Government of **Western Australia**
Department of **Health**

Principles and Best Practice for the Care of People Who May Be Suicidal

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Contents

1. Introduction

This document provides guidance to relevant health service providers, clinical teams and clinicians who provide public mental health services about the treatment of people who may be suicidal. It addresses:

- the underpinning values which determine best practice for how mental health consumers and their carers/family or personal support persons are engaged and how their views are considered
- how health service providers should respond to consumers who may be suicidal, how they should be assessed and how their care should be managed
- how health service providers should establish and maintain an effective reflective learning culture to continuously improve care.

2. Making the case for change

Historically, the focus of assessment of those who may be suicidal has been on the prediction of risk through the use of assessment tools which require the assessor to complete a checklist of consumer characteristics, aimed at stratifying consumers into categories of high, medium or low risk.

This approach, which has been termed the actuarial approach, does not provide clinicians with the means to accurately predict the risk of suicide in an individual consumer. In fact, the vast majority (97%) of people assessed as being at high risk do not lose their lives to suicide, while the majority of suicides (60%) occur in people assessed as being at low risk.[1]

In the United Kingdom, the National Institute for Health and Care Excellence (NICE) specifically advises against using risk assessment tools and scales to predict future suicide or self-harm.[2] It advises against the use of risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged. NICE guidance also advises against the use of global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm or to determine who should be offered treatment or who should be discharged. Instead, NICE recommends that assessment should focus on the person's needs and how to support their immediate and long-term psychological and physical safety.

Similarly, the New South Wales policy directive on the Clinical Care of People Who May Be Suicidal (2016) advises that the use of suicide risk factor checklists or screening tools alone cannot be recommended for use in clinical practice as a means of assessing a person's risk of suicide and 'should not be used in isolation to determine treatment decisions.'[3] In Western Australia (WA), the mandated mental health Risk Assessment and Management Plan (RAMP) and other locally developed suicide risk assessment tools and checklists should not be used in isolation to determine treatment and management decisions.

The widespread belief within the community that suicide can be accurately predicted has led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and management were more rigorously applied. However, the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.

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[1] Large MH, Sharma S, Cannon E, Ryan CE, Neilssen O. Risk factors for suicide within a year of discharge from psychiatric hospitals: A systematic meta-analysis. Aust N Z J Psychiatry 2011; 45:619–628.
[2] Nice Guideline [NG225] Self-harm, assessment, management and preventing recurrence. National Institute for Health and Care Excellence. 2022.
[3] Ministry of Health. Clinical care of people who may be suicidal. Government of New South Wales. 2016.

Operating within what can be perceived as a culture of blame, it is not surprising that there is a preoccupation with risk, with the consequence that control is largely retained by the clinician, who then takes sole responsibility for an individual's safety. Evidence suggests this approach is ineffective in keeping people safe and can lead to needlessly restrictive treatment and hamper recovery.

3. Values

In providing care to people who may be suicidal, the way in which clinicians respond is vital, both for the person and also for their carers/family and personal support person. This is important for short term resolution, and also has an impact on whether a person will engage willingly with mental health services in the future. The values which underpin this document promote care that is:

- recovery-oriented
- person-centred
- trauma-informed
- culturally competent
- developmentally appropriate.

3.1 Recovery-oriented care

Recovery-oriented practice supports people in taking responsibility for their own recovery and well-being and pursuing their life goals. In any setting, when clinicians are recognising and responding to a person who may be suicidal, recovery-oriented care involves sharing responsibility for safety with consumers to the greatest extent possible, creating opportunities for the person to regain their self-control and supporting their autonomy to pursue their life goals.

3.2 Person-centred care

Person-centred care is based on the principles of personhood, individualised care and empowerment. In providing clinical care to people who may be suicidal, it is necessary to consider the whole person within their social context, recognising their unique needs, experiences, values and preferences and supporting self-determination in decision making.

3.3 Trauma-informed care

Many people who access mental health services have experienced trauma in their lives. Trauma-informed care assists in creating physical, psychological and emotional safety for individuals who may be suicidal.

3.4 Culturally competent care

Cultural competence enables clinicians to provide care in cross-cultural situations, including with Aboriginal people, those from ethnoculturally and linguistically diverse backgrounds and people from the LGBTQIA+ communities. An awareness of the cultural values and beliefs about

health and illness that are held by an individual and their family are an important consideration in the way that care is provided.

3.5 Developmentally appropriate

Planning services and approaches should respond to the needs of young people. Developmentally appropriate care considers the level of physical, social, emotional and intellectual development of a child. This applies in particular to those circumstances where children under the age of 18 are cared for in adult environments, such as emergency departments (EDs) and adult wards.

4. From managing risk to promoting safety and recovery

Policy and practice in mental health care delivery prioritises both the promotion of recovery, which emphasises individual autonomy and control, and the minimisation of risk. These two priorities are often seen as incompatible, particularly in the current risk averse environment where risk assessment and management, which is seen primarily as the province of the clinician, too often takes precedence over recovery.

In a report of the Royal College of Psychiatrists UK (2008), consumers reported:

> '… their preference for safety enhancement rather than risk reduction as a more empowering approach to discussing risk.'[4]

Effective clinical care of people who may be suicidal requires an approach by clinicians that promotes safety and recovery, founded on shared understanding, supported decision-making and shared responsibility for safety. In promoting this approach to safety, establishing a therapeutic alliance is essential. This requires open, honest and transparent relationships where each party understands the other's perspective and constraints and where the shared goal is one of promoting recovery and self-determination.

The clinical assessment and care of people who may be suicidal requires meaningful collaboration with each individual, their carers/family and personal support person, and other agencies involved in their care. For some people, it may not be possible to involve carers/family or a personal support person, but every effort should be made to do so.

In balancing risk with safety, this document emphasises:

- proactive engagement with consumers and their carers/family and personal support person as partners in the risk assessment and safety planning process, which is based on a trusting relationship with clinicians
- supporting recovery and building on the strengths of the individual while recognising that not all risk can be eliminated
- the responsibility of the organisation, as well as the individual clinician, to support safety planning for recovery.

Where the sharing of information with 'family, carers or personal support person' is referenced within this document, the treating clinician should be cognisant of the wishes of the consumer, and where the treating clinician considers it is safe to do so, to abide with an explicit request

[4] Rethinking risk to others in mental health services: final report of a scoping group. Royal College of Psychiatrists, United Kingdom. 2008.

from adult consumers that information is not shared with others (which must be documented in the clinical file).

5. Recognising and responding to people who may be suicidal

The assessment and decision-making processes relating to the clinical care of a person who may be suicidal are to be conducted in a manner that is collaborative and culturally and developmentally appropriate. Although there are circumstances where a clinician will be working alone, most assessments and decisions regarding treatment and safety should be made by a multidisciplinary team in collaboration with the consumer and their carers/family and personal support person.

5.1 Assessment of people who may be suicidal

Assessing risk is an essential first step, but not an end in itself; rather, the primary purpose is to establish and agree on actions to promote safety and inform the clinical care of each individual.

People who may be at risk of suicide, including those presenting with suicidal ideation or self-harm, those admitted to an inpatient unit or ED and generally people in crisis, should receive a comprehensive mental health assessment.

Structured clinical judgement (an approach to risk assessment) along with a specific clinical risk assessment instrument, i.e. RAMP, should be used to assess suicide risk at the individual consumer level. It involves the clinician making a judgement about risk based on a combination of the evidence base for risk factors, individual consumer assessment including the consumer's view of their own experience and circumstances, together with clinical experience and knowledge of the consumer.

Singular simple application of standardised checklists and actuarial tools is ineffective in assessing people who may be suicidal. Assessment also requires deep perceptions of complex situations and the handling of ambiguities and unpredictable variation. It requires the clinician to gain insight into the complexity of the person's individual situation and what influences fluctuations in mood and behaviours. Services should prioritise support for clinicians to be able to conduct the necessary assessments, especially in situations where clinicians' knowledge of the mental health consumers they are assessing is limited. In the assessment of a person who may be suicidal, it is the singularity of each individual – the details of each person's narrative – that holds the most informative clues, not only for understanding that person, but also for selecting the approaches to care that are most likely to be beneficial. While knowledge of conditions and treatments are essential, knowing how best to apply that knowledge to each individual person demands a deep understanding of the person within their life context.

Assessment must be conducted in collaboration with the individual and, where possible and appropriate, their carers/family and personal support person and is to encompass:

- a detailed evaluation of all aspects of suicidal behaviour and ideation, including static risk factors, dynamic risk factors, protective factors, warning signs, foreseeable changes, available resources, risk mitigation and residual risks
- a psychiatric diagnostic assessment and suicide risk formulation
- a thorough determination of the psychosocial circumstances contributing to the clinical presentation. In the case of children and adolescents, this involves an assessment of parents'/guardians' ability to safeguard their child and contain risk.

Do not delay the psychosocial assessment until after medical treatment is completed.

A determination of the nature and severity in these domains then forms the basis of decision-making concerning consumer safety and care, with the emphasis on customising care for each individual. Risk assessment checklists and the RAMP record clinical and other information about individuals and may aid clinical decision-making and safety planning; however, they have low reliability for predictive purposes and should not be used in isolation to assess risk and inform clinical care.

Risk is fluid and can change over very short timeframes. While some risk factors are long term or stable and give an indication of an individual's general propensity for suicide, other factors are short term or dynamic and capture the fluctuating nature of risk. This latter group is critical for considering the particular conditions and circumstances that place the individual at clear and imminent risk and need to be given particular consideration in informing decisions about safety and care.

In recognising the dynamic nature of risk, assessment should be an ongoing process embedded in everyday clinical care, with particular attention given to the periods of heightened risk at critical points in care, as outlined in section 6.

5.2 Aboriginal people – special considerations

Aboriginal people are over-represented in terms of suicide risk and have a higher statistical rate of suicide and suicidal ideation.

When assessing Aboriginal patients, it is beneficial to consider the effects of historical events which have resulted in long term intergenerational trauma, including dispossession through the removal of children, systemic racism and oppression, and discrimination in all aspects of human rights.

When assessing and treating Aboriginal patients it is important to:

- self-evaluate, ask questions and use a patient-focused approach, avoiding the use of jargon
- be aware of, and avoid, unconscious bias
- address cultural safety needs and instigate cultural supervision that recognises the importance of:
    - the need for health professionals to discuss cultural issues and practices when caring for Aboriginal patients
    - further training and professional development for health professionals about factors that affect assessment and treatment for Aboriginal patients
    - peer support and group supervision
    - healing and debriefing Aboriginal patients
    - addressing vicarious trauma and its impact on Aboriginal people
    - supporting Aboriginal people in high-risk environments
    - traditional practices.

5.3 Safety planning for people who may be suicidal

Safety plans promote safety and support recovery and self-determination and should be developed for each consumer with suicide risk. This must be done collaboratively between clinicians, the consumer and, where available, their carers/family and their personal support

person. Safety planning processes should be sensitive to diverse sexualities and genders (LGBTQIA+).

The safety plan can be produced in conjunction with and be referred to in the Treatment, Support and Discharge Plan outlined in the *Mental Health Act 2014* (MHA 2014), as part of the RAMP or as a separate plan in the consumer's medical record. The safety plan must be revised and updated at points of significant transitions in care, as these represent times of potential increased risk. The 'Triage to Discharge' Mental Health Framework for Statewide Standardised Clinical Documentation contains advice about safety planning for mental health consumers.[5,6]

The consumer, their carers/family and personal support person should be invited to participate in formal multidisciplinary meetings to develop and review the safety plan. Opportunities should be provided for the consumer and their carers/family and personal support person to meet, either separately or together, with key clinicians prior to and after the meetings.

5.4 Responding to people with ongoing suicidality

People experiencing recurrent or persistent suicidal ideation and those making multiple suicide attempts and/or intentionally self-harming on multiple occasions have an underlying heightened baseline risk of suicide. This is usually associated with the presence of long-term static and historical predisposing factors (e.g. gender, childhood adversity, family history of suicide, repeated self-harm or mental illness). This base of long-term heightened propensity for suicidal ideation and dynamic risk factors (e.g. psychosocial stressors, a sense of hopelessness, non-adherence to treatment, harmful use of alcohol and other substances, hospital admission/discharge), which fluctuate in duration and intensity, can build and rapidly push the person into an episode of suicidal or self-harming behaviour.

Ongoing assessment of these dynamic risk factors and their complex interaction with longer term predisposing factors, as well as the capacity of the individual and their support network is critical for informing the person's clinical care. In recognising the fluidity of risk, the safety plan should be reviewed every time an individual has contact with a service delivering mental health care or treatment, including planning for when chronic risk becomes acute. Although the longer-term strategy is to address the underlying issues and support recovery in the community, in the short term, hospitalisation may be required as a means of establishing immediate safety.

In working with people with ongoing suicidality, it is important to treat the individual and consider their circumstances rather than drawing conclusions simply based on diagnosis or rigidly adhering to a set of clinical guidelines. It is also important to establish continuity of care and a relationship of mutual trust, which strengthens the therapeutic relationship and fosters communication.

6. Heightened risk at critical points in care

In WA, the Stokes Review identified that over one-third of Western Australian men who died by suicide between 1986 and 2005 had been admitted to a psychiatric hospital or a public hospital for psychiatric treatment at some point in their lifetime.[7] Fifteen per cent of these men completed

[5] 'Triage to Discharge' Mental Health Framework for Statewide Standardised Clinical Documentation. Version 11 2021

[6] Consumer Safety Plan

[7] Stokes, B., Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia. 2012, Department of Health, Western Australia and the Mental Health Commission: Perth, WA.

suicide on the day of discharge from their last admission. Similarly, 20 per cent of women completed suicide on the day of discharge, and 33 per cent within a month of discharge.

The immediate post discharge period is a time of marked risk, but rates of suicide remain high for many years after discharge. Patients admitted because of suicidal ideas or behaviours and those in the first months after discharge should be a particular focus of concern.[8]

Safety following discharge from psychiatric inpatient units requires assertive and coordinated follow-up, with direct contact with the person as soon as possible after discharge. While the national indicators measure 7-day follow-up, the actual timing of follow-up should be determined by the needs of the individual consumer.

Transfer of care information between service providers should take place before discharge and a clear understanding of the responsibilities of clinicians for follow-up should be documented in the safety plan. Follow-up should, where feasible, include discussion with the personal support person and an escalation plan developed in collaboration with the consumer and their carer/s.

These relatively defined periods of heightened risk, frequently associated with transitions in care, provide a real opportunity for clinicians and mental health services to develop models of service provision and practice aimed at decreasing the likelihood of suicide. Such responses should be built on the foundation of:

- a trusting relationship with clinicians, as this affects the willingness of people to seek care, reveal sensitive information and engage in treatment
- an individualised approach
- continuity and coordination of care
- supported decision-making.

In addition, within inpatient units, mental health services have a responsibility to improve consumer safety by reducing environmental hazards and risk, including by counselling consumers, carers/family and personal support people on access to lethal means.

6.1 People who may be suicidal presenting to emergency departments

Attempted suicide and self-harm are common reasons for people seeking help from an ED. It has been estimated that up to 20 per cent of people who present to an ED with self-harm will repeat self-harm in the following 12 months. The risk of suicide is elevated by between 30 and 100-fold in the year following self-harm and the risk persists, with one in fifteen people dying by suicide within 9 years of the index episode. EDs provide a unique opportunity for instigating interventions that have the potential to prevent suicide.

Consumers who have self-harmed are at high risk of death by suicide regardless of the apparent lethality of the self-harming behaviour.

A national study conducted by the Centre of Research Excellence in Suicide Prevention (2015) prepared for the Australian National Mental Health Commission found that one third of people presenting to hospital following a suicide attempt received no mental health follow-up.[9]

Aboriginal people presenting to ED are at higher risk of completing suicides and the safety plan should incorporate follow-up, which may necessitate home visits.

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[8] Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 74(7):694-702.
[9] National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention. *Care after a suicide attempt*. Commonwealth Government of Australia. 2015.

Studies reflecting feedback from people who have attempted suicide and their caregivers have identified the importance of a number of aspects of care in the ED:

- empathic, non-judgemental clinical staff with good knowledge about suicide
- having emotional distress recognised and responded to
- a private area for assessment and care
- participation in decision-making about their care
- discharge planning, including firm follow-up arrangements post-discharge
- involving families and the personal support person in a collaborative model of aftercare
- in the case of minors, including the parents/guardians in safety planning.

New South Wales Health's reference guide, *Mental Health for Emergency Departments – A Reference Guide* (2015), states that:

> 'All patients with self-harm, suicide attempt or marked suicidal ideation require mental health consultation before discharge is considered.'[10]

The Victorian Department of Health guide, *Working with the suicidal person A summary guide for emergency departments and mental health services* (2010), advocates that:

> 'When a person presents in the emergency department with suicidal ideation or self-harm risk, the treating clinician should always consider referral for mental health assessment, or at least seek to discuss the situation with an experienced mental health clinician.'[11]

As outlined above, presentation of people following a suicide attempt or self-harm provides a real window of opportunity for preventing suicide, not only in the short-term but throughout an individual's lifetime. It is important that ED staff and specialist mental health staff work closely together to establish an environment in which this goal can be realised, and consumers should be entered onto a pathway of care with safety planning and follow-up post discharge.

EDs and local mental health services should work collaboratively to develop local protocols for people presenting at the ED who are at risk of suicide. Consumer safety, referral/consultation, discharge planning and follow-up must be specifically addressed in these protocols.

Mental health services, in partnership with EDs, should align local protocols for people presenting at an ED who are at risk of suicide with the following guidance, which is informed by best practice and should shape protocol development.

Consumer safety

Waiting times should be minimised for people who present to an ED after a suicide attempt or self-harm. The consumer needs to be kept under observation to minimise the risk of leaving before full assessment or accessing objects that could be used for self-harm.

Referral/consultation

All people who present following attempted suicide or self-harm should receive a consultation with a mental health professional before discharge. This ideally would be face-to-face, but

[10] Ministry of Health. *Mental Health for Emergency Departments – A Reference Guide*. Government of New South Wales. 2015.
[11] Department of Health. Working with the suicidal person A summary guide for emergency departments and mental health services. Government of Victoria. 2010.

could, where necessary, be via telehealth. At minimum, the treating clinician should seek to discuss the situation with an experienced mental health clinician. Protocols between mental health and ED staff should address the following:

- appropriate triage and management pending handover to mental health clinicians
- notifying mental health services of the risk of imminent departure of the person from the ED
- handover and referral processes to transfer care to mental health services.

Emergency department discharge plan

Before discharge, a discharge plan needs to be developed involving the consumer and, where at all possible, their carer and personal support person. The plan needs to be in a written form and provide details about follow-up arrangements and dates of review appointments, information about community resources, details of services that can be contacted in the event of a worsening of their condition and advice about when to return to the ED. The consumer and, where possible, their carer and personal support person should be provided with a copy of the plan, advised to remove lethal means (e.g. excess medication, firearms) and monitor sudden changes in behaviours. Consumers should not be discharged alone, and staff should ensure that the carer/family/personal support person are available to supervise in the immediate post-discharge period.

Follow-up

All people leaving hospital after a suicide attempt or self-harm should be followed up and receive appropriate care from a mental health professional or their General Practitioner (GP). There should be active follow-up (e.g. telephone contact, letter, home visit, contacting carer/family member/personal support person) if a person fails to attend their post-discharge follow-up appointment, to encourage the individual to participate in post-discharge care.

People who leave prior to assessment/completion of assessment are at higher risk of repetition and suicide. If a person leaves under these circumstances, active attempts at follow-up should be made through phone contact (with the person and their next of kin), or though their GP, mental health services or the police.

7. A learning culture

Clinical care for people who may be suicidal is enhanced through a combination of individual professional, multidisciplinary team and system based organisational learning; individual learning alone is not sufficient. What is required is the cultivation of a culture of learning at all levels of the organisation that encourages and supports continuous improvement, attaches importance to research evidence, nurtures reflective practice and critical thinking, values employee contributions and fosters experimenting with new ideas.

There is much to learn from adverse events, but this can be hindered by pervasive barriers such as a lack of psychological safety and a culture of blame. Leadership that accepts that errors will occur, proactively develops strategies to minimise them and promotes a no blame culture enhances the reporting of errors, which, in turn, facilitates organisational learning and safer care.

7.1 Enhancing clinicians' knowledge and skills

Risk assessment and safety planning, which is a core competency for all mental health clinicians, is an approach to clinical practice rather than simply a set of skills taught through training. Training has a role, but only alongside the development of sound clinical skills in daily practice. Mental health services should support clinicians to provide best practice risk assessment and safety planning by ensuring that they have access to regular education and professional development, as well as on-going opportunities for reflective practice, consultation with senior colleagues and individual supervision. Clinical supervision is one component of professional development and support for staff engaged in clinical work. All clinical and managerial staff engaged in clinical work require supervision relevant to their experience and expertise.

Mental health services, regardless of setting, must proactively put processes and procedures in place to ensure all clinicians who are likely to encounter suicidal consumers are competent in suicide safety assessment and management.

7.2 Enhancing multidisciplinary team learning

In most situations, effective safety assessment and management decisions are made by a multidisciplinary team of clinicians, highlighting the importance of effective team working and communication and team learning. As Morgan (2013) asserts,

> 'In good teams, the best training happens on a routine basis as part of their case review meetings and their own practice development discussions. This is best because it allows the multidisciplinary team to come together with a potential to focus on their specific service-user group, to discuss their challenges and implement their solutions.'[12]

In this approach, learning is envisaged as a continuous process for which individual practitioners and teams have responsibility. Wherever possible, effective safety assessment and management decisions are to be made by a multi-disciplinary team and recorded in the clinical notes. Where this is not possible, the reason should be clearly documented.

While much can be learned from looking back at adverse events, including near misses, much can also be learned from good practice. Mental health services should have processes in place to systematically learn from both adverse events and good practice so that, where necessary, practices and education/professional development can be improved. Processes should be in place to review suicide or self-harm in individuals, including feedback from carers/family members or the personal support person, on the appropriateness of the response and ways in which it could have been improved. Periodic reviews of all such events should be undertaken by teams and services to try to identify common factors or patterns that may be amenable to practice and service change.

7.3 Enhancing organisational learning

Health service providers have statutory requirements under the MHA 2014 for reporting and investigating a suspected death by suicide or an attempted suicide. This information, which is routinely collected, should be regularly collated and evaluated by health service providers, supplied to the Department of Health and made widely available to help shape policy and improve services.

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[12] Morgan S (2013). *Risk decision-making: working with risk and implementing positive risk-taking*. Middlesex, United Kingdom: Pavilion Publishing and Media.

The National Confidential Inquiry into Suicides and Homicide by People with Mental Illness[13], which has been tracking trends in suicide and homicide in the United Kingdom since 2002, reports annually and recommends measures by which services might reduce the risk of such adverse incidents. This could provide a useful model for WA in evaluating the impact of policies and understanding changes in self-harm, attempted suicide and deaths by suicide over time.

8. Support following self-harm or suicide

Serious incidents of self-harm or loss of life by suicide are distressing for the person's carers/family, personal support person and friends and for those involved in their care, treatment and support. Mental health services should adopt clear protocols for post-incident management in order to minimise the ongoing impact of such events on staff, carers/family, the personal support person and other consumers who may have witnessed the incident or have developed a relationship with the person. Families and personal support persons should be contacted by the mental health service and offered support as soon as possible after a suspected death by suicide. This should include the offer of referrals to bereavement counselling/support services.

Team debriefing should be provided for staff and any individual clinician affected by the death should be offered support from their team manager and clinical supervisor and, where necessary, referral to the Employee Assistance Program. Staff should have training in 'mental health first aid'. Consumer debriefing may be appropriate, particularly following the death of an individual in an inpatient setting.

9. Documentation and sharing information

All significant assessment and rationales for safety planning decisions should be recorded in a clear and timely way in the consumer's clinical notes. The way in which information is held, accessed and communicated should be designed to enhance clinical care and remove unnecessary barriers to sharing important, relevant medical information between those service providers directly involved in the consumer's treatment and care, having due regard for the confidentiality requirements of the MHA 2014 and the Health Services Act 2016.

Currently, a minimum requirement is that clinicians document care using MP 0155/21State-wide Standardised Clinical Documentation for mental health services. Suicide risk assessment tools cannot be relied upon to predict or grade the level of risk of suicide, and they should not be used alone. There is no substitute for a full assessment as set out in section 5.1 of this document.

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[13] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *Making Mental Health Care Safer: Annual Report and 20-year Review*. University of Manchester. 2016.

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