

# Suicide Risk Assessment and Management Protocols

## Community Mental Health Service



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## Related documents

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

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

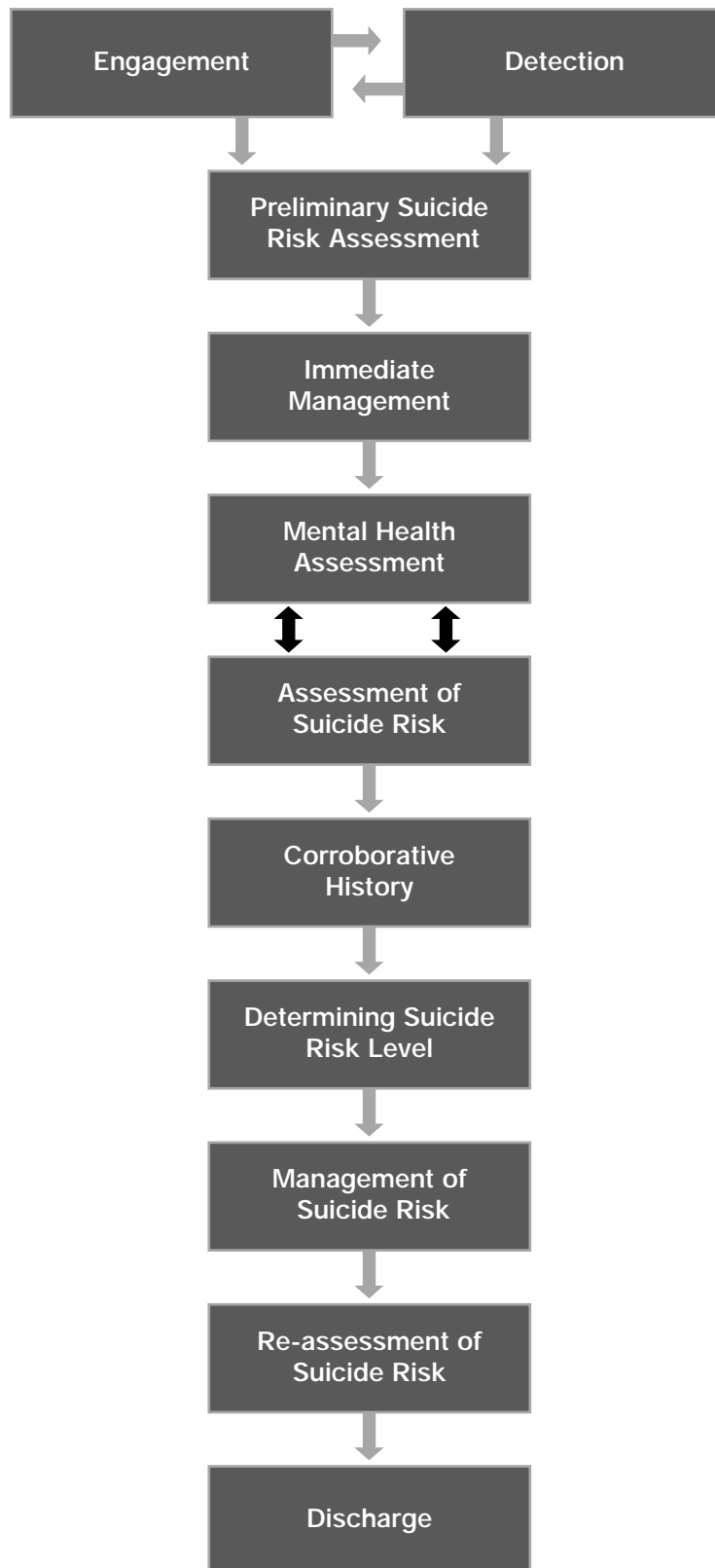
Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185

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

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

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

# Framework for Suicide Risk Assessment and Management for NSW Health Staff



# Introduction

These protocols refer to situations where a person has presented to a community health service, where mental health professionals are assessing someone at risk of suicide in the community or where a person has presented to an emergency department and the mental health service is contacted for assessment.

All mental health professionals are required to conduct thorough clinical assessments and manage people regarded as being at risk of suicide.

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

# Assessment of suicide risk

## Detection

It has been estimated that up to ninety percent (90%) of people who die by suicide suffer from a diagnosable mental disorder.<sup>3</sup> It is vital that a preliminary suicide risk assessment is conducted periodically on all people known to have a mental illness.

A comprehensive suicide risk assessment should be made for the following presentations:

- people who present following a suicide attempt or an episode of self-harm:
  - those who report or are reported to be preparing for suicide or have definite plans
- people with probable mental illness or disorder:
  - those who are depressed or have schizophrenia or other psychotic illness
- people whose presentations suggest a probable mental health problem:
  - those who report accidental overdoses or unexplained somatic complaints
  - those who present following repeated accidents, increased risk-taking behaviour, increased impulsivity, self-harming behaviours (eg superficial wrist-cutting), co-morbidity (eg with alcohol and other drugs, intellectual disability, organic brain damage)
- people recently discharged from an acute psychiatric in-patient unit, especially within the previous month
- people recently discharged from an emergency department following presentation of psychiatric symptoms or repeat presentations for somatic symptoms.

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

Examples include:

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

**Hopelessness** is one of the main factors mediating the relationship between depression and suicidal intent.<sup>4</sup> 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.<sup>5</sup>

**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.

## Psychiatric assessment

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

## 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 the 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 the 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 escalates the level of suicide risk. These include hopelessness, despair, agitation, shame, anger, guilt and psychosis. 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 in the current circumstances?
- Is there a history of suicide of a family member or friend?

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

## Assessment of suicide risk

### 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?

### Lethality/intent

- What is the person's degree of suicidal intent? How determined were/are they?
- Was their attempt carefully planned or impulsive?
- Was 'rescue' anticipated or likely? Were there elaborate preparations and measures taken to ensure death was likely?
- Did the person believe they would die? (Objectively question the person's perception of lethality.)
- Has the person finalised personal business, 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 when assessing a person following a suicide attempt, and asked in the present and future tenses when assessing a person contemplating suicide.

### Presence of a suicide plan

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

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

### Access to means and knowledge

- Does the person have access to lethal means? Is there a firearm available? (If a person at long-term high risk of suicide has access to firearms, the police should be contacted before the person is discharged to discuss the possibility of removing the firearms.<sup>6</sup>) 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 method chosen 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.<sup>7</sup>

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?

## **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 for the clinician to 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.

### **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 of suicide risk

Another factor that might indicate a level of uncertainty in the assessment is conflicting information, or a lack of corroborative 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 following a limited number of questions asked by the clinician. The clinician must feel confident with the person's response. Premature closure (concluding there is not 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.

### Corroborative history

- All means for accessing further information to assist with the risk assessment should be actively sought. The purpose of a corroborative history is to confirm the clinician's assessment, confirm the level of support and promote collaboration with the person and his/her support person/s.
- Corroboration helps to provide accuracy around the changeability of suicide risk status, enhances the assessment confidence, provides opportunities to assess family support 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
  - interview/phone contact with other relevant people, 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.

- There is a need to be aware that due to stigma and shame some families or support persons may not reveal the extent of the person's problems. Some cultures may fear repercussions, for example, an unwell mother having her children taken away.
- Assess the family/support person's belief about the 'at risk' person's current presentation (distress, 'attention seeking') and determine their response to the situation (worried, angry).
- Assess the family/support person's willingness and capacity to facilitate a protective environment for the person at risk on discharge (monitoring safety, removal of means).
- There should be careful consideration of the person's privacy prior to obtaining corroborative history.

### Determination of risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.<sup>8, 9,10</sup> A thorough assessment of the individual remains the only valid method of determining risk.

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

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

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

## Changeability

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

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

**High Changeability:** The clinician recognises the need for careful re-assessment and gives consideration as to when the re-assessment should occur, eg within 24 hours. 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 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.

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

- High Changeability Flag
- Low Assessment Confidence Flag

## Consultation with colleagues

- Assessment of people at risk of suicide is a complex and demanding task. It requires involvement of a mature, experienced clinician at some level.
- Wherever possible, all assessments of suicide should be discussed with a colleague or senior clinician at some stage of the assessment process.
- Consideration of the timing of consultation should be based on the degree of concern for the person. The greater the concern, the sooner the consultation should be sought.
- All teams involved in the assessment of people at risk should have access to regular (at least weekly) clinical forums such as a clinical case review where cases are presented and discussed.

## Documentation

- All details of risk assessment, management plans and observations are to be clearly documented in the person's medical record using the relevant Mental Health – Outcomes and Assessment Tools (MH-OAT) Clinical Modules.
- Document relevant sources of corroborative history and outcome from contact with each source.
- Response to clinical interventions should be noted.
- The rationale and reasons for the decision to manage the person in the community as opposed to hospitalisation and the management plan to support the decision should be documented.
- Contact details for the person, 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 concerns should be documented.

**Suicide Risk Assessment Guide<sup>2</sup>**

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

Issue	High risk	Medium risk	Low risk
<b>'At risk' Mental State</b> – 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.
<b>Suicide attempt or suicidal thoughts</b> – 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.
<b>Substance disorder</b> – 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.
<b>Corroborative History</b> – 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).
<b>Strengths and Supports (coping &amp; connectedness)</b> – 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.
<b>Reflective practice</b> – 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.
<b>No (foreseeable) risk:</b> 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

## Maximising a safe environment

- In most cases, proper management consists of supporting the safety of the person while the underlying mental health problem is treated.
- Assessing the degree of intervention required is dependent on many factors, some of which include:
  - severity of illness
  - degree of impulsivity of person
  - degree of insight displayed by the person
  - safety of current situation
  - supports available, for example, family, friends
  - the person's willingness and ability to engage.
- These factors need to be considered when determining the level of observation required for the person during the crisis period. The person and their family (if considered appropriate) should always be involved in the discussion of the most appropriate management setting and strategies to minimise the degree of suicide risk.
- If at any stage of contact a staff member is made aware that the person is in possession of or can gain easy access to a firearm and there is concern about the person's mental state, the risk of suicide or threat to public safety, the police should be contacted before the person is discharged to discuss the possibility of removing the firearm.<sup>6</sup>
- If a person who is considered to be at risk leaves the facility or other community setting, including the person's home, prior to assessment and/or management arrangements being completed, every effort should be made to locate the person. If there is serious concern, the police should be immediately contacted and provided with a description of the person and the likely areas they may be located.

### **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 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**

Definite but low suicide risk. The clinician considers a person at this level of risk requires review at least monthly. The person at risk should be provided with written information on 24-hour access to suitable clinical care.

- 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), which 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

## Management

- 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
- there is the ability for the person or carer to gain access to appropriate clinical expertise 24 hours a day. This will require the service being able to provide 24-hour access and to inform the person or carer how, when and where help will be available.
- The use of the *Mental Health Act 1990 (NSW)* may be necessary in the following instances to enable the continued observation and safety of the person:
  - if suicidal thoughts or verbal intentions are persistent and intense, or
  - the self-harming is serious in nature, or
  - there is evidence of serious mental disorder or illness.
- Management in the community is not appropriate when suicide risk escalates beyond a critical level and there are significant limits in the levels of support available for the person. Critical level is indicated by an assessment of high lethality and high intent.
- The rationale and reasons for the decision to manage a person at high risk of suicide in the community as opposed to hospitalisation and the management plan to support the decision should clearly be 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.

Measures which will facilitate risk reduction include:

- support
- collaboration with the person and all parties concerned

- regular review, including specialist reviews by a psychiatrist
- problem solving
- supporting and encouraging the person to see a general practitioner.

Psycho-education should be provided to the person and, if appropriate, their family, and strategies should be in place targeting the broader psychosocial needs of the person – housing, income maintenance, food, employment and social skills development.

Psycho-educational themes that might be helpful to explore include relapse prevention, information about the seriousness of persistent suicidal ideation and deliberate self-harm behaviour, education about depression management and treatment, and information about the link between mental illnesses (schizophrenia, depression and bipolar disorder) and suicide.

All attempts must be made to negotiate a management plan of ongoing support in an environment that minimises access to means of suicide.

## Management plan for a person in the community

- Before the person leaves the hospital or other facility, he/she should be given a management plan including the level of support to be provided by the service, written information about how to seek further help, including a 24-hour telephone number and the name of a contact person.
- 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.
- The management plan should be negotiated with the person and family/support person. 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.

When the person is being managed in the community, the following strategies are the minimum management requirements:

- Appropriate supports have to be identified who are willing to manage the person at risk.

- A face-to-face re-assessment must be conducted within the relevant time period according to the level of risk.
- The person and their family/support person(s) are to be informed of the name of the clinician who has prime responsibility for the person's care, wherever possible. (Where team management operates, a phone contact and the names of staff on duty over the next 24 hours should be provided).
- The person and family/support person should be provided with:
  - the time and place for the re-assessment interview
  - detailed information about the 24-hour availability of the service and how to re-contact the service if concern increases or the person's situation changes and earlier re-assessment is required
  - 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.
- Contingency planning for urgent and rapid reassessment must be in place for those at high or medium risk.
- 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 they are with; and how to contact the team for an urgent re-assessment.
- When a person has been assessed as 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.

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

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

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

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

## Coordination and communication

- At team shift hand-over, staff must be made aware of the person's level of risk and the current management plan.
- The person's level of risk is to be indicated in a place that is easily identified by staff, eg the whiteboard.
- The full treating team should regularly discuss the person's general progress and revision of the suicide risk.
- The person's general practitioner, private psychiatrist or other professionals involved in the person's care and the family and other support people should be kept informed of changes in management.

## Managing a suicide attempt

- If the person is in any physical distress or requires medical care, telephone 000 for an ambulance. Do not leave the person.
- Remove the person from danger without placing any other person present at risk.
- Assess the person's current suicide risk. An attempted suicide usually indicates the person is at high risk in the immediate and short-term period.
- Provide support to other people present who may be acutely distressed, including staff.
- Follow all related procedures in regard to incident reporting, management and review.<sup>11</sup>

## Managing a suicide death

- Refer to NSW Health, *Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities*.<sup>12</sup>

# Re-assessment of risk

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

For people at **high risk** and/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 reassessment 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 reassessment 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**.

- The re-assessment of risk provides another opportunity to consolidate the therapeutic relationship between the health service, person, family and other relevant service providers, to review the risk and protective factors and to 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.
- Re-assessment of risk will include a re-evaluation of previously detected 'at risk' mental states.
- 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.

- Collateral information, particularly from the family or support person, should always be sought as part of the re-assessment of suicide risk. Reports from the Coroner's office are very clear that this is a source of information frequently ignored by clinicians.
- 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.

## Re-entry pathway

- When a person exits from a mental health service or is discharged from a particular setting within a mental health service the following precautions should be in place and documented in the discharge plan:
  - the person and their family or support person knows how to re-enter the previous level of care through a re-assessment process
  - the person and their family or support person has confidence that there are no barriers to re-assessment and, if appropriate, re-entry to the previous level of care
  - a clinician who knows the person is nominated as the preferred point of contact.



# References

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