NSW HEALTH

Framework for Suicide Risk Assessment and Management

for NSW Health Staff

Contents

Related documents

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

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

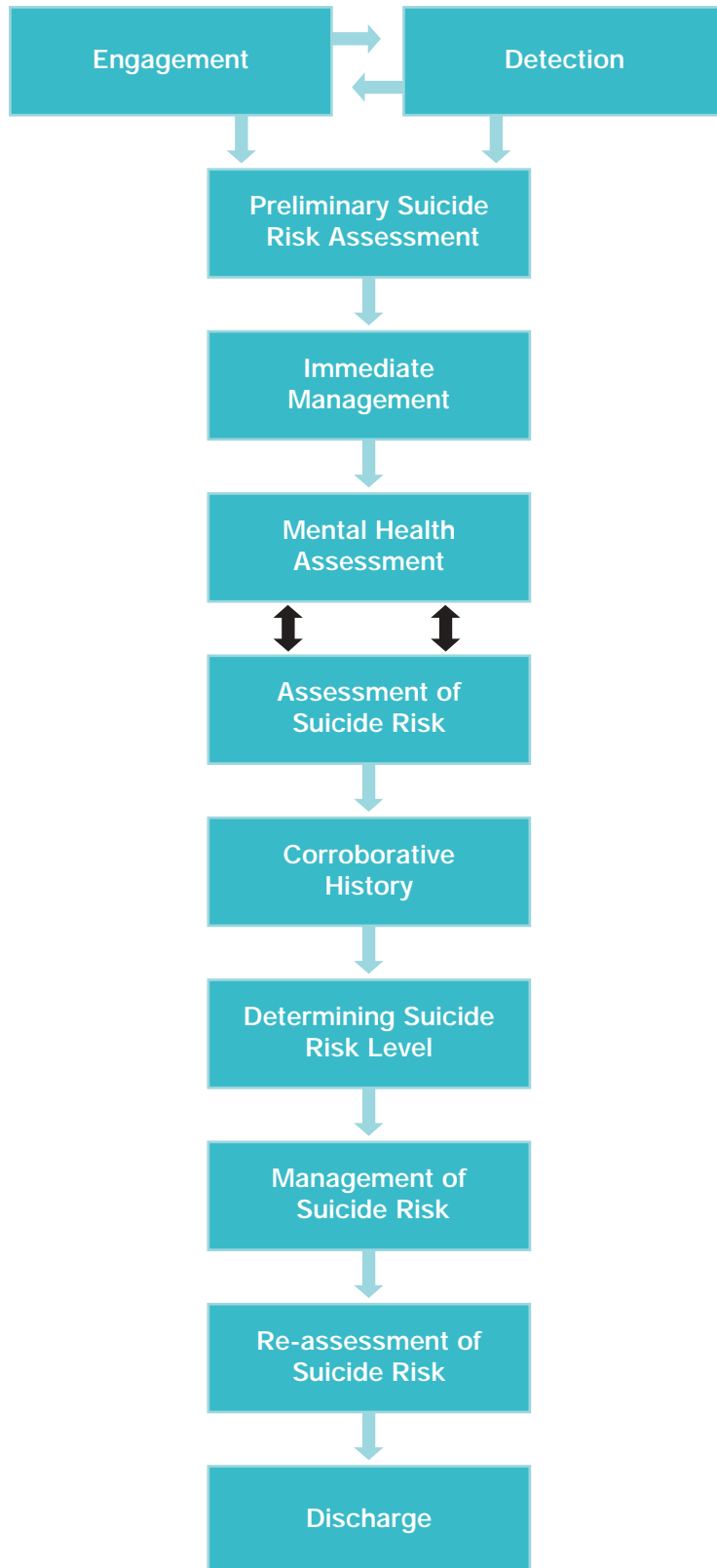Suicide Risk Assessment and Management Protocols: General Community Health Service – SHPN (MH) 040187

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Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit – SHPN (MH) 040183

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Framework for Suicide Risk Assessment and Management for NSW Health Staff

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Executive summary

The *Framework for Suicide Risk Assessment and Management for NSW Health Staff* is a key component of 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 is relevant to all health settings. It 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 has been developed to link with the NSW Health Mental Health – Outcomes and Assessment Tools (MH-OAT) comprehensive mental health assessment and management protocols (only applicable to mental health services). It is also linked to the NSW Health *Discharge and Follow Up Protocols for NSW Mental Health Services and Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities.*[2]

People with possible suicidal behaviour must receive preliminary suicide risk assessment and, where appropriate, a referral for a comprehensive mental health assessment including a detailed suicide risk assessment. The goal of a suicide risk assessment is to determine the level of suicide risk at a given time and to provide the appropriate clinical care and management. Assessment is a continuing process occurring along a pathway of care from the person's first presentation to a health service, through to the provision of treatment leading to discharge.

The assessment and management of suicide risk is conducted within a collaborative partnership between the relevant health services, the person at risk of suicide and their family.

Suicide risk assessment generates a clinician rating of the risk that the person will attempt 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. The level of changeability of the person and the confidence of the clinician in the assessment rating are also taken into account.

There are circumstances where generalist health staff and services will conduct comprehensive suicide risk assessments and be responsible for the ongoing management of people at risk of suicide. These services may include Sexual Assault, Sexual Health, Drug and Alcohol and Generalist Counselling services. The type and level of services provided will depend on the skill and competency of the health worker.

HIGH RISK or HIGH CHANGEABILITY and/or LOW ASSESSMENT CONFIDENCE

The clinician ensures that the person is in an appropriately safe and secure environment. The clinician organises re-assessment within 24 hours, and ongoing management and close monitoring are indicated. Contingency plans are in place for rapid re-assessment if distress or symptoms escalate.

MEDIUM RISK

Significant but moderate risk of suicide. The clinician ensures that a person at this level of risk receives a re-assessment within one week and contingency plans are in place for rapid re-assessment if distress or symptoms escalate.

LOW RISK

Definite but low suicide risk. The clinician considers a person at this level of risk requires review at least monthly. The timeframe for review should be determined based on clinical judgment. **After discharge from an in-patient unit, the review is to be conducted within one week**. The person at risk should be provided with written information on 24-hour access to suitable clinical care.

NO (FORESEEABLE) RISK

Following comprehensive suicide risk assessment there is no evidence of current risk to the person. There are no thoughts of suicide or history of attempts and they have a good social support network.

Changeability

Changeability of risk status, especially in the immediate period, should be assessed and **high changeability** should be identified. When high changeability is identified the clinician recognises the need for careful re-assessment and gives consideration as to when the re-assessment should occur, eg within 24 hours. 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**:

■ factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage

■ factors in the social environment, such as impending court case, divorce with child custody dispute

■ factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

When there is low assessment confidence the clinician recognises the need for careful consideration of when re-assessment should occur, eg within 24 hours. A more vigilant management is adopted with respect to safety of the person in the light of the gaps in information or rapport.

The *Framework for Suicide Risk Assessment and Management for NSW Health Staff* outlines a comprehensive framework to guide the suicide risk assessment and management process. The framework contains the standards of practice that must be implemented in key treatment settings throughout all health services. This framework includes specific

protocols that describe the responsibilities and requirements for health professionals in the generalist health and specialist mental health settings in the assessment and management of suicide risk. Specific protocols have been developed for the following settings or groups:

■ Emergency Department

■ General Hospital Ward

■ General Community Health Service

■ Community Mental Health Service

■ Mental Health In-Patient Unit

■ Justice Health Service Long Bay Hospital.

The framework was developed following an extensive review of the literature and consultation with recognised experts in the field. It represents the essential components for best practice in the assessment and management of suicide risk.

The framework aims to assist clinicians to:

■ cover specific components of assessment of suicide risk

■ adopt a reflective practice style in which clinicians are encouraged to consider the quality of the assessment in relation to:

– the likelihood of the person's suicide risk changing in the next 24 hours

– the clinician's assessment of the quality of the alliance with the person

– the clinician's confidence that he/she has all the required information

■ consider the most appropriate management plan given the current level of suicide risk assessed

■ plan when to review the suicide risk with the person.

Introduction

Suicide prevention is the concern of all health workers and the whole community. Health workers play a key role in early detection and intervention with people who are at risk of suicide.

Suicidal behaviour is complex and despite the best available expertise and exemplary care, some individuals will go on to suicide. There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.[3, 4, 5] 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. The aim of this document is to assist health staff to make informed judgments about risk by providing a framework and information on good practices.

Team management is central to effective management of a person at risk of suicide. In particular, transitions in care can be highly vulnerable periods in the management of a person at risk. Clear, concise documentation of assessments, including observations and clinical decisions, is the most helpful process to assist in good team management. Where a clinician remains uncertain after a clinical assessment, it is important to consult with a senior colleague.

The *Framework for Suicide Risk Assessment and Management for NSW Health Staff* outlines a comprehensive framework to guide the suicide risk assessment and management process. The framework contains the standards of practice that must be implemented in key treatment settings throughout all health services. This framework describes the responsibilities and requirements for health professionals in the generalist health and specialist mental health settings in the assessment and management of suicide risk. Additional specific protocols have been developed for the following settings or groups:

- Emergency Department
- General Hospital Ward
- General Community Health Service
- Community Mental Health Service
- Mental Health In-Patient Unit
- Justice Health Service Long Bay Hospital.

In general:

- Clear concise documentation of observations, results of examination and clinical decisions are the most helpful process to assist management of an individual by a team.

- If you remain uncertain after a clinical examination, it is best to consult with a colleague and share your uncertainty. Consultation up the seniority chain can be a significant help.

- Teamwork is central to good management and care of a person at risk of suicide.

- Transitions in care are vulnerable times for any team.

Framework for Suicide Risk Assessment and Management for NSW Health Staff

The Framework for Suicide Risk Assessment and Management for NSW Health Staff (Figure 1 opposite) was developed following an extensive review of the literature and consultation with recognised experts in the field. It represents the essential components for best practice in the assessment and management of suicide risk.

The framework aims to assist clinicians to:

- cover specific components of assessment of suicide risk

- adopt a reflective practice style in which clinicians are encouraged to consider the quality of the assessment in relation to:

  – the likelihood of the person's suicide risk changing in the next 24 hours

  – the clinician's assessment of the quality of the alliance with the person

  – the clinician's confidence that he/she has all the required information

- consider the most appropriate management plan given the current level of suicide risk assessed

- plan when to review the suicide risk with the person.

Health workers in general hospital and general community health settings will not always be required to complete every step in the assessment process. At a minimum, generalist health staff are required to conduct a preliminary suicide risk assessment to determine the current level of risk prior to making a referral to a mental health service or other specialist clinician or practitioner, for example, a private psychiatrist. The components of a suicide risk assessment relevant to general health staff include engagement, detection, preliminary suicide risk assessment and immediate management.

The role of NSW Health clinicians

Risk detection

Suicide prevention is the concern of all health workers and the general community. Health workers play an important role in suicide risk detection and subsequent management or referral to appropriate, specialist services. All people for whom a suicide risk is detected should receive a comprehensive suicide risk assessment.

Preliminary suicide risk assessment

All clinical health staff who come into contact with people detected to be at risk of suicidal behaviour must be able to perform a preliminary suicide risk assessment. This includes assessment of the person's physical condition, previous suicide attempts, alcohol and other drug use, current mental state, history of mental illness, psychosocial factors and determination of current risk of suicide.

Comprehensive mental health assessment

All people at risk of suicide are to receive a comprehensive mental health assessment that includes a psychiatric assessment, psychosocial assessment and a corroborative detailed suicide risk assessment. In some settings and services, comprehensive suicide risk assessment may be conducted by generalist health professionals in consultation with, and with back-up from, a specialist mental health service.
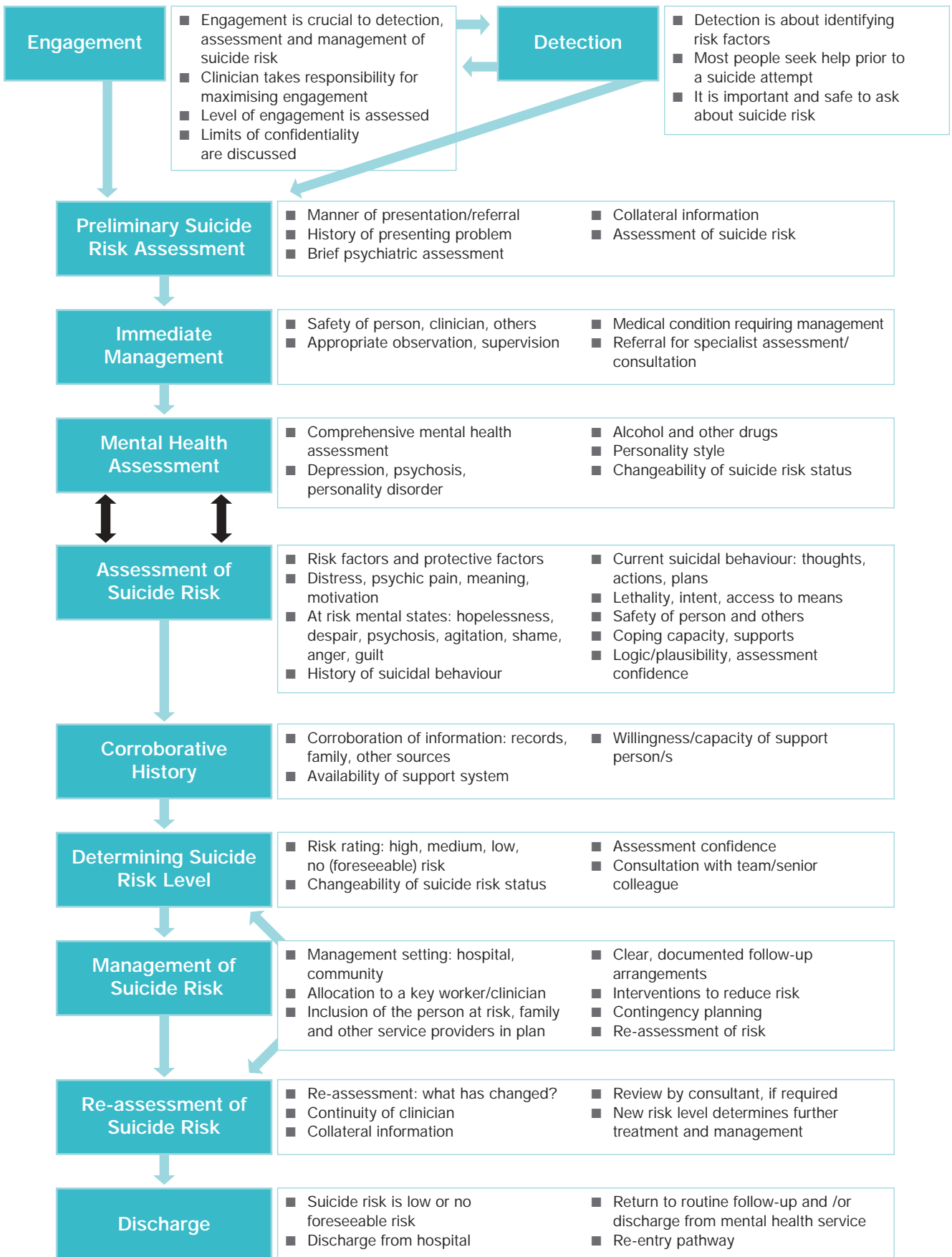
Regular and ongoing assessments

Suicide risk is a dynamic, changing phenomenon. Therefore, risk assessment needs to be an ongoing process continuing from triage, through assessment, review and discharge.

Documentation

A thorough, well-documented assessment and management plan is essential to the effective management of suicide risk and is to be documented in the person's medical record. For mental health services, documentation must be completed using the Mental Health – Outcomes and Assessment Tools (MH-OAT) Clinical Modules. Care must be taken to ensure the person's privacy and confidentiality with respect to any sensitive information contained in the documentation of the assessment.

Figure 1: Framework for Suicide Risk Assessment and Management for NSW Health Staff

Engagement	
	■ Engagement is crucial to detection, assessment and management of suicide risk ■ Clinician takes responsibility for maximising engagement ■ Level of engagement is assessed ■ Limits of confidentiality are discussed

Detection	
	■ Detection is about identifying risk factors ■ Most people seek help prior to a suicide attempt ■ It is important and safe to ask about suicide risk

Preliminary Suicide Risk Assessment	
	■ Manner of presentation/referral ■ Collateral information ■ History of presenting problem ■ Assessment of suicide risk ■ Brief psychiatric assessment

Immediate Management	
	■ Safety of person, clinician, others ■ Medical condition requiring management ■ Appropriate observation, supervision ■ Referral for specialist assessment/consultation

Mental Health Assessment	
	■ Comprehensive mental health assessment ■ Alcohol and other drugs ■ Depression, psychosis, personality disorder ■ Personality style ■ Changeability of suicide risk status

Assessment of Suicide Risk	
	■ Risk factors and protective factors ■ Current suicidal behaviour: thoughts, actions, plans ■ Distress, psychic pain, meaning, motivation ■ Lethality, intent, access to means ■ At risk mental states: hopelessness, despair, psychosis, agitation, shame, anger, guilt ■ Safety of person and others ■ Coping capacity, supports ■ Logic/plausibility, assessment confidence ■ History of suicidal behaviour

Corroborative History	
	■ Corroboration of information: records, family, other sources ■ Willingness/capacity of support person/s ■ Availability of support system

Determining Suicide Risk Level	
	■ Risk rating: high, medium, low, no (foreseeable) risk ■ Assessment confidence ■ Changeability of suicide risk status ■ Consultation with team/senior colleague

Management of Suicide Risk	
	■ Management setting: hospital, community ■ Clear, documented follow-up arrangements ■ Allocation to a key worker/clinician ■ Interventions to reduce risk ■ Inclusion of the person at risk, family and other service providers in plan ■ Contingency planning ■ Re-assessment of risk

Re-assessment of Suicide Risk	
	■ Re-assessment: what has changed? ■ Review by consultant, if required ■ Continuity of clinician ■ New risk level determines further treatment and management ■ Collateral information

Discharge	
	■ Suicide risk is low or no foreseeable risk ■ Return to routine follow-up and /or discharge from mental health service ■ Discharge from hospital ■ Re-entry pathway

In practice, the progressive steps described in this framework might not necessarily be carried out in this order.

Suicide risk as a medical emergency

Presentations of people with suicide risk are to be treated as a medical emergency. Comprehensive suicide risk assessment must be arranged as soon as possible. Also refer to the section on 'Ongoing suicidality and self-harm' on page 24.

Collaborative partnership

Suicide risk assessments should be conducted within a collaborative partnership to maximise the involvement of the person at risk, family and other care providers including primary care services and general practitioners. Information gathered from a single source should be validated with other sources.

Education and information

People at risk of suicide, their families and significant others should be provided with information to assist in their understanding of suicide risk, the actions being taken to minimise risk, contact details for 24-hour services, other support services and options for management.

Requirements for all Area Health Services

All Area Health Services must ensure that:

- an active approach to suicide prevention is encouraged in all staff. All suicidal behaviour must be taken seriously

- training is provided for Area Health Service staff in the assessment and management of suicide risk, consistent with their experience and exposure to people at risk of suicide

- all staff are aware of and have easy access to this framework and other relevant policies in relation to suicide prevention, including *Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities*[1] and any future amendments to the circular

- there is a clear local protocol for consultation with specialist mental health services or other specialist assistance when required

- all staff have access to appropriate clinical supervision. This should also include discussion regarding high-risk persons and the opportunity for reflection on management interventions

- staff have access to consultation or advice from a senior staff member or colleague at all times

- all staff are proficient in performing standardised procedures and protocols for assessing, managing and providing follow-up for people who are at risk of suicide, relevant to the health care setting

- clinical skills in suicide risk assessment and management are reviewed and updated on a regular basis

- all relevant staff in the service understand the provisions of the *Mental Health Act 1990* (NSW) and when it should be invoked.

Note: these requirements are adapted from the New England Area Health Service *Policy for the management of possible suicidal behaviour*.[6]

Components of a comprehensive suicide risk assessment

Engagement
■ Engagement is crucial to detection, assessment and management of suicide risk ■ Clinician takes responsibility for maximising engagement   ■ Level of engagement is assessed   ■ Limits of confidentiality are discussed

■ Engagement and detection are interdependent. Engagement is often crucial to detecting a person's suicide risk and is the first task once suicide risk is suspected.

■ It is important that clinicians also attempt to engage the person's family or immediate support people. Engagement of family is vital in many cultures.

■ The level of engagement between the clinician and the person is an important determinant of the degree to which the person is willing to assist in the assessment by revealing their 'inner world'. The level of engagement is also an indicator of the likelihood of the person's participation in the management plan.

To assist the engagement process, the clinician should:

– be professional, non-judgmental, non-threatening

– show genuine interest and concern for the person's situation

– be empathic and provide reassurance and hope

– offer an ability and willingness to provide practical assistance, if required

– invite an appropriate level of partnership

– listen to the family/support person's reactions (such as distress, anger, confusion, fear) without taking sides.

■ Cultural aspects of engagement need to be considered. How does the person differ from their peers? What might be considered good rapport or evasive behaviour in their country of origin? What are their common cultural beliefs or prior experiences that may interfere with engagement?

■ Clinicians often feel strong personal reactions when confronted with assessing an individual with suicidal or self-harming behaviour. This is often referred to as countertransference. (Further information on countertransference as well as transference and 'malignant alienation' is provided in the glossary). The clinician needs to have a capacity to observe and manage such reactions in him/herself and in other professional colleagues. Clinical supervision and consultation are important supports to ensure clinicians gain experience in managing such situations.

■ The assessment of the capacity of the person to establish rapport and trust will provide important information on the level of alliance and partnership which is likely to develop in the immediate period. It will be the key indication of the prospects of the clinician in influencing the person in a positive, safety-enhancing manner. Clinicians should consider the level of confidence in the quality of the connection established with the person.

■ At some stage of the assessment, often in the initial stages, the clinician will need to discuss the issue of confidentiality. This will include informing the person of the need to contact other relevant people to acquire further information to assist in determining the current suicide risk status. On matters directly relevant to safety, complete confidentiality cannot be guaranteed.

Components of a comprehensive suicide risk assessment

Detection
■ Detection is about identifying risk factors ■ Most people seek help prior to a suicide attempt   ■ It is important and safe to ask about suicide risk

■ The majority of people who die by suicide have consulted a primary health care professional in the few weeks prior to their death.[8]

■ It has been estimated that up to ninety percent (90%) of people who die by suicide suffer from a diagnosable mental disorder.[9] Detection of suicide risk and linking those at risk with specialist health care is essential to save lives.

■ Certain situations or risk factors should elicit a high index of suspicion in clinicians. The threshold for conducting comprehensive suicide risk assessment should be lowered in these situations. The first 28 days following a discharge from psychiatric in-patient care is a critical time in terms of suicide risk, particularly for people admitted following a suicide attempt, suicidal ideation and/or depression.[10] Similarly, people who re-present after a recent suicide attempt or self-harm behaviour require careful re-assessment. The clinician should avoid premature closure based on the findings of earlier assessments.

■ When risk is suspected it is important for the health professional to inquire if the person is feeling suicidal. Carefully eliciting suicidal ideation does not increase the risk of suicide.[11]

When a person has been identified as possibly being at risk of suicide, before the mental health service is contacted a preliminary assessment is to be conducted by the appropriate health professional (such as medical officer, emergency department physician or triage nurse, nursing unit manager, registered nurse, psychologist, social worker, physiotherapist, occupational therapist, geriatrician, rehabilitation specialists, drug and alcohol worker). The attending medical officer and treating team should be made aware immediately of the suicide risk issue.

> Intoxication precludes a valid immediate assessment. If suicide risk is identified in an intoxicated person they should be detained in an appropriate and safe setting until a full assessment is conducted. Enduring risk cannot be judged until the person is sober.

Preliminary Suicide Risk Assessment	
■ Manner of presentation/referral ■ History of presenting problem ■ Brief psychiatric assessment	■ Collateral information ■ Assessment of suicide risk

All clinical health staff who come into contact with people detected as being at risk of suicidal behaviour must be able to perform a preliminary suicide risk assessment. This includes assessment of the person's physical condition, previous suicide attempts, alcohol and other drug use, current mental state, history of mental illness, psychosocial factors and determination of current risk of suicide.

The purpose of this assessment is to determine:

■ the severity and nature of the individual's problems

■ the risk of danger to self or others

■ whether a more detailed risk assessment is indicated.

Factors that need to be considered prior to the suicide risk screening include:

■ the details of the presentation, referral or the circumstance (for example, an incident) that has brought the issue of suicide risk to the attention of staff

■ a brief chronological account of the presenting problem (why the person has come to the health service) should be elicited.

Brief psychiatric assessment

■ Is the person experiencing any current psychiatric symptoms (presence of depressed mood and symptoms of depression such as reduced energy, concentration, weight loss, loss of interest, psychosis, especially command hallucinations)?

■ Is there a past history of psychiatric problems? (A history of a mental Illness should raise the clinician's concern that the current presentation may be a recurrence or relapse.)

■ Coping skills, capacity and supports:

– Has the person been able to manage serious problems or stressful situations in the past?

– Does the person employ maladaptive coping strategies such as substance or alcohol abuse?

– Are there social or community supports? Can the person use them?

■ Mental state assessment (GFCMA: Got Four Clients Monday Afternoon):

– **G**eneral appearance (agitation, distress, psychomotor retardation)

– **F**orm of thought (person's speech logical and making sense)

– **C**ontent of thought (hopelessness, despair, anger, shame or guilt)

– **M**ood and affect (depressed, low, flat or inappropriate)

– **A**ttitude (insight, cooperation).

■ What collateral information is available, for example from medical records, nursing reports, police and other health providers including the general practitioner?

■ Obtain information from family and friends to establish whether the behaviour is out of character, how long it has been evident, how they deal with crisis.

Assessment of suicide risk

A hierarchy of screening questions that gently leads to asking about suicidal ideas is a generally accepted procedure for all health professionals (Figure 2).

Figure 2: Assessment of suicide risk (screening questions)

■ Have things been so bad lately that you have thought you would rather not be here?

■ Have you had any thoughts of harming yourself?

■ Are you thinking of suicide?

■ Have you ever tried to harm yourself?

■ Have you made any current plans?

■ Do you have access to a firearm? Access to other lethal means?

Components of a comprehensive suicide risk assessment

Immediate Management
■ Safety of person, clinician, others   ■ Medical condition requiring management ■ Appropriate observation, supervision   ■ Referral for specialist assessment/consultation

■ The safety of the person being assessed and of the clinician is the primary concern at all times throughout the assessment process. Wherever possible, assessments should not be conducted in a person's home in situations that indicate risks to safety. Assessments should be conducted where assistance is readily available, for example emergency department, community health centre. The precaution of two staff conducting the assessment, ensuring security personnel are close at hand or requesting police assistance are also strategies that may be considered to ensure safety.

■ The level of observation/supervision needs to be considered during the time that the person is waiting to be assessed and after the assessment while referral arrangements are being made. The level of observation required will depend on the risk and the physical environment. A person assessed as being at high or immediate risk of self-harm should not be left alone.

■ Is the person medically well enough to participate in the interview? Do they require medical assessment?

■ People assessed to be at risk of suicide should be referred to relevant specialist clinicians for a comprehensive mental health risk assessment and further management where required.

Referral to specialist service/practitioner

The actions to be taken in referring a person at risk of suicide to specialist services include:

■ obtaining consent from the person and, if under 16 years, his/her parents' consent as well, to make the referral. The person must be informed of, and agree to any plans. If the person is at high risk and unable to give consent, the *Mental Health Act 1990* (NSW) provisions may need to be initiated

■ collecting information to make the referral

■ deciding on appropriate referral agency or agencies

■ making the referral

■ ensuring a comprehensive suicide risk assessment occurs.

The attending medical officer and relevant members of the treating team are notified of the preliminary suicide risk assessment and management plan.

Mental Health Assessment	
■ Comprehensive mental health assessment	■ Personality style
■ Depression, psychosis, personality disorder	■ Changeability of suicide risk status
■ Alcohol and other drugs	

■ Most frequently, suicidal behaviours are symptoms of underlying mental health problems or disorders.[9] Therefore, a suicide risk assessment must include a comprehensive mental health assessment.

■ The clinician needs to assess for depression, schizophrenia, other psychotic illness, bi-polar disorder, anxiety, the person's personality style, current and previous drug and alcohol use and trauma issues.

■ Exploration of these areas will provide further important information on the **changeability of risk** status. For example, a person with a history of impulsivity under stress would be assessed as having a high level of changeability. How plausible is the denial of suicidal ideation in the context of a person's recent psychotic experiences or with the current severity of their depression?

■ Assess whether the person is psychologically competent to enter into a therapeutic alliance. For example, a person who is distressed and deluded (eg think that they are responsible for the AIDS epidemic) cannot give a meaningful reassurance that 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.

Components of a comprehensive suicide risk assessment

Assessment of Suicide Risk

- Risk factors and protective factors
- Distress, psychic pain, meaning, motivation
- At risk mental states: hopelessness, despair, psychosis, agitation, shame, anger, guilt
- History of suicidal behaviour

- Current suicidal behaviour: thoughts, actions, plans
- Lethality, intent, access to means
- Safety of person and others
- Coping capacity, supports
- Logic/plausibility, assessment confidence

Risk factors specifically associated with a higher risk of dying from suicide can be classified into three categories: demographic factors, groups at higher risk and current personal risk factors (Table 1).

Table 1: Examples of demographic, group and personal risk factors for dying from suicide

Demographic factors	Groups at higher risk	Current personal risk factors
■ Male	■ Previous history of attempts or self-harm	■ 'At risk mental status', for example, hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes
■ Between 25-44 years of age	■ History of a mental illness, particularly depression, schizophrenia, other psychotic illness, personality disorder	■ Recent interpersonal crisis, especially rejection, humiliation
■ Older people	■ History of sexual or physical abuse or neglect	■ Recent major loss or trauma or anniversary
■ Living in rural area	■ First presentations of mental illness	■ Alcohol intoxication
■ Members of minority groups (eg Aboriginal and Torres Strait Islander people)	■ Victims of domestic violence	■ Drug withdrawal state
■ People with sexual identity conflicts	■ Alcohol and other substance abuse; co-morbidity	■ Chronic pain or illness
■ Immigrants, refugees, asylum seekers	■ Older immigrants from non-English speaking backgrounds	■ Financial difficulties, unemployment
■ Homelessness	■ Immigrants from northern and eastern Europe	■ Impending legal prosecution
	■ Refugee victims of torture and trauma	■ Family breakdown, child custody issues
	■ Serious physical illness or disability	■ Lack of social support network
	■ People in prison or police custody	■ Unwillingness to accept help
		■ Cultural or religious conflicts
		■ Difficulty accessing help due to language barriers, lack of information or support, or negative experiences with mental health services prior to immigration

Research suggests that suicidal behaviour commonly results from a convergence of multiple predisposing and concurrent risk factors that combine to elevate the risk of suicide.[12]

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** (the current mental state) that are impacting on the individual's life at the present time.

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

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

Hopelessness is one of the main factors mediating the relationship between depression and suicidal intent.[13] 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.

The first **28 days following** discharge from a psychiatric in-patient facility is a period of **increased risk** for suicide.[10]

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.

Comprehensive suicide risk assessment

A comprehensive suicide risk assessment should explore the following elements.

Distress, psychic pain

- What is the nature and level of the person's inner distress and pain?

- What are the main sources of this person's distress?

Meaning, motivation

- What is the person's understanding of their predicament? What is the meaning of recent events for them?

- What is motivating this person to harm himself or herself? Has the person lost his/her main reason for living?

- Does the person believe that it might be possible for their predicament to change and that they might be able to bring this about?

- Explore cultural aspects of meaning and motivation with persons from culturally and linguistically diverse backgrounds.

'At risk' mental states

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

History of suicidal behaviour

- Has the person felt like this before?

- Has the person harmed himself or herself before?

- What were the details and circumstances of the previous attempt/s?

- Are there similarities to 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, for example, guilt, delusions or thoughts of reunion)?

- When did these thoughts begin?

- How frequent are they?

- How persistent are they?

- What has happened since these thoughts commenced?

- Can the person control them?

- What has stopped the person from acting on their thoughts so far?

Intent, lethality

- What is the person's degree of suicidal intent? How determined were/are they?

- Was their attempt carefully planned or impulsive?

- Was 'rescue' anticipated or likely? Were there elaborate preparations and measures taken to ensure death was likely?

- Did the person believe they would die? (Objectively question the person's perception of lethality.)

- Has the person finalised personal business, for example, made a will, made arrangements for pets, debts, goodbyes and giving away possessions?*

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 which are 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 for assessment of a person following a suicide attempt and asked in the present and future tenses for assessment of 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 a firearm available? (If a person at long-term high risk of suicide has access to a firearm, the police should be contacted before the person is discharged to discuss the possibility of removing the firearm.[14]) Are there poisons in the house or shed? Are there lethal medications such as insulin, cardiovascular medications or tricyclic antidepressants available to the person? Ensure these questions are also asked of a reliable corroborative source.

- Is the chosen method irreversible, for example, shooting, jumping?

- Has the person made a special effort to find out information about methods of suicide or do they have particular knowledge about using lethal means?

- Type of occupation? For example, police officer, farmer (access to guns), health worker (access to drugs).

In most cases, if a person has developed a potentially fatal or effective plan and has the means and knowledge to carry it out, the chances of dying from a suicide attempt are much higher.[15]

It is important to assess the level of intention and the person's understanding of the level of lethality of their suicide attempt or plan.

Safety of others

- Have the person's thoughts ever included harming someone else?

- Has the person harmed anyone else?

- What is the person's rationale for harming another person?

- Is there a risk of murder-suicide? Is the person psychotic?

- Are there issues with custody of children and/or financial issues?

- Are the children safe?

- Is there evidence of postnatal depression?

Coping potential or capacity

- Does the person have the capacity to enter into a therapeutic alliance/partnership?

- Does the person recognise any personal strengths or effective coping strategies?

- How have they managed previous life events and stressors? What problem-solving strategies are they open to?

- Are there social or community supports (for example, family, friends, church, general practitioner)? Can the person use these?

- Is the person willing to comply with the treatment plan?

- Can the person acknowledge self-destructive behaviours? Can the person agree to abstain from 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?

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

In some situations, it is reasonable for a clinician to conclude 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.

Another factor that might indicate a level of uncertainty in the assessment is a lack of corroborative information, or conflicting information. Reflecting on the quality of their engagement and rapport with the person will also assist the clinician in determining their confidence in the assessment.

Care also needs to be taken when a person responds that suicide is not an issue after a limited number of questions asked by the clinician. The clinician must feel confident with the person's response. Premature closure (concluding there is not a 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 and consider referring to a senior colleague for a second opinion.

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

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

Corroborative History
■ Corroboration of information: records, family, other sources ■ Willingness/capacity of support person/s ■ Availability of support system

- 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 available to the person and promote collaboration with the person and his/her support person/s.

- Corroboration helps to provide accuracy around the changeability of suicide risk status, enhances the assessment confidence, provides opportunities to assess family supports and assists with collaboration about management and discharge planning.

- Sources of information include:

  – communication with other clinicians immediately involved, for example, emergency department staff, ambulance officers

  – interview of any people accompanying the person at risk to determine the circumstances of the person's recent behaviour

  – interview or phone contact with other relevant people, for example, general practitioner, primary care team, family members, close friends, significant others, care coordinators/case managers, treating psychiatrist, therapists, school counsellors and other relevant health and welfare service providers who know the person

  – where possible, access to previous files.

- Clinicians need to be aware that due to stigma and shame some families and support persons may not reveal the extent of the person's problems. Some cultures may fear repercussions, for example, an unwell mother might fear having her children taken away.

- Assess the family or support person's belief about current presentation of the person at risk (distress, 'attention seeking') and determine their response to the situation (worried, angry).

- Assess the family or support person's willingness and capacity to facilitate a protective environment for the person at risk when they are discharged (eg monitoring safety, removal of means).

- Corroboration can also provide an opportunity for engagement with the family or carer, where appropriate.

- There should be careful consideration of the person's privacy prior to obtaining corroborative history.

> It is important to involve the family and/or other carers in obtaining corroborative history, as they can be an important source of information, including recent behaviour of the person and his/her usual coping capacity.

Determining Suicide Risk Level

- Risk rating: high, medium, low, no (foreseeable) risk
- Changeability of suicide risk status
- Assessment confidence
- Consultation with team/senior colleague

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.[3, 4, 5] A comprehensive assessment of the individual remains the only valid method of determining risk. Assessments are based on a careful assessment of the mental state and current factors in a person's life; the way in which they interact at a given time determines suicide risk.

Suicide risk assessment generates a clinician rating of the risk that the person will attempt 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**.

Changeability

Changeability of risk status, especially in the immediate period, should be assessed and high changeability should be identified. Risk status is dynamic and requires re-assessment. It is important to identify **highly changeable** risk status because it will guide clinicians as to the safe interval between risk assessments.

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

Assessment confidence

- The clinician should consider the confidence he/she has in the risk assessment. Several factors may indicate **low assessment confidence**:

  – factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage

  – factors in the social environment, such as impending court case, divorce with child custody dispute

  – factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

Suicide risk ratings
☐ High Risk
☐ Medium Risk
☐ Low Risk
☐ No Foreseeable Risk
☐ High Changeability
☐ Low Assessment Confidence

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

> The **Suicide Risk Assessment Guide** (p 20) is meant to be used as a **guide only** and **not to replace clinical decision-making and practice**. The clinician must use his/her experience, knowledge and skill in estimating the current level of suicide risk. A reflective practice approach is important. The clinician needs to use judgment in evaluating the quality and appropriate weighting of all the available information.

Consultation with team or senior colleague

- Assessment of people at risk of suicide is a complex and demanding task that requires involvement of an experienced clinician at some level.

- Wherever possible, all assessments of suicide should be discussed with a colleague or senior clinician.

- Consideration of the time of consultation should be based on the degree of concern for the person at risk. The greater the concern, the sooner the consultation should be sought.

- All teams involved in the assessment of persons at risk should have access to regular (daily, or at least weekly) clinical forums such as a clinical case review where all cases are presented and discussed.

- For persons from culturally and linguistically diverse backgrounds, consideration needs to be given to obtaining information from a cultural consultant.

Confidentiality

Health workers have professional and legal obligations to keep client information confidential. There are circumstances, however, when it will be appropriate to disclose information:

- when the person is capable of giving consent and consents to the information being disclosed to specific person/s

- when a clinician considers that failure to disclose information could place the individual at serious risk of physical harm or death and disclosure is justified in order to avoid this risk

- when a clinician considers that failure to disclose information could place other members of the community at serious risk of physical harm or death and disclosure is justified in order to avoid this risk

- when there is a need to consult a supervisor or a colleague

- when the person is under 16 years of age and the information is disclosed for the purposes of notification under child protection legislation.

Information sharing

Information about the outcome of a suicide risk assessment and the management plan may need to be communicated to a range of other people including family or carers (unless this is not appropriate), the general practitioner, other members of the treating team or other teams of a mental health service. Information about a person may be passed to someone else:

- with the person's explicit consent, or

- on a 'need to know' basis when the recipient needs the information because he/she will be involved with the person's care or treatment, or

- if the need to protect the person at risk or others outweighs the duty of confidentiality to the person.

Where staff from more than one agency are involved, the person at risk needs to be told that some sharing of information is likely to be necessary.

Documentation

- All details of risk assessment, management plans and observations are to be clearly documented in the person's medical record. For mental health services, documentation must be completed using MH-OAT Clinical Modules.

- Regular reviews, including re-assessment of risks and response to clinical interventions should be noted.

- The rationale and reasons for the decision to manage a person in the community rather than in hospital and the management plan to support the decision should be documented.

- Contact details for the person at risk, relatives and treating professionals should also be noted.

- If family or other care providers and health professionals contact a clinician in regard to a person at risk, all relevant information including the family's concerns should be documented.

Suicide Risk Assessment Guide[2]

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 – 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 – 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 – 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 – 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) – 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 – level & quality of engagement – changeability of risk level – assessment confidence in risk level.	Low assessment confidence or high changeability or no rapport, poor engagement.		– 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 of Suicide Risk
■ Management setting: hospital, community   ■ Clear, documented follow-up arrangements ■ Allocation to a key worker/clinician   ■ Interventions to reduce risk ■ Inclusion of the person at risk, family and other   ■ Contingency planning   service providers in plan   ■ Re-assessment of risk

Management setting

- The first management decision in treating a person at risk of suicide is to determine the most appropriate and available treatment setting.

- Management consists of supporting the safety of the person while the underlying mental health problem is treated.

- Not all persons at risk of suicidal behaviours can or should be hospitalised. Indeed hospitalisation may have little predictable benefit and even an element of increased risk for some people. Many issues are involved in the decision to hospitalise a person with suicide risk. The decision should be made on clinical grounds with involvement of the person and their family.[16]

- Assessing the degree of intervention required is dependent on many factors, some of which include:
  - diagnosis
  - severity of illness
  - degree of impulsivity
  - degree of insight
  - safety of current situation
  - whether the person is willing and able to engage with the treating team and other supports
  - identified protective factors such as supportive family, friends.

Key worker or responsible clinician

- A person who is assessed to be at risk of suicide must be assigned a key worker or clinician who has responsibility for coordination of appropriate care and re-assessment.

- The person at risk and their family must be provided with the name and contact details of the key worker or responsible clinician.

HIGH RISK or HIGH CHANGEABILITY or LOW ASSESSMENT CONFIDENCE
– Re-assess within 24 hours

The clinician ensures that the person is in an appropriately safe and secure environment. The clinician organises re-assessment within 24 hours. Ongoing management and close monitoring are indicated. Contingency plans are in place for rapid re-assessment if distress or symptoms escalate.

MEDIUM RISK
– Re-assess within one week

Significant but moderate risk of suicide. The clinician ensures that a person at this level of risk receives a re-assessment within one week and contingency plans are in place for rapid re-assessment if distress or symptoms escalate.

LOW RISK
– Re-assess within one month
– After discharge from an in-patient unit, re-assess within one week

Definite but low suicide risk. The clinician considers a person at this level of risk requires review at least monthly. The timeframe for review should be determined based on clinical judgment. After discharge from an in-patient unit, the review is to be conducted within one week. The person at risk should be provided with written information on 24-hour access to suitable clinical care.

- Where a team is managing a person at risk, procedures for effective communication of the person's progress and changes to the management plan must be in place.

- Where key responsibility is handed over because the key worker or responsible clinician is on leave or otherwise unavailable, procedures must be in place for effective communication of the handover to another clinician, to other team members and to the person and their family.

> The person and their family (unless considered inappropriate) should always be involved in the discussion of the most appropriate management setting and strategies to minimise the degree of suicide risk.

In addition, the following factors need to be considered when determining the level of observation required for the person during the crisis period:

- the capacity of the service to maximise safety

- the involvement of families, including those from culturally and linguistically diverse backgrounds, requires careful thought and planning. For example, which family member should be approached to support the person? Are there unspoken fears due to the illegal nature of suicide in the family's country of origin?

- using the strengths of Aboriginal and Torres Strait Islander families and communities to mobilise supports.

The clinical team may consider community care more appropriate than immediate hospitalisation when:

- suicidal intent is judged to be manageable in that setting

- there is good rapport with the person at risk

- the mental health team has a management plan that is clearly communicated to the person and their support person/s, and includes a rapid response capacity for re-assessment and appropriate escalation of care levels

- the management plan includes specific strategies for the person and their support person(s) to deal with symptoms and distress

- the person has adequate psychosocial supports

- it would be considered a further risk to admit a particular individual to an acute observation ward, for example a frail older person, a very young person, some people of Aboriginal background

- it has been assessed that the family or another carer is willing and has the capacity to take on the responsibility

- there is clear and timely communication between the referring agent and the provider of community care

- the person or carer has the ability to gain access to appropriate clinical expertise 24 hours a day.

Management in the community is not appropriate when suicide risk escalates beyond the available level of care and support from the health service and family and social supports.

The rationale and reasons for the decision to manage a person at high risk of suicide in the community or in hospital and the management plan to support the decision should be clearly documented.

Management plan

The management plan is a record of interventions and contingency plans. The management plan should clearly articulate roles, responsibilities and timeframes for the period between assessments. The management plan should also include explicit plans for responding to non-compliance and missed contact by the client. Suicide risk assessment is not static and the management plan should be updated with the most current information available.

If an intervention that is indicated to reduce risk is not available, this should be clearly recorded in the management plan and/or the patient's medical record and discussed with the Service Manager. A realistic management plan within the resources available still needs to be made recognising that treatment options may be limited. This should also be discussed with the 'at risk' person.

Management in the community

Where the person is being managed in the community the following strategies are the minimum management requirements.

■ Appropriate supports are identified who are willing to manage the person at risk.

■ A face-to-face re-assessment is conducted within the relevant time period according to the person's level of risk.

■ The person and their family/support person are informed of the clinician who has prime responsibility for the person's care, wherever possible. Where team management operates, the phone number and the names of staff on duty over the next 24 hours should be provided.

■ The person and family/support person are provided with:

– the time and place for the re-assessment interview

– detailed information of the 24-hour availability of the service and how to re-contact the service if concern increases or the person's situation changes and requires earlier re-assessment

– a clear understanding of what response will be provided by the health service should the person need to access further help because their distress or suicide risk has increased. This must also be explained to the family member or support person nominated in the management plan.

■ Information concerning the management of the person should also be conveyed to the referrer, treating psychiatrist, general practitioner and other relevant health providers in contact with the person.

■ Family and support people are to be provided with information on how to manage a person with suicidal behaviour. The most important instructions are:

– maintaining appropriate supervision

– knowing where the person is at all times and who will be with them

– how to contact the team for an urgent re-assessment.

■ When a person has been assessed as being at risk of suicide and is believed to be at continuing risk, but does not attend a follow-up appointment, he/she must be contacted immediately to assess his/her risk of suicidal behaviour.

■ The management plan is negotiated with the person and family/support person. Contingency planning for urgent and rapid re-assessment is in place for those at high or medium risk.

Mental health in-patient unit management

Where the person is being managed in a **mental health in-patient unit**, the appropriate observation care levels are allocated based on the current level of risk. Refer to 'Nursing observation levels' in *Suicide Risk Assessment and Management Protocols – Mental Health In-Patient Unit* (p 10) or *Justice Health Long Bay Hospital* (p 10) as appropriate.

Where the person is being managed in a **general hospital ward**, refer to the *Suicide Risk Assessment and Management Protocols: General Hospital Ward*.

Some examples of interventions for risk management plans are provided in Table 2.[7]

Contingency planning

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

■ deterioration of family relationships

■ increase in symptoms (depression, insomnia, hallucinations, suicidal feelings)

■ temporary unavailability of the clinician or acute team.

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

1. If…….………........, then the person will……................, the family will……........., the service will……….........

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

Components of a comprehensive suicide risk assessment

Table 2: Interventions to reduce suicide risk

Immediate Interventions		Longer term Interventions
■ Level of containment and observation levels	■ Ensuring basic needs such as food and household supplies are in place	■ Treatment of mental illness, eg depression
■ Environmental safety	■ Symptom control, treatment of mental illness	■ Treatment for substance misuse
■ Making apparent risks safe, including possible removal of firearms by police	■ Seeking information from other services to further inform risk assessment	■ Relapse prevention
■ Providing the caring and empathic responses that will foster the therapeutic alliance	■ Short-term psychological interventions, eg problem-solving	■ Identify and address psychological and emotional issues to reduce distress and increase coping skills
■ Offering continuity of care for the crisis period by ensuring the involvement of the key worker and clear communication of the assessment and management plan when there are 'handovers' of the care to other clinicians in the team	■ Practical assistance with problems, eg housing	■ Specific management plan for the person who repeatedly presents
	■ Referral to other services for further investigations to clarify and address risk factors	■ Education on illness and risk management for person and carers
	■ Exploring incidents with the person looking at motivation and circumstances	■ Anger management training
■ During the crisis period, increasing support from family, friends or colleagues	■ Identifying individual risk and protective factors	■ Supported accommodation
■ Contacting others involved in the person's care to ensure support is provided and coordinated	■ Developing contingency and relapse plans	■ Health promotion
■ Instilling hope	■ Family assessment and/or ensuring family and social supports are enlisted in care and informed of contingency plans	■ Pre-discharge plans
■ If person is intoxicated, sobering them up		■ Follow-up arrangements
■ Consideration given to admission		■ Access to appropriate social supports
■ Use of the *Mental Health Act 1990* (NSW) if necessary		
■ Police involvement		
■ De-escalation techniques		
■ Use of medication		
■ Advice on sleep, hygiene, exercise		

Ongoing suicidality and self-harm

Suicide risk management can be especially challenging when clinicians are faced with potentially high-risk situations involving ongoing suicidal and/or self-harm behaviours and urges. Persons diagnosed with personality disorders, particularly borderline or antisocial personality disorders, present a spectrum of suicidal behaviour that ranges from exaggerated threats to actual suicide. Additionally, a frequent occurrence is self-injurious behaviour without lethal intent.[17]

Research has suggested that approximately one in 10 persons diagnosed with borderline personality disorder will die by suicide and approximately 70% will engage in self-injurious behaviours.[18] Factors which increase suicide risk in this group include co-morbidity with major mood disorders, addiction and some anxiety disorders, and a history of childhood sexual abuse. Impulsivity has also been identified as an essential factor related to suicide risk.[19, 21]

People who deliberately self-harm are more likely to have deficits in active problem-solving skills and assertive behaviour, and are less able to request assistance and deal effectively with interpersonal situations.[20] They may exhibit low frustration tolerance, high levels of anger, impulsivity and affective instability. Staff dealing with such people require access to supervision so that transference and countertransference issues can be identified and managed.

Principles for management of recurrent or ongoing suicidality

■ Avoid minimising the seriousness of the risk of suicide.

■ Establish a team approach.

■ Actively treat all co-morbid conditions.

■ Carefully assess and appropriately address any childhood abuse history.

■ Set clear limits, including a clear management plan and guidelines on expected behaviour of the person.

■ Combination of appropriate psychotherapy and medication.

■ Clarify problems.

■ Provide psychiatric crisis intervention.

■ Provide brief symptom-focused hospitalisations when the ongoing suicidal threat crosses the boundary into an acute suicidal state.

■ There should be close collaboration between in-patient treatment providers and aftercare services for continuity of care.

■ Careful monitoring of transference and countertransference is important.[21]

Beyond crisis intervention and life-saving short-term hospital admission, there is a need for effective treatment methods for chronically suicidal persons with personality disorders that can be applied within community health settings.

Some of the management strategies that may be developed in the context of a planned therapeutic approach for people with a personality disorder (for example, Dialectical Behaviour Therapy – DBT) may vary from what is described in this document. A planned intervention may be negotiated with the person and relevant others to minimise any crisis response to an expressed threat or self-harming behaviour so as to not reinforce negative behaviours.

It is acknowledged that there is an inherent risk in these forms of intervention but the current literature supports the idea that taking a longer term therapeutic approach can be of more benefit than responding to short-term risk behaviours. In such situations when there are ongoing regular therapeutic interventions, there needs to be room for the treatment plan to override the general risk assessment and management framework. However, when that treatment plan or the therapeutic relationship breaks down then the suicide risk assessment and management framework is to be followed.[22]

An ongoing clinical risk remains in the long-term management of chronically suicidal individuals. However, there is good evidence to support structured and planned approaches that focus on a longer-term therapeutic approach, rather than only responding to the acute short-term behaviours. If services manage particular clients within a structured program, relevant clinicians need to collaborate as a team and be sufficiently flexible to respond in acute situations if the treatment plan is clearly not working.

The treatment plan and therapeutic procedures in managing the chronic suicidal situation (as opposed to managing an acute suicidal situation), including the rationale for the specific interventions, must be documented clearly and specifically in the person's medical record.

Components of a comprehensive suicide risk assessment

Re-assessment of Suicide Risk
■ Re-assessment: what has changed? ■ Review by consultant, if required ■ Continuity of clinician ■ New risk level determines further treatment and management ■ Collateral information

A mandatory component of managing a person at risk of suicide is the re-assessment of that risk.

- The management plan should include the date and in some cases even the time that a re-assessment of risk will be undertaken. This will depend on the level of risk determined at the previous assessment.

- Re-assessment of risk will include a re-evaluation of previously detected 'at risk mental states' and review of treatment for any underlying mental illness/disorder.

- The re-assessment of risk provides another opportunity to consolidate the therapeutic relationship between the health service, person, family and other relevant service providers; review the risk and protective factors and facilitate a review by a consultant. This step also facilitates the re-assessment of the **changeability** of risk. The re-assessment also assists the clinician to re-appraise **assessment confidence** in the current risk status.

- Is there evidence of a developing partnership? Continuity of the clinician responsible for the re-assessment facilitates engagement and generally enhances the accuracy of the assessment.

- In addition to reviewing the person's state of mind, the re-assessment of risk needs to include circumstances in the social environment that may have changed.

- For people at **high risk** or where there is a **low assessment confidence** in the risk level assessed or **high changeability** in the person or their environment, a face-to-face re-assessment should occur **within 24 hours**. Contingency planning for rapid re-assessment should be in place.

- The person at **medium risk** of suicide should be re-assessed face to face **within one week**. Contingency planning for rapid re-assessment should be in place.

- The person at **low**, **but current**, **risk** of suicide should be re-assessed face to face, wherever possible, **within one month**. Following **discharge from an in-patient unit**, this review should be conducted **within one week**.

- Collateral information, particularly from the family or support person should always be sought as part of the re-assessment of suicide risk.

- A consultant psychiatrist's opinion should be sought early, wherever possible, in the assessment and management of a person with suicide risk. This may be available as part of the team's routine case review meeting.

Discharge
■ Suicide risk is low or no foreseeable risk   ■ Return to routine follow-up and /or discharge from mental health service   ■ Discharge from hospital   ■ Re-entry pathway

Key areas to address at the time of discharge from acute care are:

■ the person's current mental state

■ resolution of precipitating factors or events

■ significant relationships and social circumstances including accommodation, employment and financial situation

■ follow-up or re-entry arrangements made and communicated to the person.

Suicide risk is low or no foreseeable risk

The assessment and management of suicide risk aims to assist the person through a period of immediate or imminent risk of suicide. When the person's risk can be revised down to low risk or no foreseeable risk, levels of care can be safely and appropriately reduced. The person can be assessed for return to routine follow-up care and/or discharged from the care of the mental health service.

Discharge from hospital

People who have been at risk of suicide require close follow-up when discharged from hospital. The first 28 days after discharge from hospital has been identified as a period of elevated risk of suicide.[10]

The management plan for people being discharged from hospital or acute care is to be documented on the MH-OAT Clinical Module D1 (Discharge/Transfer Summary) and includes:

■ re-assessment within the first week following discharge

■ a booked appointment with a nominated clinician who has responsibility for the person's community management

■ confirmation that the person and his/her family or support person(s) have been provided with contact details for rapid response re-assessment

■ liaison with the general practitioner.

Re-entry pathway

When a person is discharged from a mental health service, or discharged from a particular setting within a mental health service there are precautions that should be in place and documented in the discharge plan.

■ The person and their family or support person know how to re-enter the required and appropriate level of care through a re-assessment process.

■ The person and their family or support person have confidence that there are no barriers to re-assessment and, where necessary, re-entry to the appropriate level of care.

■ Wherever possible, the preferred point of contact is a clinician who knows the person.

Appendix 1: Special needs groups

Cultural sensitivity

A culturally sensitive approach to working within a multicultural society requires health professionals to be aware of their own cultural values and beliefs. It is recommended that when working cross-culturally, staff approach the person with sensitivity to and respect for the social context of the client's problems and their personal and social history. It is important to understand the personal meaning of the illness and suffering for the individual, their family and their community.

Culturally and linguistically diverse communities

A comprehensive suicide risk assessment will take into account the diverse issues facing migrants, refugees and refugee claimants. Factors that are associated with increased risk of suicide for immigrants and refugees from non-English speaking backgrounds include low levels of English language proficiency and the resulting difficulties in accessing health services. Accessing mental health services might be complicated by stigma about mental illness and lack of knowledge about how services operate in NSW. Stressors are frequently experienced during the process of adjusting to mainstream Australian culture and in the case of refugees this may be superimposed on a background of pre-arrival experiences of torture or trauma. Other factors that might be experienced following immigration include a decrease in socio-economic status, lack of recognition of overseas qualifications and separation from social, religious and cultural networks. Immigrants and refugees might also experience prejudice, discrimination and breakdown of traditional family structures with inter-cultural conflict between generations being a major feature.

Consideration needs to be given to cultural context when exploring assessment issues, in particular the possible meaning of an act of suicide to the individual, their family and their community. Clinicians need to give attention to cultural differences in the expression of emotions and symptoms and how these differences are interpreted. In relation to management, when a situation involves a person from a culturally and linguistically diverse community, consideration needs to be given to how family members and culture-specific community support services will be involved.

Health staff are encouraged to network more widely than traditional avenues when providing services to individuals from different cultures to incorporate their community supports (eg church and community leaders, Migrant Resource Centres, the Ethnic Communities Council).

Where complex or unknown cultural dynamics are involved, consideration needs to be given to the use of a cultural consultant, wherever possible (refer to Glossary). This should be considered irrespective of the need for an interpreter service. For cultural advice, the NSW Transcultural Mental Health Centre intake officer is available on 9840 3800 or 1800 648 911.*

Culturally and linguistically diverse people and their families should have the same accessibility as English-speaking communities to mental health services, wherever possible. They must be informed, in their own language, of the 24-hour telephone interpreter service and how to access it. They must be provided with the 24-hour interpreter service telephone number, together with the 24-hour contact number for the mental health service on a card.

> Contact numbers for telephone interpreter services:
> - Business hours – 1300 655 030
> - After hours – 131 450

Aboriginal and Torres Strait Islander communities

The suicide rate for Indigenous males accounts for 2.8 times as many deaths as expected based on total suicide rates for Australian males. For Indigenous females, suicide accounts for 1.9 times as many deaths as expected based on total Australian female rates. Younger Aboriginal people are at particular risk of suicide.[23] Due to the problems with identification of Indigenous persons in death records, these figures are likely to be underestimates.[24]

* Information provided by NSW Transcultural Mental Health Centre.

There are strong reasons to believe that the elevated suicide rate of Aboriginal people is a reflection of the overall health and wellbeing of the communities within which Aboriginal people are living.[25] Aboriginal youth suicide appears to reflect a range of inequities in access to services that promote the appropriate development of children and youth. These factors include poorer access to health, recreation, education and employment opportunities. Of particular current concern is the exposure of young Aboriginal people to racism, substance abuse, violence and sexual assault.

Although Aboriginal people are subject to many of the same risk factors for suicide that apply to non-Aboriginal people it appears that many of these risk factors are concentrated in Aboriginal communities.[26] In relation to Aboriginal youth suicide, the high proportion of suicidal behaviour that occurs in rapid response to negative events requires particular recognition. Services need to address and assist young Aboriginal people who have poor coping abilities, impulsive response styles and elevated stress responses resulting from early and prolonged exposure to trauma and grief.
Additionally, the exposure of Aboriginal people to suicide in their families and communities and to representations of Aboriginal suicide in the media requires that services work with Aboriginal communities to target the perception that suicide is a culturally appropriate response to distress and negative events.

Many Aboriginal suicidal crises are precipitated by conflict or offence within family or community. These may be surrounded with shame and reluctance to engage with services that require extensive albeit sensitive probing by the health care provider. Equally there may be cultural violations or breaches of cultural law that may be significant in individual cases. Elders tend to know what to do and how to resolve these issues.

A related issue that may contribute to ongoing elevation in suicide risk is that an Aboriginal person may have felt unable to return to their country (and family) for a long period of time. On occasion this may have been the result of shame or of a perceived cultural offence. The strength of Aboriginal family and community ties are significant protective factors against suicide. Resolution of long-term drifting and homelessness through the provision of assistance to resolve long-standing barriers to the person's return is an important service that requires the utmost sensitivity and appropriate input from Aboriginal people and staff.

Additionally, even if an Aboriginal person is obviously unwell, there may be cultural beliefs that underlie the distress observed in their current mental state. Therefore, despite a good response to medication, they may continue to feel agitated and distressed if the cultural healing/resolution has not been engaged. The resolution of these difficulties may be achieved by community elders and traditional healers. Where cultural issues are suspected to underlie an Aboriginal person's distress, contact and referral should be made to the local Aboriginal Medical Service.

Aboriginal people are, understandably, sensitive to the imposition of Western values and solutions. It is crucial, therefore, that assessment, treatment and management of Aboriginal persons at risk of suicide are conducted in a collaborative context of partnership between the person and the service. This requires that services listen to the person and address the needs that he/she finds to be most distressing. The trust of an Aboriginal person needs to be earned through progressive interaction that meets the need of the person at all steps of the way. Overly clinical approaches that diverge from the person's perceived needs are likely to result in treatment failure.

Wherever possible the involvement of Aboriginal mental health workers in all stages of assessment and management and, in particular, at time of discharge, is essential to the effective engagement of Aboriginal clients. If Aboriginal mental health workers are unavailable then consultation with Aboriginal health workers, Aboriginal Medical Services, community and family members is strongly recommended.

Holistic assessment and care

- Assess the individual in the context of family and community.
    - Assess the family's capacity and willingness to support the client.
    - Consider the quality/stability of the family environment to be integral to risk assessment.
    - Seek advice from Aboriginal staff and the Aboriginal Medical Service in the person's area on cultural issues that may underlie elevated risk.

Appendix 1: Special needs groups

- – Use Aboriginal staff or family to assess for
  issues of shame, cultural and family or
  community conflict:
    - ensure that the person feels able to
      return home
    - explore any reluctance to 'return to country'
      in terms of underlying cultural or community
      issues that may require resolution to allow the
      person to return to their family/community
    - use an Aboriginal (Mental) Health Worker to
      consult with the community and/or elders on
      the resolution of cultural or conflict issues,
      where available
    - if cultural issues are suspected, explore the
      possibility of traditional healing with
      Aboriginal Health staff, Aboriginal Medical
      Service staff or a community/family member.

- ■ Assess for resolution of life stressors.

- ■ Physical health assessment.

- ■ Welfare assessment including housing, social
  security, Department of Community Service issues.

- ■ Assess for other needs and supports.

    - – If substance abuse was involved at the time of
      elevated risk, advise the family to monitor/control
      the person's substance abuse:
        - ensure referral to (Aboriginal) Substance
          Misuse Worker, where available
        - consider discharge to an appropriate
          rehabilitation service.

Glossary

Affect

Observed emotional state, as identified by facial expressions, gestures and tone of voice which are outwardly observable to others. Described in terms of range and reactivity (from flat or depressed, blunted, restricted, normal or elevated labile) and appropriateness (appropriate or inappropriate to the content of speech or ideation). Descriptors include euphoric, anger, flat and sadness.

Anhedonia

Loss of the capacity for enjoyment and inability to experience pleasure in normally pleasurable activities. Anhedonia is an indication of depression.

Assessment confidence

The sense of confidence a clinician has about the assessment of an individual's safety and level of suicide risk in the short-term (12-24 hours). It is usually expressed in terms of assessment confidence (high or low), which is determined by:

■ the quality of the engagement and rapport with the person

■ the consistency of the person's history

■ the availability of collaborative information necessary for psychiatric and suicide risk assessments

■ the ability to access sources of corroborative information

■ the clinician's intuition, including the unspoken or unknown information.

In some situations, it is reasonable for a clinician to conclude that, on the available evidence, their assessment is tentative and thus of low confidence. It is important that low assessment confidence is flagged as an indication for re-assessment as soon as is appropriate. Suicide risk is complex, dynamic and ultimately unknowable.

Changeability of risk

Refers to the possible change in the psychosocial status of the person being assessed. Suicide risk is often changeable, at times it changes very quickly. This may be due to a number of factors including:

Personal factors

■ degree of depression

■ psychosis

■ alcohol and/or other substance abuse problems

■ impulsivity

■ vulnerable personality.

Environmental factors

■ impact of further (or impending) life events, eg impending divorce, prosecution

■ quality of interpersonal relationships

■ interpersonal conflict

■ discontinuities in the person's support network

■ changing level of engagement with therapist

■ countertransference and negative therapeutic reaction.

When these and other relevant factors are present, clinicians should re-assess risk status frequently and introduce monitoring measures during the high risk periods.

Cultural consultant

A relatively new concept is that of the cultural consultant in medicine and psychiatry. In a sense the cultural consultant serves as a bridge between the medical model and the refugee's or immigrant's world view. Ideally, the cultural consultant should have experience and training in health care and should be bicultural and bilingual. Awareness of one's own identity, behaviour and biases is also important. Ultimately the cultural consultant's chief task is to answer the question, 'Is this behaviour normal?'. This question lies at the heart of cross-cultural psychiatry, which must determine normality in its cultural context.[27]

Further to this task the cultural consultant may be able to provide specific information about the client's culture and their role within it. The aim of this is to assist clinicians to find the common ground needed to build a therapeutic alliance.

Delusions

Beliefs or thoughts that are bizarre and are different from most people in that person's culture, eg a person believing they are being persecuted or plotted against, that their thoughts are being broadcast aloud, or that they are someone else, such as a famous person or religious figure.

Hallucinations

Sensing or feeling something that is not there, even though it seems real, eg hearing voices, seeing people or things that aren't there, feeling or smelling something which is not real. Hallucinations are feelings or sensations that a person experiences which do not exist in the external reality. Hallucinations may be very vivid to a person experiencing them and quite often the person will not realise their experiences are not real. They can occur in any of the senses and are classified as auditory, gustatory, olfactory, tactile or visual.

Malignant alienation

This term refers to a sequence of events, often related to recurrent relapse and failure to respond to treatment, in which certain patients who are suicidal experience profound loss of sympathy and loss of support from staff members and relatives who may view the patient's behaviour as provocative, unreasonable or overdependent.

Negative therapeutic reaction

This term refers to the situation where a clinician's (often well-intended and rational) therapeutic endeavours are experienced as unempathic and unhelpful by the patient who responds negatively. The clinician may then respond defensively or punitively and patient and clinician might join in a counterproductive cycle of interactions.

Personality disorder

This term describes a range of disorders characterised by a pattern of thoughts, feelings and behaviour which are markedly different from those shown by other people in that person's culture and which cause distress or poor functioning. The unusual thoughts and behaviour have to be extreme to warrant a diagnosis of a personality disorder, and go far beyond the usual variations between individuals. They are ongoing and affect most aspects of the person's life.

While personality disorders begin in adolescence or early adulthood, the person's condition may not be recognised clinically until later in life. People with these disorders will require treatment and support from a specialised mental health professional.

Possible suicidal behaviour

Suicidal behaviour includes threats, ideation (thoughts), intent in the absence of a suicide attempt and actual suicide attempts.

Suicide attempt

A suicide attempt is defined as an act of self-inflicted harm that is intended to cause death.

Parasuicide

An act of self-inflicted harm that is intended to communicate distress. It is similar to attempted suicide in appearance, but it is not intended to cause death. Parasuicide is important as it is much more common than attempted suicide and may be repeated with fatal consequences (intentionally or not).

Self-mutilation

An act of self-inflicted injury that is often ritualistic or repetitive and is not intended to cause death or to appear that way.

Psychosis

A period of mental illness in which a person loses contact with reality and may experience delusions, hallucinations, mood changes, disorganised thoughts and behaviour and other symptoms.

Re-entry

When a person is discharged, they and their family, partner or friend have a clear understanding of pathways for re-entering specialist mental health care at a later date if required. The Mental Health Service has procedures in place to ensure that re-entry is easy and effective.

Transference and countertransference

One of the characteristics of the client-clinician interaction is transference, where the client begins to transfer the feelings from previous relationships, which emerge in clinical interaction with the therapist. The client may come to like or to hate the therapist. Transference in the assessment and treatment situations provides important information about the client but is a potential challenge to the therapeutic alliance. Transference needs to be recognised and contained or carefully responded to by the clinician.

Countertransference is when the therapist, during the course of therapy, develops positive or negative feelings toward the patient. Countertransference is not a failure of therapeutic style or professionalism, it is a natural human response. However, it is important for the clinician/therapist to identify countertransference reactions and adjust their responses accordingly. Clinicians need to consider their own underlying beliefs, values and attitudes about suicide and how these may influence the way in which assessments are undertaken.

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