Clinical care of people who may be suicidal

Summary To direct NSW Mental Health Services to implement processes consistent with the requirements of this Policy Directive to ensure the provision of timely evidence-based, minimum standards for the clinical care of people who may be suicidal.

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Secretary, NSW Health

NSW Health

POLICY DIRECTIVE

Clinical care of people who may be suicidal

POLICY STATEMENT

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

The requirements of this Policy Directive apply specifically to the specialist mental health workforce providing clinical care across community, inpatient and emergency settings and in collaboration with other health professionals and the individual's support network.

SUMMARY OF POLICY REQUIREMENTS

NSW Mental Health Services are to implement processes consistent with the requirements of this Policy Directive to ensure the provision of timely evidence-based clinical care of people at risk of suicide in NSW Health services.

All NSW Health staff have a role in identifying and responding to people who may be suicidal.

Local Health District and Specialty Health Network Chief Executives and Health Service Executives need to assign responsibility, personnel and resources to implement and provide line managers with support to mandate this Policy in their areas.

Ensure that local protocols are in place in each facility to support implementation and ensure that all mental health service staff are aware of the requirements.

NSW mental health services and clinicians are to meet minimum standards for the clinical care of people who may be suicidal which includes the key components of:

- Identification: the early identification of suicide risk, including subsequent triage and interim observational management followed by timely and appropriate referral for further assessment.
- Assessment: the comprehensive mental health assessment of people presenting with, or identified as possibly having, suicidal thoughts or behaviour. Assessment includes but is not limited to appropriate supervisory consultation and documentation of mental state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and any other actions and precautions taken as an outcome of those assessments.
- Formulation: synthesising and documenting information collected during the assessment to develop an understanding of the person and their circumstances to inform care planning such as appropriate interventions and treatment.

- Brief intervention: activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk.
- Treatment: refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan, in consultation with the person and their support system.
- Transition and discharge: Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality as these stages represent times of potential increase in suicide risk.

Processes and protocols for the clinical care of people who may be suicidal are to align with requirements for incident management, open disclosure and mental health clinical documentation where applicable.

Local Health District and Specialty Health Network policies, procedures and standards need to be developed in consultation with the Mental Health Branch, NSW Ministry of Health to ensure they are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document.

Health services are to ensure that all staff undertake appropriate education and training.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2022_043 September-2022	A/Deputy Secretary, Health System Strategy and Planning	Updated policy directive to incorporate current evidence and key revisions that align with Towards Zero Suicides. This policy reinforces the emphasis on comprehensive assessment and broadens the focus on provision of care to all people presenting to health services who may be suicidal.
PD2016_007 March-2016	Deputy Secretary, Strategy and Resources	Updated policy directive This policy is targeted towards mental health services and clinicians in suicide prevention.
PD2005_121 January-2005	Director General	New policy directive

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1. BACKGROUND

Suicide prevention is everyone's business, and all NSW Health staff have a role to play. It is important that all health staff can identify people at risk of suicide, take action that may prevent suicide deaths and implement management strategies, including referral to relevant services for further assessment and expert supports.

This Policy has been specifically developed for the specialist mental health workforce providing care across community, inpatient and emergency settings, in collaboration with other health professionals and the individual's support network.

Mental health clinicians may work in emergency departments, mental health telephone triage services, community mental health services, mental health inpatient facilities and general health facilities. When care is provided by community teams this will extend to other settings such as the home, school, aged care facilities and other community settings.

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

Non-clinical mental health staff and supports also have a vital role to play in comprehensive and effective suicide prevention in the health system.

In 2020 NSW Health instituted the Zero Suicides in Care Initiative, informed by the Zero Suicide Healthcare Framework which identified that evidence-based practices can be applied across the elements of suicide care, supported by leadership, training and ongoing improvement. The Zero Suicide Healthcare Framework includes an aspirational goal of eliminating suicide deaths, implemented within a safety culture that supports consumers, family, carers and staff to heal following critical incidents.

Consistent with Zero Suicides in Care, NSW mental health services[1]:

- Lead system-wide culture change committed to reducing suicides:

  Supporting the development of organisations that demonstrate leadership, providing tangible supports to staff, promoting a culture of restorative justice and learning, and ensuring people with lived experience co-design the development and evaluation of the program.

- Train a competent, confident, and caring workforce:

  Commitment to the ongoing development of all mental health staff utilising local and state-wide resources and ensuring that all staff, both clinical and non-clinical, are able to engage with people who may be suicidal.

- Care for all people presenting to mental health services:

  Responding to the needs of people at risk of suicide in a manner that is caring, compassionate, trauma-informed, culturally responsive, respectful, and non-judgmental.

- Improve policies and procedures through continuous quality improvement:

Organisations collect data and evaluate clinical outcomes and the effect of training and clinical model change through continuous quality improvement in a safety oriented and supportive culture.

1.1. Principles of care

Building positive therapeutic engagement with a person who is experiencing suicidal ideation is essential for compassionate clinical care for people who may be suicidal at all stages of suicide care. Research shows a strong link between the quality of the therapeutic relationship and therapeutic outcomes[2].

An empathetic and compassionate approach by the clinician will build important trust and rapport. A good therapeutic relationship includes trust, care and respect, agreement on the goals of care, and collaboration on the care plan and tasks to be undertaken.

Compassionate care of people who may be suicidal is also culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed (including recognising the potential of mental health service environments and interventions to cause or compound trauma), and evidence-based.

1.2. About this document

This Policy Directive establishes minimum standards that NSW mental health services and mental health clinicians are required to meet; in the identification of people who may be suicidal, and the assessment and treatment of people with suicidal thoughts and behaviour within NSW Health care settings.

This Policy reinforces the emphasis on comprehensive assessment and broadens the focus on provision of brief interventions to all people presenting to health services who may be suicidal and, where appropriate, providing advice about or referral to appropriate clinical and non-clinical services within or outside of NSW Health.

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 roles and responsibilities of mental health services and clinicians to inform local policies and procedures
- Support a consistent and coordinated evidence-informed approach to the application of clinical guidelines and training.

1.3. Key definitions

Carer	An individual who provides care and support to a family member or friend who lives with a disability, mental illness, alcohol or drug dependency, chronic condition, terminal illness or who is frail due to age.

Culturally responsive	Culturally responsive services and staff are self-aware, respectful of all cultures, and actively respond to the cultural needs and strengths of all people, paying particular attention to social and cultural factors in managing therapeutic encounters and providing culturally safe care environments.
Cultural safety	Cultural safety requires healthcare professionals and their healthcare organisations examine the potential impact of their own culture on service delivery. Healthcare professionals and organisations are required to acknowledge and address their biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care. Cultural safety encompasses a critical consciousness with ongoing self-reflection, self-awareness and accountability for providing culturally responsive care, as defined by consumers and their communities, and as measured through progress towards achieving health equity. Cultural safety has universal application but is most important in the Australian context for Aboriginal and Torres Strait Islander people.
Evidence-based care	Healthcare practice that involves integrating the best available research evidence with clinical knowledge and expertise, while considering consumers unique needs and preferences.
Family	'Family' has different meanings for different people, and customs for parenting, marriage and kinship vary across cultures and societies. Family usually means two or more people with shared ancestry or enduring legal or cultural ties to each other and may encompass any significant person including partners, parents, children, grandparents, siblings, extended family and others significant to the person.
Mental Health Clinician	A person who provides evidence-based, clinical care for mental health, including medical practitioners, nurses and allied health clinicians.
Mental health service	Any specialised mental health service within NSW Health or funded by NSW Health, including clinical and non-clinical care services and settings.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception, or memory.
Mental State Examination	An examination used to gain an understanding of a persons psychological functioning at a particular point in time including but not limited to consideration of appearance and behaviour, speech, mood, affect, thought, perception, cognition, insight and judgement.

Non-clinical care services and settings	Mental health services that predominantly or exclusively provide non-clinical care and support, such as Safe Havens.
Peer worker	A staff member who has personal, lived experience of mental illness or suicide, and recovery, or of supporting family or friends with mental illness or suicidality. This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.
Person-centered care	Care that is respectful of, and responsive to, the preferences, needs and values of the individual patient.
Priority populations	Population subgroups identified as having a risk of suicide or self-harm that is higher than that of other populations, the impact on the community is different or they have specific requirements for culturally appropriate suicide prevention or postvention services.
Psychosocial history	An evaluation of the patient that includes a history of psychiatric illness, developmental history, educational history, marital and family life, and employment history.
Recovery	From the perspective of the individual, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.
Recovery-oriented care	The application of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.
Restorative justice	A process to involve, to the extent possible, those who have a stake in a serious adverse incident and collectively identify and address harms, needs and obligations in order to heal and put things as right as possible.
Restorative, just and learning culture	A culture within a mental health setting of restorative justice and forward-thinking accountability that is non-blaming, supports healing for consumers, families and staff, and ensures learnings are translated into actions to improve systems of care.
Risk stratification	A systematic process to classify patients who are at risk of suicide, and inform interventions offered. This is not the current best practice approach; mental health services and clinicians are to offer treatment for the individual based on comprehensive individual assessment.

Safety planning intervention	A collaborative process with the person, clinician and family and carers that leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis.
Self-harm	Any behaviour that involves the deliberate causing of pain or injury to oneself.
Suicide	An act of intentionally terminating one's life.
Suicide attempt	Self-initiated, potentially injurious behaviour with the intent to die, but does not result in a fatal outcome.
Suicide prevention	An approach that aims to decrease the number of people who die by suicide or attempt suicide, focusing on reducing risk factors in individuals for suicide and enhancing available resources that prevent suicide and suicidal behaviour.
Suicide risk factors	Biological, psychological and social factors that are associated with an increased risk of suicide, including modifiable and non-modifiable risk factors.
Suspected suicide	The term used until the Coroner has made the determination the death was suicide.
Trauma-informed care	An approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.

1.4. Implementation

Local Health District and Specialty Health Network Chief Executives and 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 that all mental health service staff are aware of the requirements of this Policy
- Ensure mental health clinicians undertake training in assessment and management of suicidality
- Work together with the Mental Health Branch, NSW Ministry of Health to ensure Local Health District and Specialty Health Network policies, procedures and standards are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document

- Comply with this Policy including role modelling behaviours consistent with a restorative just culture.

Implementation of this policy is to be supported by:

- Integration of peer workers across clinical settings, as well as establishing care pathways and collaborative approaches between clinical and non-clinical services
- Consultation and partnerships with Aboriginal mental health workers and community
- Co-design approaches, where appropriate.

1.5. Legal and legislative framework

The NSW Health Legal Compendium contains the full list of NSW Health legislation, policy directives and guidelines and are to be referred to for a complete list of relevant Policy Directives and Guidelines and the most up to date version of all documents.

1.5.1. NSW Legislation

- *Children and Young Persons (Care and Protection) Act 1998* (NSW)
- *Disability Inclusion Act 2014* (NSW)
- *Guardianship Act 1987* (NSW)
- *Health Administration Act 1982* (NSW)
- *Health Administration Regulation 2020* (NSW)
- *Health Care Complaints Act 1993* (NSW)
- *Health Records and Information Privacy Act 2002* (NSW)
- *Health Records and Information Privacy Regulation 2022* (NSW)
- *Health Services Act 1997* (NSW)
- *Mental Health Act 2007* (NSW)
- *Privacy and Personal Information Protection Act 1998* (NSW)

1.5.2. Key policy directives and guidelines

- NSW Health Policy Directive *Mental Health Triage Policy* (PD2012_053)
- NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025)
- NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).
- NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045)
- NSW Health Policy Directive *Seclusion and Restraint in NSW Health Settings* (PD2020_004)

- NSW Health Policy Directive *Incident Management* (PD2020_047)
- NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039)

Refer to the NSW Health Legal Compendium, Mental Health for additional relevant Policy Directives and Guidelines.

2. WORKING WITH DIVERSE PEOPLE AND SPECIFIC NEEDS

Clinical care of people who may be suicidal needs to be respectful of, and responsive to, the preferences, needs and values of the individual person. This includes consideration of the whole person, including factors such as their culture, language, age, gender identity, sexual orientation, physical and mental health and abilities, occupation, socioeconomic status, and geographic location, and modifying approaches where appropriate.

All NSW Health mental health services are to ensure:

- Locally developed protocols are in place that respect diversity and guide the delivery of care that is person-centered, respectful, trauma-informed, culturally responsive and appropriate to the local population and context
- All mental health service staff complete appropriate training for working with culturally, socially and linguistically diverse people and priority populations
- All mental health services are delivered in culturally safe service environments with access to Indigenous and/or culturally responsive non-Indigenous staff
- All consumers, families and carers who do not speak English as a first language, or who are deaf have access to professional healthcare interpreters in accordance with the NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).

All mental health clinicians have the responsibility to ensure a person's social and cultural context and identity is considered and respected when developing care plans, providing interventions, engaging with families, carers and support networks, and when connecting a person with healthcare supports including peer workers and Aboriginal health workers.

Different characteristics of the individual's need are to be considered together, as many people may belong to more than one diverse or cultural group and this intersectionality can lead to different needs and experiences within healthcare[3].

3. IDENTIFICATION

All NSW Health staff have a role to play in the early identification of suicide risk, which can occur:

- In any part of the health system, including where health services are provided in the home or community
- As part of structured screening in health services which may include use of screening tools to increase early identification of suicidal risk beyond self-disclosure or clinical judgement (noting that screening tools alone must not be used to assess risk or determine treatment)[3, 4].

- At any stage of an individual's interaction with health and mental health services.

All mental health services are to:

- Ensure locally developed protocols are in place that support:
    - Appropriate and timely triage of persons experiencing suicidality and interim observational management pending referral to mental health services
    - Staff to ask people directly about their suicidal ideation, as many people do not talk about suicidal thoughts and plans unless asked directly[5]
    - Establishment of referral pathways to assist in early identification and access to care for people with suicidal behaviour or ideation.
- Provide guidance to staff regarding expected processes for identifying emergent suicidal ideation during care.

The NSW Health Policy Directive *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 express self-harm ideation.

4. ASSESSMENT

All mental health clinicians undertaking assessment are to:

- Provide clinical management and care in accordance with the *Mental Health Act 2007* (NSW)
- Undertake a comprehensive mental health assessment with people presenting with, or identified as possibly having, suicidal thoughts or behaviour, and seek supervision and support in this responsibility where appropriate
- Ensure clinical records document ongoing mental health state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and actions and precautions taken as an outcome of those assessments
- Include consultation with supervisors and the person's key carer network where management plans change to support ongoing communication across the care and social support systems
- Complete a NSW Police Force Firearms Registry Disclosure of Information by Health Professionals Form if the person is known to have access to a firearm, and there is an assessed level of risk of harm to self or others.

A comprehensive mental health assessment:

- Is an opportunity to build therapeutic engagement and show compassion and understanding
- Is based on a comprehensive clinical interview conducted by the mental health clinician/s in collaboration with the person at risk of suicide and their family and carers. Corroborative history is to be obtained whenever possible

- Includes assessing suicidal thoughts and behaviour, medical and psychiatric history, psychosocial history, life stressors, drug and alcohol history including current use and withdrawal status, presence of risk factors for suicide including current access to lethal means, a person's strengths and protective factors, and available supports and ability to recover in the community
- Includes review of current care levels, engagement and observation or status in the community
- Includes a Mental State Examination (MSE)
- Is to be sensitive to the distress of the person and the fact that assessment involves significant disclosure. This must be carried out in a manner that is culturally safe, recovery-oriented and trauma-informed
- Focuses on treatment planning and risk minimisation, not prediction or risk stratification
- Provides an understanding of the person at a point in time. This understanding will evolve and be reviewed over time.

A further comprehensive mental health assessment may be required to reassess a person's suicide risk and planned care, particularly in response to any changes in personal circumstances or care needs.

5. FORMULATION

Formulation is the process of synthesising information collected during an assessment to develop an understanding of a person and their circumstances and informs care planning.

When a person is identified as having suicidal ideation, mental health clinicians must undertake suicide prevention formulation. Suicide prevention formulation is relevant to a person's suicide risk. It aims to capture how a person's history and context interact to produce and mitigate suicide risk.

A person-centered suicide prevention formulation provides the best way to ensure that the most effective care can be tailored to a person's needs and the process includes:

- Considering the suicide risk factors a person presents, as identified in the comprehensive assessment
- Identifying which risk factors are modifiable and can be addressed
- Determining the nature of an individual's internal coping resources and how they can be strengthened
- Detailing the external resources available to help a person navigate distress such as family, social network, professional supports or wider community
- Considering the changeability of the current situation including factors internal to the person, potential changes in important relationships and external factors that could rapidly escalate risk

- Consulting and collaborating with colleagues, including advice sought from senior colleagues, particularly where the decision is made not to admit someone to a mental health inpatient unit where ongoing suicidality is identified.

The suicide prevention formulation provides the basis for the safety plan and, where appropriate, a comprehensive care plan. Suicide risk formulations are reviewed regularly and updated with any significant changes in presentation, context or availability of support.

Suicide prevention formulation is documented in the electronic medical record system (eMR).

Most people requiring ongoing mental health care will require a comprehensive mental health formulation in addition to a suicide risk formulation.

6. BRIEF INTERVENTION

Brief interventions refer to activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk. Brief interventions can be used early in the therapeutic engagement process – as early as first contact. This enables timely support to be provided and immediate needs to be addressed, while also promoting ongoing engagement with care.

Brief intervention is to be outlined in a safety plan that incorporates the following activities routinely used when a person is identified with suicidal risk:

- Address access to lethal means
- Provide education and information to the person, and their family and carers
- Identify contingency plans in the event of acute deterioration using an agreed escalation process
- Where appropriate, identify non-clinical services within and outside of NSW Health where the person may be able to access support in future crisis or receive short term support to address interpersonal or social factors contributing to the suicidal crisis.

A safety planning intervention is a collaborative process with the person and clinician and family and carers wherever possible. The intervention leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis. The safety planning intervention is to include identification of warning signs, internal coping strategies, identification of social contact that may distract from suicidal thoughts, access to social supports to help resolve the crisis, professional supports and counselling on access to lethal means. Clear actions and roles and responsibilities for addressing access to lethal means are also be agreed upon in this process.

The safety plan is to be put in place as early as possible and reviewed regularly as circumstances change, including after a crisis or suicide attempt.

In addition to the person having a copy of the safety plan, a copy must be documented in the electronic medical record (eMR) system in accordance with the requirements for clinical documents.

7. TREATMENT

All people who are identified as requiring ongoing clinical care in NSW specialist mental health services are to address the risk of suicide, require a comprehensive care or treatment plan. The plan is to be developed in collaboration with the person, their family, carers and key supports. Treatment refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan that:

- Addresses modifiable risk factors
- Mitigates the impact of long-standing risk factors
- Consolidates and builds on a person's strengths and available resources.

Modifiable risk factors include mental illness (mood disorders, psychosis, anxiety disorders, bipolar disorder, eating disorders), impact of past trauma, substance misuse, pain, physical illness, isolation, unemployment and factors related to social and cultural networks.

Suicidal thoughts can be treated directly using evidence-based treatment models known to specifically reduce suicidality.

Ongoing management of a person's mental health and/or suicidal risk requires mental health clinicians regardless of their setting to:

- Prioritise the safety and wellbeing of the person at risk of suicide and NSW Health staff
- Consider decisions about care and treatment in accordance with the *Mental Health Act 2007* (NSW), including that:
    - 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 obtain the person's consent and to involve them in treatment and recovery planning, considering their capabilities, preferences, views and expressed wishes
    - The views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about the person
- Ensure care in a public health facility includes a safe physical environment
- Routinely consider a person's cultural context and identity, and how this may influence suicidality and pathways to recovery
- Regularly reassess the person noting that suicidal risk can fluctuate with both deterioration and improvement in overall mental state
- Review the treatment plan regularly along the care pathway, including transition points or when the context or other factors change.

8. TRANSITION OF CARE AND DISCHARGE

Transitions of care and discharge represent times of potential increase in suicide risk[6].

Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality. Follow-up arrangements must consider factors such as the person's age, cultural identity, geographic location, diagnosed mental illness, access to communication technology, domestic situation and support networks[3].

All mental health clinicians regardless of their setting are to:

- Ensure the requirements outlined in the NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045) are followed for the care of people with suicide risk
- Review and update assessments and care plans at points of significant transitions in care
- Conduct warm handover to other service providers that combines written referrals with a person-to-person discussion using a consistent format such as ISBAR (Introduction, Situation, Background, Assessment, Recommendation)
- Follow up within 24-48 hours of transition of care where possible or as agreed in the care plan based on clinical need and the person's individual circumstances, and document accordingly
- 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 and ideally within 72 hours, or within a maximum of 7 days.
- At each transition point, ensure accurate and up to date contact details for the person, their next of kin or carer, and their general practitioner are recorded in the person's electronic medical record (eMR).

8.1. Discharge

Discharge planning is a collaborative process involving the person and their family or carers. Discharge planning commences on entry to the service.

Safe discharge from an acute inpatient care unit requires mental health clinicians to deliver assertive and coordinated follow-up through direct contact as soon as possible following discharge. 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. Ongoing care options include:

- Community mental health services
- The person's general practitioner
- Inpatient and community private sector care
- Non-clinical services such as The Way Back Support Service
- Drug and Alcohol Services.

Discharge from the mental health service must be accompanied by:

- Written details of discharge plans including referrals to other treatment teams, such as general practitioners or non-clinical assertive follow-up supports provided to the person

- Information about how the person or their family/carers can escalate concerns about deterioration including access to the 24/7 Mental Health Line 1800 011 511.

8.2. Responding to people with ongoing suicidality

Mental health services are required to develop 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 are to involve all relevant parties, integrating clinical and non-clinical care and supports (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 suicidal ideation and assess the risk at each presentation
- Where available, refer to brief intervention models such as Project Air for more comprehensive care planning
- 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 and linkage to programs that promote emotional self-mastery and problem-solving skills.

9. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE

The NSW Health Policy Directive *Incident Management* (PD2020_047) outlines how services identify all people affected by suspected death by suicide including; consumers, carers and staff, the needs of those people, and who is responsible for addressing their needs.

A serious adverse event review (SAER) is required for suspected death by suicide of a person:

- Within an acute psychiatric unit or acute psychiatric ward
- Who has received care or treatment for a mental illness from the relevant health services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation
- Who is a NSW Health staff member.

All NSW Mental Health Services are to ensure:

- Effective local incident management systems are consistent with the NSW Health Policy Directive *Incident Management* (PD2020_047)

- Effective local open disclosure processes are consistent with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028), including the provision of ongoing support for families, carers and staff which is responsive to their needs and expectations, for as long as is required
- There are active measures to support their workforce and any staff member affected by a suicide death or suicide attempt is offered support from their team manager, clinical supervisor and the Employment Assistance Program (EAP).

All mental health clinicians regardless of their setting need to:

- Demonstrate compassion, openness, respect and empathy to the family and carers of a person who has died
- 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 NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- Advise any clinician (including private psychiatrists and general practitioners) or non-clinical psychosocial support service who has been managing care of the deceased in the community of the death as soon as possible.

10. CLINICAL SUPERVISON AND SUPPORT

All NSW Mental Health Services are to:

- Ensure clear local protocols are in place to support less experienced clinicians to seek advice from more senior clinicians regarding the clinical assessment or care of people who may be suicidal
- Ensure that mental health clinicians have access to appropriate clinical supervision, consultation or advice from a senior clinician at all times
- Recognise the ongoing impacts on clinicians and aim to mitigate times of high distress including anniversaries.

11. CLINICAL DOCUMENTATION

All NSW public mental health services are required to use available electronic medical record (eMR) systems for the documentation of clinical practice and care.

All NSW Mental Health Services need to ensure mental health clinicians complete training in mental health clinical documentation, and related eMR systems and processes.

All mental health clinicians regardless of their setting have a professional and legal responsibility to maintain clear, accurate and timely records and to document clinical practice and care as mandated in the NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039).

12. ENVIRONMENTAL HAZARDS

Mental health inpatient facilities are to remove or reduce environmental hazards for patients with suicidal behaviour and ideation.

All NSW Mental Health Services are to:

- Ensure respectful and trauma-informed development and implementation of standardised practices intended to improve patient safety, eliminate hazards and reduce the likelihood of adverse incidents occurring, including:
    - Ensuring each shift changeover incorporates assessment of environmental risks
    - Undertaking monthly 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
    - Ensuring strategies to monitor and prevent potentially dangerous items being brought into the inpatient unit by patients, family, carers or friends
    - 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
    - Designating a staff member responsible for undertaking the environmental audit which is to be dated, signed and retained as a formal record.

The *Access to Means of Suicide and Deliberate Self-Harm Facility Checklist* (appendix 16.1) has been developed to specifically address safety issues in mental health inpatient facilities.

Mental health inpatient units are also to ensure minimum standards of observation and engagement to manage the risk or concern of harm to a consumer or others, consistent with the NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025).

13. EDUCATION AND TRAINING

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

All NSW Mental Health Services are to ensure that:

- All mental health clinicians, regardless of setting, undertake training in identification and assessment of the person at risk of suicide, suicide risk formulation, safety planning, treatment and management
- All mental health service staff undertake appropriate training in culturally responsive practice and trauma-informed care.

All mental health clinicians, regardless of their setting, need appropriate education and training to:

- Understand current clinical and legal responsibilities in the delivery of mental healthcare
- Integrate the key principles of good clinical care in the delivery of clinical management and care of people with suicidal behaviour and ideation, including:

  - Empathetic and compassionate approaches
  - Building positive therapeutic engagement
  - Providing care that is culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed and evidence-based.
- 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
- Maintain competency in undertaking detailed evaluations of suicidal behaviour and ideation.

14. REFERENCES

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15. APPENDIX – ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF HARM CHECKLIST

This checklist may be used or adapted to assist with review of the physical structure of the mental health inpatient unit to identify:

- Any obstructions to the observation of high-risk patients
- Structures that could be used in suicide by hanging.

Inpatient units must remove (or make inaccessible) all likely ligature points

Safety risks are to be determined with reference to the workplace health and safety matrix as outlined in NSW Health Policy Directive *Enterprise-Wide Risk Management* (PD2022_023).

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Hanging points				
Non-collapsible curtain rails				
Non-collapsible bed frames				
Non-collapsible shower frames				
Internal piping				
Shower or bath fittings and curtains				
Exhaust fan				
Wardrobes and cupboards, including clothes rod				
Light fittings, ceiling fans and ceiling panels				
Bedroom and bathroom doors, hinges, door handles and knobs				
Windows, blinds and curtains				
Fire/duress alarms and signage				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Blind spots				
Corners				
Alcoves				
Under stairways				
Power-board rooms				
Other				
Access to facility and exit points				
Door security including use by non-regular staff				
Gate security including use by non-regular staff				
Garden fences and walls, including movable garden furniture/objects				
Air conditioning vents				
Other				
Hazards at exit points				
Consider potential access to busy roads, railway lines, rivers, oceans, cliffs and other hazards				
Poisonous substances kept in locked cupboard or storeroom				
Medication				
Reagents				
Cleaning fluids				
Any other hazardous material				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Windows – structure and design				
Are windows made of full glass, meshed glass or small panes				
Safety policy and procedures				
Search of patient on admission				
Leave plans include search on return relevant to risk assessment				
Further search of patient (where permissible) when there are grounds for suspicion				
Monitoring of items conveyed from 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				
Removal of linen from patient's bedroom where there are concerns around self-harm				
Careful observation of: - cutlery, including plastic cutlery - tools - power cords, phone chargers - plastic bags - any other potentially dangerous objects				
Incident reporting, investigating and reviewing				

Actions required to reduce risk:

Implementation procedure:

Completed by:	Name:	
	Signature:	
Next review date and time:		