration with other health professionals. The policy aims to support the provision of timely evidence-based clinical care of people at risk of suicide, outline the role and responsibilities of mental health services and clinicians and support a consistent and coordinated evidence informed approach to support application of clinical guidelines and training.

Document type Policy Directive

Document number PD2016_007

Publication date 01 March 2016

Author branch Mental Health

Branch contact 02 9391 9180

Review date 01 March 2022

Policy manual Not applicable

File number 13-301

Previous reference N/A

Status Review

Functional group Clinical/Patient Services - Mental Health, Nursing and Midwifery Personnel/Workforce - Learning and Development

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Community Health Centres, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Public Hospitals

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Ministry of Health

Audience Clinical; GMOs; mental health; nursing; allied health; EDs; social work; community health

Secretary, NSW Health

POLICY STATEMENT

CLINICAL CARE OF PEOPLE WHO MAY BE SUICIDAL

PURPOSE

A significant proportion of people who die by suicide have had contact with a health professional in the weeks prior to their suicide. It is therefore essential that health staff identify people at risk of suicide and prevent suicide by implementing effective management strategies including referral to relevant services for further assessment and expert supports.

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies to prevent suicide including facilitating access to appropriate care. This policy has been specifically developed for the specialist mental health workforce providing care across community, inpatient and emergency settings and in collaboration with other health professionals and the individual's support network.

This policy directive is intended to:

- Support the provision of timely evidence-based clinical care of people at risk of suicide to ensure people remain safe and are supported in their recovery
- Outline the role and responsibilities of mental health services and clinicians to inform local policies and procedures, and
- Support a consistent and coordinated evidence informed approach to support application of clinical guidelines and training.

MANDATORY REQUIREMENTS

This policy and its directives the *Clinical Care Of People Who May Be Suicidal (*Attachment 1), establishes minimum standards that NSW mental health services and clinicians are required to meet in the identification, assessment and management of people with suicidal behaviour and ideation in all care settings.

IMPLEMENTATION

Local Health District, Specialty Network Chief Executives, Health Service Executives need to:

- Assign responsibility, personnel and resources to implement this policy
- Provide line managers with support to mandate this policy in their areas
- Ensure local protocols are in place in each facility to support implementation
- Ensure mental health clinicians undertake training in suicide risk assessment and management
- Work together with the Mental Health and Drug Alcohol Office to ensure Local Health District (LHD) policies, procedures and standards are consistent with statewide policies, procedures referred to in the attached *Clinical Care Of People Who May Be Suicidal* policy directive and those NSW Heath policies and guidelines referenced within that document

- Report compliance with this policy to the NSW Ministry of Health as required

NSW Health Service staff and visiting practitioners providing relevant services need to comply with this policy.

REVISION HISTORY

Version	Approved by	Amendment notes
March 2016 (PD2016_007)	Deputy Secretary, Strategy and Resources	This policy is targeted towards mental health services and clinicians in suicide prevention.
January 2005 (PD2005_121)	Director General	New policy

ATTACHMENTS

1. Clinical Care of People Who May Be Suicidal: Procedures.

Clinical Care of People Who May Be Suicidal

NSW GOVERNMENT Health

PROCEDURES

Issue date: March-2016

PD2016_007

CONTENTS

1. ABOUT THIS POLICY DIRECTIVE 1

2. IDENTIFICATION AND CARE OF PEOPLE WITH SUICIDAL BEHAVIOUR OR IDEATION 1

2.1 Comprehensive mental health assessment 1
2.2 Psychiatric evaluation 2
2.3 Psychosocial assessment 2
2.4 Assessment of risk 2

3. CLINICAL CARE OF THE PERSON 3

4. RESPONDING TO PEOPLE WITH ONGOING SUICIDALITY 4

5. TRANSFER OF CARE AND DISCHARGE 4

6. CLINICAL SUPERVISION AND SUPPORT 5

7. CLINICAL DOCUMENTATION 6

8. ENVIRONMENTAL HAZARDS 6

9. EDUCATION AND TRAINING 7

10. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE 8

APPENDIX A - RELEVANT NSW HEALTH LEGISLATION, POLICY DIRECTIVES, GUIDELINES AND INFORMATION BULLETINS 10

APPENDIX B – NSW POLICE FORCE – FIREARMS REGISTRY 12

APPENDIX C - ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF-HARM FACILITY CHECKLIST 13

APPENDIX D - RECOMMENDED RESOURCES 15

REFERENCES 19

1. ABOUT THIS POLICY DIRECTIVE

Suicide is the leading cause of death due to injury in Australia[i]. Most people who go on to die by suicide do so because of overwhelming and unbearable psychological distress - if people are safely helped through this period of high risk they can usually recover their equilibrium and do well.

It is important mental health clinicians are able to recognise the presentation of possible suicidal behaviour in different age groups and diagnostic categories and to respond effectively.

Education and training is available to all NSW Health staff through the Health Education and Training Institute (HETI) to support clinical skill training in suicide prevention.

2. IDENTIFICATION AND CARE OF PEOPLE WITH SUICIDAL BEHAVIOUR OR IDEATION

Mental health service clinicians in all settings have a responsibility to undertake assessment of people presenting with suicidal behaviour or ideation. Settings may include emergency departments, mental health telephone triage services, community mental health services, mental health inpatient facilities and general health facilities. When undertaken by assertive community teams these will extend to other settings such as the home or school.

People at risk of suicide, including those presenting to health services with self-harm and those admitted to a mental health facility, should receive a comprehensive mental health assessment incorporating a psychiatric evaluation, a culturally and developmentally appropriate psychosocial assessment including current stressors and a detailed assessment of suicide risk[ii].

2.1 Comprehensive mental health assessment

The comprehensive mental health assessment should be conducted by a mental health clinician in collaboration with the person at risk, their family and carers and other relevant people related to the presenting situation such as specialist mental health services.

Risk measurement checklists or tools should not be used in isolation to determine treatment decisions. Use of suicide risk factor checklists or screening tools alone cannot be recommended for use in clinical practice as a means of accurately predicting a person's risk of suicide as no rating scale or clinical algorithm has proven predictive value in the clinical assessment of suicide[iii]. There is moderate to low quality evidence for their use; they have insufficient sensitivity and specificity; and therefore lack reliability for predictive purposes[iv].

The goal of a suicide risk assessment is to determine the level of suicide risk at a given time, including an assessment of changeability and impulsivity in the person, quality of informal support networks, level of engagement in care planning and wider support network, to provide the appropriate clinical care and management plan[v].

A comprehensive assessment should be sensitive to the distress of the person and the fact that assessment involves significant disclosure. This should be carried out in a manner that is recovery-orientated and trauma-informed.

2.2 Psychiatric assessment

A psychiatric assessment evaluates recent symptoms, current mental state and past history, and seeks to determine if a relapsed, untreated, or previously undiagnosed psychiatric disorder may be the cause of the clinical presentation.

2.3 Psychosocial assessment

A psychosocial assessment evaluates external factors that may contribute to the person's current distressed state. This may include stressors, any significant changes in life circumstances or challenging life events including significant loss, and the use of alcohol or drugs which may increase risks of impulsive behaviour. Protective factors inclusive of strong social supports, good coping and problem-solving skills, and an ability to seek and access help should also be explored as these may protect the person from suicide.

2.4 Assessment of suicide risk

Assessment of risk determines the severity of self-harm, suicidal thoughts or behaviour including identifying any specific plans for suicide, access to means, potential lethality of the chosen method, persistence of ideation, what precautions against discovery were planned, impulsivity and distorted thinking, and details of any previous suicide attempts[vi].

The *Mental Health Triage Policy (PD2012_053)* defines and outlines the clinical processes to identify the presenting factors that suggest risk, the appropriate response required, and how to manage call situations including callers who threaten to harm themselves. (http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_053.pdf)

Local Health Districts (LHDs) and Health Networks that implement electronic medical records (EMRs) for inpatient and community mental health services should avoid the use of risk assessment checklists or forms as the sole predictive or decision-making tools.

Minimum requirements

All mental health professionals regardless of the setting have an obligation to:

- Provide clinical management and care in accordance with the *NSW Mental Health Act (2007)*
- Undertake a comprehensive mental health assessment inclusive of risk for people with suicidal behaviour or ideation and not use risk measurement tools or checklists in isolation to determine treatment decisions
- Undertake a comprehensive mental health assessment inclusive of risk on entry to any mental health service, and monitor the status of this throughout the patient's care episode through regular reassessment, particularly in response to changes in personal circumstances or care
- Develop a management plan with the involvement of the person, their family / principal carers and key stakeholders
- Ensure clinical records include documentation of ongoing mental state,

assessments of risk, and actions and precautions taken as an outcome of those assessments including consultation with supervisors and person's key carer network where management plans change to support ongoing communication across the care system

- Complete a Notification to NSW Police and Firearms Registry Form (Appendix B) if the person is known to have access to a firearm, and there is an assessed level of risk to self or others

Mental Health Services have an obligation to :

- Ensure locally developed protocols are in place at all entry points to health care including emergency departments that support the:
  - Appropriate triage of at risk patients and interim observational management pending handover to mental health
  - Consultation with persons with suspected suicidal risk, and referral for comprehensive mental health assessments
  - Person's immediate safety and notify mental health services of the risk of imminent departure from the emergency department by a patient known to be at risk of self-harm
  - Establish pathways to care to assist in early identification and access for people with suicidal behaviour or ideation.

3. CLINICAL CARE OF THE SUICIDAL PERSON

Of utmost importance is the safety and wellbeing of people at risk of suicide regardless of health setting. The management plan should:

- Be recovery oriented, trauma-informed and inclusive of the persons perceptions as well as of family and carers
- Be informed by consideration of the person's capacity to make decisions about their treatment and safety
- Ensures continuity of care and provision of essential information across settings and service providers
- Ensure care in a public health facility includes a safe physical environment
- Ensure clinical management and care is in accordance with the *Mental Health Act (2007)* chiefly:
  - People receive care and treatment in the least restrictive environment possible enabling the care and treatment to be effectively given.
  - Every effort that is reasonably practicable is made to seek the person's views and consent to treatment and care. The person's expressed wishes should be incorporated into their recovery plan to the fullest extent that is possible.
  - The views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about

treatment and whether interventions are provided as voluntary or involuntary under the Act.

Clinical judgment of mental health professionals is central to the assessment and management of a person at risk of suicide, and is based on their clinical experience, the person's clinical presentation, the assessment and management options available and, information from relevant others[vii]. Consultation with, or the advice of, a senior colleague should be sought - particularly where the decision to not admit someone with a suicide risk is made. Appropriate community follow up should also be arranged. Consultation outcomes should be clearly documented as part of the assessment formulation.

4. RESPONDING TO PEOPLE WITH ONGOING SUICIDALITY

People with recurring or ongoing risk from suicide ideation or behaviours require particular consideration. These include the incorporation of clear strategies to support the person's recovery, to respond to changes in risk over time and to ensure that services have strategies to contain emotional distress. This will necessitate review of the historical and dynamic nature of risk and the capacity of the person and their support network to utilise personal coping strategies. Reviews should involve all relevant parties (including case conferencing) and include regular reviews of the management plan. Some overarching principles include:

- Establish a team approach to risk formulation and response
- Acknowledge the underlying distress that drives self-harm ideation and assess the risk at each presentation
- Actively respond to all co-existing conditions
- Set clear expectations of the assessment and support process, including a clear management plan and guidelines on expected behaviour of the person
- Facilitate the person's engagement with / linkage to programs that promote emotional self-mastery and problem solving skills.

Minimum requirements

Ongoing management of a person's mental health treatment requires mental health professionals regardless of their setting to:

- Consider decisions about care and treatment in accordance with the *NSW Mental Health Act (2007)*
- Consider the person's preferences and capacity to consent to treatment as indicated in Section 68 of the *NSW Mental Health Act (2007)*
- Engage designated carers and / or principal care providers and key stakeholders in ongoing discussions with the person about treatment and care planning including management of risk of harm and management plans.

5. TRANSFER OF CARE AND DISCHARGE

Transitions in the care of a person with mental health issues should be identified as points of potential increase in risk[viii].

PD2012_060 (*Transfer of Care from Inpatient Mental Health Services)* refers to situations where the mental health consumer's care is transferred from a mental health inpatient unit across health settings including to another inpatient service, to the community, or during periods of approved leave. The policy sets out the treating team's responsibilities in relation to advice, information sharing, and documentation to ensure continuity of care and safety are maintained during the transfer process(http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_060.pdf).

The period immediately following discharge from an acute psychiatric admission is a period of greatly increased risk. Discharge planning must include early engagement with relevant supports well ahead of the proposed transfer date. Suicide risk assessments and management plans should be regularly revised and updated.

Safe discharge requires Mental Health clinicians to deliver assertive and coordinated follow-up through direct contact as soon as possible following discharge from psychiatric inpatient units or emergency departments. This contact needs to assess the success of initial transition back into the community and therefore must include both direct contact with the person and, where possible, discussion with the person's principal carer. Discharge must be accompanied by:

- Written information for the person with details of discharge plans including referrals to other treatment teams or community services, and
- Information about access to the 24/7 Mental Health Line 1800 011 511.

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Ensure the requirements outlined *in Transfer of Care from Inpatient Mental Health Services PD2012_060* are followed for the care of people with suicidal intent and behaviours
- Revise and update suicide risk assessments and management plans at points of significant transitions in care as these represent times of potential increase in risk
- Make direct contact with mental health consumers discharged from an acute psychiatric admission to the community within the timeframe indicated in the *Transfer of Care Plan* or within a maximum of 7 days.

6. CLINICAL SUPERVISION AND SUPPORT

Mental Health Services need to ensure clear local protocols are in place to support less experienced clinicians to seek advice on clinical matters from more senior clinicians regarding the assessment or management of patients who are suicidal and support the implementation of protocols for clinical supervision and support.

Mental Health clinicians should understand the meaning of recovery based care, capacity and consent within the *Mental Health Act (2007).* They should also understand their

responsibilities and procedures to work collaboratively with relevant support agencies, essential to supporting a person's recovery and safety.

Minimum requirements

All mental health services regardless of the setting have an obligation to:

- Ensure that mental health clinicians have access to appropriate clinical supervision, consultation or advice from a senior clinician at all times.

7. CLINICAL DOCUMENTATION

Mental health clinicians have a professional and legal responsibility to maintain clear, accurate and timely records.

The *Mental Health Clinical Documentation Policy Directive PD2010_018* describes in detail the clinical documentation requirements for NSW mental health services. (http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_018.pdf)

Any locally developed electronic medical records (EMRs) for inpatient or community mental health services should avoid the use of risk assessment checklists or forms as the sole predictive or decision-making tools.

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Ensure that mental health clinicians use the Mental Health Clinical Documentation modules to document care as mandated in the *Mental Health Clinical Documentation Policy Directive PD2010_018*
- Ensure mental health clinicians complete clinical documentation training
- Refer: http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_018.pdf

8. ENVIRONMENTAL HAZARDS

Mental health inpatient facilities can reduce environmental hazards for patients with suicidal behaviour and ideation. Conducting regular environmental safety audits is recommended for LHD and Speciality Network mental health services.

The Access to Means of Suicide and Deliberate Self-harm Facility Checklist (Appendix C) has been developed to specifically address safety issues in mental health inpatient facilities[ix] and may be a useful tool.

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Develop and implement standardised practices intended to improve patient safety, eliminate hazards and reduce the likelihood of adverse incidents occurring

including:

- Each shift changeover incorporating a patient's risk assessment
- Undertaking annual environmental safety audits that identify and ameliorate the risks presented by low-lying ligature points and non-collapsible curtain rails
- Undertaking annual environmental safety audits that identify any obstructions to the observation of high risk patients in mental health inpatient facilities
- Strategies to monitor and prevent potentially dangerous items being brought into the inpatient unit by patients, family, carers or friends. This needs to be conducted in a respectful and trauma-informed manner
- Using processes to escalate and address safety issues, and for this to include the use of tools and checklists that are specifically developed in the mental health inpatient facility, and
- Designating a staff member responsible for undertaking the environmental audit which is to be dated, signed and retained as a formal record(refer Appendix C).

9. EDUCATION AND TRAINING

Maintaining effective and current clinical skills and practice in assessing and managing suicidal behaviour and ideation are core requirements of all mental health clinicians.

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Recognise the need to respond respectfully and in a non-stigmatising manner to those who attempt suicide and who self-harm
- Understand current clinical and legal responsibilities in the delivery of mental healthcare
- Know the minimum requirements mental health services and clinicians are required to observe in the assessment and management of people with suicidal behaviour and ideation, in accordance with this policy
- Integrate the key principles outlined in this policy directive in the delivery of clinical management and care of people with suicidal behaviour and ideation
- Deliver evidence-based clinical practice in the assessment and management of people with suicidal behaviour and ideation
- Recognise the differing presentations of possible suicidal behaviour in different age groups and diagnostic categories to respond effectively and efficiently in the provision of ongoing care
- Possess competency in undertaking detailed evaluations of suicidal behaviour and ideation.

Mental Health Services have an obligation to :

- Ensure mental health clinicians regardless of setting undertake training in suicide risk assessment and management.

10. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE

The suspected suicide of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from a health service requires an internal review and referral for investigation to NSW Police if the death occurs within seven (7) days of the person's last contact with the health service, or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the health service.

At the discretion of NSW Police the incident may be referred to the NSW Coroner.

The suspected suicide of a person (meeting the circumstances outlined in the preceding paragraph) falls in the highest severity assessment category, a SAC 1 and requires the submission of a reportable incident brief (RIB) to the Ministry of Health (MoH): within 24 hours of notification.

The *Incident Management Policy PD2014_004* provides direction to health services regarding the management of clinical (and corporate) incidents and includes the provision of appropriate feedback to patients, families, support persons and clinicians.

Policy *PD2014_004* outlines the reporting of specific healthcare incidents to the NSW MoH reportable incident brief (RIB) system.

The *Open Disclosure Policy PD2014_028* outlines a standardised approach in communicating with families and other carers after an incident in care and includes acknowledgement of a patient safety incident to the patient's support person(s) as soon as possible; the provision of truthful, clear and timely communication; and an apology to the patient's carers as early as possible, including the words "I am sorry" or "we are sorry".

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Demonstrate compassion, openness, respect and empathy to the family and carers of a person who has died where it is a suspected suicide
- Ensure an offer of ongoing support to family, carers and others
- Be aware of and observe a standardised approach in communicating with families and other support people after an incident in care that is consistent with the *Open Disclosure Policy* PD2014_028 http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_028.pdf
- Advise any clinician who has been managing care of the deceased in the community (including private psychiatrists, general practitioners) of the death as soon as possible

Mental Health Services are responsible for ensuring:

- Effective local incident management systems are consistent with the *Incident Management Policy* PD2014_004 and are followed. http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_004.pdf
- Any mental health clinician affected by a suicide death is offered support from their team manager, clinical supervisor and the Employment Assistance Program (EAP).

APPENDIX A - RELEVANT NSW HEALTH LEGISLATION, POLICY DIRECTIVES, GUIDELINES AND INFORMATION BULLETINS

NSW Health Legislation

NSW Health Legislation can be accessed at:
http://www0.health.nsw.gov.au/aboutus/legal/legal.asp

1. *Children and Young Persons (Care and Protection) Act 1998* (revised 2010) No. 157
2. *Disability Services Act 1993* No. 3
3. *Guardianship Act 1987* No. 257
4. *Health Administration Act 1982* No. 135
5. *Health Administration Regulation 2010*
6. *Health Care Complaints Act 1993* (NSW) No. 105
7. *Health Records and Information Privacy Act 2002* No. 71
8. *Health Records and Information Privacy Regulation 2012*
9. *Health Services Act 1997* No. 154
10. *Mental Health Act 2007* No. 8
11. *Mental Health Amendment (Statutory Review) Act 2014* No. 85
12. **Privacy and Personal Information Protection Act 1998**

NSW Health Policy Directives and Guidelines

NSW Health Policy Directive, Guidelines and Information Bulletin can be accessed at:
http://www.health.nsw.gov.au/policies/pages/default.aspx

Policies, Guidelines and Information Bulletin	Document No.
Transfer of Care from Mental Health Inpatient Services	PD2012_060
Children and Adolescents with Mental Health Problems Requiring Inpatient Care	PD2011_016
Child Wellbeing and Child Protection Policies and Procedures for NSW Health	PD2013_007
Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services	PD2010_037
Clinical Handover – Standard Key Principles	PD2009_060
Coroners Cases and the Coroners Act 2009	PD2010_054
Culturally and Linguistically Diverse (CALD) Carer Framework: Strategies to Meet the Needs of Carers	GL2009_018
Departure of Emergency Department Patients	PD2014_025

Policies, Guidelines and Information Bulletin	Document No.
Electronic Information Security Policy - NSW Health	PD2013_033
Incident Management Policy	PD2014_004
Information Bulletin – Keep Them Safe – Making a Child Protection Report	IB2010_005
Medication Handling in NSW Public Health Facilities	PD2013_043
Mental Health Clinical Documentation	PD2010_018
Mental Health Clinical Documentation Guidelines	GL2014_002
Mental Health Triage Policy	PD2012_053
NSW Health Privacy Manual (Version 2)	PD2005_593
NSW Clinical Guidelines - For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (2008)	
Open Disclosure Policy	PD2014_028

APPENDIX B – NSW POLICE FORCE – FIREARMS REGISTRY

www.police.nsw.gov.au
ABN 43 408 613 180

NSW POLICE FORCE - FIREARMS REGISTRY

Disclosure of Information by Health Professionals

Section 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998*

Section 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998* protect disclosures of information to the NSW Commissioner of Police by health professionals where they are of the opinion that a person they are treating may pose a risk to public safety or to the person's own safety if in possession of a firearm or prohibited weapon. Of particular interest are high risk mental health patients known to have access to firearms.

Sections 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998* provide protection from civil or criminal liability, that may otherwise arise including a breach of confidentiality, when disclosing information to the Commissioner of Police.

A health professional, is defined in S79 of the *Firearms Act 1996* and for the purposes of section 38 of the *Weapons Prohibition Act 1998*, as any of the following persons: a medical practitioner, psychologist, nurse , social worker or professional counsellor.

PROCESS TO FOLLOW

1. Complete the form and Fax to: 0266 708558 and mark 'Attention - Team Leader Licensing', AND
2. Fax this form to the police station nearest the residential address of the patient. If you are unsure of the nearest police station, ring the Police Assistance Line on 131444.

PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH | TELEPHONE

HOME ADDRESS

Where is the patient currently located? eg inpatient, Accident and Emergency, at residential address etc.

If in hospital, anticipated date of discharge. To ensure safety issues can be addressed, please give at least 6 hours notice to Police. DATE OF DISCHARGE

ADDRESS WHERE PATIENT WILL BE DISCHARGED (if different from residential address).

Describe the circumstances that lead you to believe that the person may pose a threat if in possession of a firearm/prohibited weapon. Include relevant conversation, observations, circumstances, effect of medical condition or treatment on person's capacity etc.

Does the person have access to their own firearms/prohibited weapons? ☐ YES ☐ NO ☐ UNKNOWN

Does the person have access to other firearms/prohibited weapons? ☐ YES ☐ NO ☐ UNKNOWN

If 'YES' indicate below the address where the firearms/prohibited weapons are located?
For example, with friends, neighbours, spouse or other relative.

HEALTH PROVIDER INFORMATION

☐ Medical Practitioner ☐ Psychologist ☐ Reg/Enrolled Nurse ☐ Social Worker ☐ Counsellor

NAME | CONTACT NUMBER

SIGNATURE | DATE

Reporting Location (eg hospital, mental health hotline, private clinic, facility etc)

ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE

Vers 3.0 *February 2013*

APPENDIX C - ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF-HARM FACILITY CHECKLIST

All services should review the physical structure of the mental health inpatient unit to identify:

i. Any obstructions to the observation of high risk patients

ii. 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			
Bedroom and bathroom door handles and 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			

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 and return from any period of leave off the unit			
Further search of patient when there are grounds for suspicion			
Monitoring of items conveyed from relatives, friends and family to patients and information provided on the safety of items bought in to the unit.			
Access to areas of particular risk –bathrooms, kitchens, toilets			
Careful observation of cutlery, removal of linen from patients bedroom where there are concerns around self-harm, power cords, tools, plastic bags and any other potentially dangerous implements			
Incident reporting, investigating and reviewing			

Actions required to reduce risk:

Implementation procedure:

Completed by:

Name:

Signature:

Next Review Date/Time:

APPENDIX D - RECOMMENDED RESOURCES

Literature

Management of suicidal behaviour – a review of evidence for models of care: an Evidence Check rapid review Matheson SL, Shepherd AM, Carr VJ. Commissioned by the Mental Health Drug and Alcohol Office (MHDAO) NSW Ministry of Health and brokered by the Sax Institute (www.saxinstitute.org.au), March 2014. Available at https://www.saxinstitute.org.au/publications/management-of-suicidal-behaviour/

A series of three articles on suicide from **The Lancet Psychiatry,** Vol. 1 Issue 1 available online at http://www.thelancet.com/journals/lanpsy/onlinefirstt

- *The neurobiology of suicide*

  Prof Kees van Heeringen PhD a , Prof J John Mann MD b

  The Lancet Psychiatry 2014 Vol. 1 Issue 1; Pages 63 - 72, June 2014 doi: http://dx.doi.org/10.1016/S2215-0366(14)70220-2

- *The psychology of suicidal behaviour*

  Prof Rory C O'Connor PhD, Prof Matthew K Nock PhD The Lancet Psychiatry, June 2014 Vol. 1No. 1 pp 73-85.

  doi: http://dx.doi.org/10.1016/S2215-0366(14)70222-6

- *Effects of suicide bereavement on mental health and suicide risk*

  Dr Alexandra Pitman MSc[Econ], David Osborn PhD, Prof Michael King PhD, Annette Erlangsen PhD

  June 2014 The Lancet Psychiatry, Vol. 1 No. 1 pp 86-94 .doi: http://dx.doi.org/10.1016/S2215-0366(14)70224-X

Guidelines and Resources for mental health professionals

The 1800 011 511 NSW Mental Health Line

The 1800 011 511 NSW Mental Health Line aims to facilitate universal and equitable access to mental health care through a 24/7 mental health telephone triage, referral and advice service staffed by mental health professionals. The line is also a resource for service partners seeking advice about an individual's clinical symptoms, the urgency of their need for care and local treatment options. The 1800 011 511 number is accessible Australia-wide and links to LHD mental health telephone triage services.

Mental Health for Emergency Departments - A Reference Guide

Mental Health and Drug and Alcohol Office, NSW Ministry of Health. Sydney, Amended March 2015.

This Reference Guide is intended to assist emergency department staff and other clinicians in their care of people experiencing emergency mental health problems.This resource is a reference guide for clinicians working as first responders to mental health

presentations, particularly for emergency and acute presentations. The purpose of the guide is to provide practical guidance in the initial clinical assessment and management of mental health presentations. This Reference Guide builds upon the earlier versions of the reference guide (2001; 2002; 2009) and is available in electronic format at http://www.health.nsw.gov.au/mhdao/publications/Publications/mental-health-ed-guide.pdf

Clinical Practice Guidelines

Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm

Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm
https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_DSH-pdf.aspx

Framework for Suicide Risk Assessment and Management for NSW Health Staff

The Framework provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of generalist and mental health services to guide the suicide risk assessment and management process. The Framework is suite of resources released in 2005 and includes:

- Framework for Suicide Risk Assessment and Management for Health Staff
- Suicide Risk Assessment and Management – Emergency Department
- Suicide Risk Assessment and Management Protocols – General Hospital Ward
- Suicide Risk Assessment and Management Protocols – General Community Health Service
- Suicide Risk Assessment and Management Protocols – Community Mental Health Service
- Suicide Risk Assessment and Management Protocols – Mental Health In-Patient Unit

http://www.health.nsw.gov.au/mhdao/Pages/pubs-index-mh.aspx

SANE Australia – The Suicide Prevention and Recovery of Guide

The SANE Australia Suicide Prevention and Recovery Guide aims to help mental health professionals support people who are experiencing suicidal thoughts and behaviours – through the prevention of suicide, and in crisis management.

http://www.davcorp.com.au/media/20526/sane_australia_-_suicide_prevention_and_recovery_guide.pdf

Aboriginal and Torres Strait Islander mental health care

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed new online resources to support the work of health professionals and improve knowledge and understanding of Aboriginal and Torres Strait Islander mental health care.

The resources include a new Aboriginal and Torres Strait Islander mental health web page, as well as four competency based training and Continuing Professional

Development modules addressing key factors to be considered when working and engaging with Aboriginal and Torres Strait Islander peoples and/or communities.

The four e-learning modules are accessible online to College members and cover:

1) Interviewing an Aboriginal or Torres Strait Islander patient
2) Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient
3) Formulation of a case involving an Aboriginal or Torres Strait Islander patient
4) Review of a model of mental health service delivery in an Aboriginal or Torres Strait Islander community.

The resource is accessed at https://www.ranzcp.org/News-policy/News/New-resources-on-Aboriginal-and-Torres-Strait-Isla.aspx

Cultural Considerations & Communication Techniques: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person. Aboriginal Mental Health First Aid Training and Research Program. Melbourne: Mental Health First Aid Australia and beyondblue; 2008. This resource is accessed at https://mhfa.com.au/sites/default/files/AMHFA_Cultural_guidelines_email_2012.pdf

Resources for Aboriginal and Torres Strait Islanders

Finding your way back – A resource for people who have attempted suicide has been written to guide you through some of the physical, social and emotional issues that often come up after a suicide attempt.
http://resources.beyondblue.org.au/prism/file?token=BL/1289

Resources for Emergency Departments, Teachers, Communities

i. Mental Health for Emergency Departments A Reference Guide 2015

ii. *Seeking Solutions to Self-Injury: A Guide for Teachers.*

Martin, G., Hasking, P., Swannell, S., & McAllister, M. (2011)

Centre for Suicide Prevention Studies, The University of Queensland, Brisbane.
http://www.familyconcernpublishing.com.au/products-page/products/the-school-staff-guide-2nd-edition/

iii. *Seeking Solutions to Self-Injury: A Guide for Emergency Departments*

Martin, G., Swannell, S., Hasking, P., & McAllister, M. (2014)

Centre for Suicide Prevention Studies, The University of Queensland, Brisbane.

http://www.familyconcernpublishing.com.au/products-page/products/seeking-solutions-to-self-injury-the-emergency-staff-guide/

iv. *Conversations Matter*

Conversations Matter is a new suite of online resources developed to support community discussion about suicide. The resources provide practical information for communities and professionals to guide conversations about suicide. The professional resources have been developed in separate modules that provide advice about prevention-focussed conversations, intervention-focussed

conversations and postvention-focused conversations occurring in the community. http://www.conversationsmatter.com.au/professional-resources

Suicide Postvention Guidelines

A framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide (2010).South Australia: Government of South Australia, Department of Education and Children's Services. South Australia Department of Education and Children's Services, Catholic Education South Australia and Association of Independent Schools.
http://www.decd.sa.gov.au/docs/documents/1/SuicidePostventionGuide-1.pdf

Resources for individuals and families

i. Lifeline's 13 11 14
The NSW Government has extended and increased its support for Lifeline Australia with a $10.5 million funding commitment over four years (from 2015-16 to 2018-19) to support Lifeline NSW Centres to operate 24/7 crisis telephone service.

ii. beyondblue https://www.beyondblue.org.au/
A range of resources are available on the beyondblue website on suicide. This includes for individuals, families and friends, workplaces, schools and universities.

REFERENCES

[i] Matheson SL, Shepherd AM, Carr VJ. Management of suicidal behaviour – evidence of models of care: a rapid review. An Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health, March 2014. https://www.saxinstitute.org.au/wp-content/uploads/Management-of-suicidal-behaviour-evidence-for-models-of-care-a-rapid-review.pdf

[ii] ibid

[iii] ibid

[iv] ibid

[v] O'Connor, N. Warby, M. Raphael, B. Vassallo, T. (2004) Changeability, Confidence, Common Sense, Corroboration and Comprehensive Suicide Risk Assessment. Australasian Psychiatry, December, Vol 12, 4, p352-360.

[vi] Matheson SL, Shepherd AM, Carr VJ. Management of suicidal behaviour – evidence of models of care: a rapid review. An Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health, March 2014. https://www.saxinstitute.org.au/wp-content/uploads/Management-of-suicidal-behaviour-evidence-for-models-of-care-a-rapid-review.pdf

[vii] http://www.nice.org.uk/guidance/cg16/resources http://www.nice.org.uk/guidance/cg16/resources/cg16-selfharm-the-treatment-and-management-of-selfharm-in-emergency-departments

[viii] While D, Bickley H, Roscoe A, Windfuhr K, Rahman S et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study. Lancet 2012;379(9820):1005–1012.

[ix] Suicide Risk Assessment and Management Protocols : Mental Health In-Patient Unit SHPN: 040183 ISBN: 0 7347 3720 3 from the Framework for Suicide Risk Assessment and Management for NSW Health Staff SHPN (MH) 040184, ISBN 0 7347 3721 1