



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

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1. INTRODUCTION

The purpose of this document is to provide guidance to relevant Health Service Providers and Contracted Health Entities (who provide public mental health services), clinical teams and clinicians about the treatment of people who may be suicidal. It was developed to support the implementation of the Clinical Care of People Who May Be Suicidal Policy and addresses:

- the underpinning values which determine best practice for how mental health consumers and their personal support persons are engaged and how their views are taken into account.
- how Health Service Providers and Contracted Health Entities should respond to consumers who may be suicidal, how they should be assessed and how their care should be managed.
- requirements to establish and maintain an effective learning culture to continuously improve care.

2. MAKING THE CASE FOR CHANGE

Each year, about three hundred and sixty Western Australians die by suicide and it has been estimated that one quarter will have had contact with a mental health service¹ in the year preceding their death. Reducing these tragic deaths remains a priority for all clinicians and Mental Health Services.

The challenges for an individual clinician faced with the assessment of a person who may be suicidal are twofold: firstly, it is an uncommon event, even within mental health services, with rates of around one person per one thousand episodes of care or hospital admissions; and secondly, there is no set of risk factors that can accurately predict suicide in the individual patient.

All too often, however, the focus has been on the *prediction* of risk through the use of assessment tools which basically require the assessor to complete a checklist of patient characteristics, aimed at stratifying patients into categories of high, medium or low risk.

¹ Mental health service definition - (*Mental Health Act, 2014* section 4)

a) means any of these services:

- a hospital, but only to the extent that the hospital provides treatment or care to people who have or may have a mental illness;
- a community mental health service;
- any service, or any service in a class of service, prescribed by the regulations for this definition; and

b) does not include:

- a private psychiatric hostel; or
- a declared place as defined in the Mentally Impaired Accused Act section 23.

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

In the United Kingdom, the National Institute for Health and Care Excellence (2011) has recommended against using risk assessment tools and scales to predict future suicide although it did note that they may be helpful in structuring the risk assessment (as an 'aide memoire'). Similarly, the New South Wales policy directive on the *Clinical Care of People Who May Be Suicidal (2016)*, has advised 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*'.

The widespread belief within the community that suicide is able to 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 risk 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.

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 not only ineffective in keeping people safe but it can lead to needlessly restrictive treatment and can also 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 family and personal support person. This is important not just for short term resolution but also has an impact on whether a person will engage willingly with mental health services in the future. The values which underpin this document are informed by the *Chief Psychiatrist's Standards for Clinical Care 2015* which 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 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 his / her 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 approaches to care assist 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 culturally and linguistically diverse backgrounds and people from the lesbian, gay, bisexual, transgender and intersex communities. An awareness of the cultural values and beliefs about health and illness that are held by an individual and their families are an important consideration in the way that care is provided.

3.5. Developmentally appropriate

The best interest of the child is a primary consideration, and developmentally appropriate care is necessary. This applies in particular to those circumstances where children under the age of eighteen 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, as well as 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.”

A recovery-focus in the clinical care of people who may be suicidal necessitates a shift in the current approach from clinicians *managing risk* to one that *promotes safety and recovery*; founded on shared understanding, shared decision-making and shared responsibility for safety. In promoting this approach to safety, establishing a therapeutic alliance is central and requires:

“ ... open, honest and transparent relationships where each understands the other’s perspective and constraints and where the shared goal is one of promoting recovery and self-determination.”

Essentially, the clinical assessment and care of people who may be suicidal requires meaningful collaboration with each individual, their family and personal support person, and other agencies involved in their care. For some people it may not be possible to involve family or 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 families and personal support person as partners in the risk assessment and safety management process which is based on a trusting relationship.
- 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 this approach.

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 is to be conducted in a manner that is collaborative and culturally and developmentally appropriate. Although there are circumstances where a clinician is working alone, most assessments and decisions regarding treatment and safety should be made by a multidisciplinary team in collaboration with the consumer and their 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 what is to be done to promote the safety and inform the clinical care of each individual.

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

Structured clinical judgement, an approach to risk assessment and not a specific clinical risk assessment instrument, is the preferred approach to the assessment of suicide risk at

the individual patient level. It involves the clinician making a judgement about risk based on a combination of the evidence base for risk factors, individual patient assessment including the consumer's view of their own experience and circumstances, together with clinical experience and knowledge of the consumer.

The simple application of standardised checklists and actuarial tools is not effective in assessing people who may be suicidal, rather the assessment entails constructing deep understandings of complex situations and the handling of ambiguities and unpredictable variation. It requires the clinician to formulate a narrative understanding of the rich complexity of the person's individual situation and what influences fluctuations. 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 disease and treatment are essential, knowing how best to apply that knowledge to each individual person demands a deep understanding of the person within his / her life context.

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

- a) a detailed evaluation of all aspects of suicidal behaviour and ideation;
- b) a psychiatric diagnostic assessment and formulation; and
- c) a thorough determination of the psychosocial circumstances contributing to the clinical presentation. In the case of children and adolescents, this involves assessment of parents' / guardians' ability to safeguard their child and contain risk.

A determination of the nature and severity in these domains then forms the basis of decision-making concerning patient safety and care, with the emphasis on customising care for each individual. Risk assessment checklists or tools have low reliability for predictive purpose and, while they may aid clinical decision-making, should not be used in isolation to assess risk and determine 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 special 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 below.

5.2. Responding to people who may be suicidal

Safety Plans promote safety and support recovery and self-determination and must be developed for each consumer who has a suicide risk. This must be done collaboratively between clinicians, the consumer, their family and their personal support person. The Safety Plan can be incorporated as part of the treatment, support and discharge plan outlined in the *Mental Health Act 2014*. The Safety Plan must be revised and updated at points of significant transitions in care as these represent times of potential increased in risk.

The consumer, their 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 family and personal support person to meet, either separately or together, with key clinicians prior to and after the meetings.

The Safety Plan must:

- recognise the individuality of risk by identifying specific triggers and circumstances which may compromise safety.
- describe how responsibility for safety will be shared by specifying agreed actions and roles for the consumer, their family and personal support person and clinicians in implementing the Safety Plan.
- formulate strategies to reduce risk and enhance safety which also:
 - take into account the views of the consumer and their family and personal support person in identifying which interventions are likely to work;
 - link strategies to the consumer's strengths and their recovery / life goals;
 - enhance the consumer's capacity to keep himself / herself safe;
 - empower parents/guardians to safeguard the child / adolescent by being active participants in the Safety Plan.
- identify the actions to be taken, when and by whom in the event of a crisis.
- identify how the consumer, their family and personal support person and the clinician will regularly monitor the person's safety.
- detail the responsibilities of clinicians for follow up.
- schedule times for regular reviews of the Safety Plan. Additionally, reviews are to be conducted at times where it is identified that safety arrangements may need to be reviewed and at times that are recognised to be periods of heightened risk.

Risk can never be completely eliminated. Positive risk management, which recognises all decisions carry some element of risk, should be integral to the process of safety planning. This approach, which builds on the consumer's strengths and enhances their recovery, is based on a trusting therapeutic relationship and uses the least restrictive practice. It involves:

- working alongside the consumer and their family and personal support person, weighing up the potential benefits and harms of possible actions;

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- being willing to take a decision that involves an element of risk where the potential benefits outweigh the risks; and
 - communicating this decision, together with the rationale, to all involved.

While shared responsibility for safety is a principle that underpins the response to people who may be suicidal, there will be situations where the consumer lacks the decisional capacity to assess the implications of their actions. In these circumstances a clinician has a clear duty of care to intervene in the best interests of the individual to support their safety and that of others.

When agreement regarding decisions in the Safety Plan cannot be reached with consumers and their families and personal support person, their views are to be acknowledged, decisions discussed with them and continued efforts made to assist the individual regain control over their own safety. The differing views and reasons for decisions are to be documented in the clinical file notes.

The content of the Safety Plan is to be shared with the consumer, their family and personal support person and if any aspect is not to be communicated, the reason for this decision is to be documented in the clinical file notes.

5.3. Responding to people with ongoing suicidality

People experiencing recurrent or persistent suicidal ideation and those making multiple suicide attempts and/or multiple occasions of intentional self-harm have an underlying heightened baseline risk of suicide 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). It is upon this base of long-term heightened propensity for suicide that the dynamic risk factors (e.g. psychosocial stressors, a sense of hopelessness, non-adherence to treatment, hospital admission / discharge), which fluctuate in duration and intensity, build and can rapidly tip the person over into an episode of suicidal or self-harming behaviour.

On-going assessment of these dynamic risk factors and their complex interaction with longer term pre-disposing 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. Although the longer term strategy is to address the underlying issues and support recovery, 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 rather than to draw conclusions simply on the basis of diagnosis or rigidly adhere 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

The best available long-term data on periods of heightened risk for patient suicides, defined as those people who had been in contact with mental health services within a year of their death, comes from findings by *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015*. Of patient suicides in England, nine percent were inpatients, seventeen percent occurred within three months of discharge and fourteen percent were among people under Crisis Resolution / Home Treatment.

Amongst inpatients, suicide risk was heightened in the first week of admission, during the immediate pre-discharge period and after going missing from hospital. Death by suicide in the post discharge period was most frequent in the first week, with fourteen percent dying before the first follow-up appointment. It was found that suicide was more common following self-discharge and following discharge from non-local inpatient units. Suicide of people in the care of Crisis Resolution / Home Treatment teams was high compared with those in inpatient settings, with twenty four percent of deaths occurring within one week of discharge from the person's inpatient care.

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 seven day follow-up, the actual timing of follow-up should be determined by the needs of the individual patient.

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.

These relatively defined periods of heightened risk, frequently associated with transitions in care, accounting for almost forty percent of patient suicides, 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 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; and
- shared decision-making.

In addition, within inpatient units, mental health services have a responsibility to improve patient safety by reducing environmental hazards.

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 twenty percent of people who present to an ED with self-harm will repeat self-harm in the following twelve months. The risk of suicide is elevated by between thirty and one hundred fold in the year following self-harm and the risk persists with one in fifteen people dying by suicide within nine years of the index episode. EDs provide a unique opportunity for instigating interventions that have the potential to prevent suicide.

All too often, non-suicidal self-injury has been viewed as being distinct from suicidal behaviour and low lethality suicide attempts have been misconstrued as suicidal gestures. However, self-injury patients are at high risk of death by suicide regardless of apparent lethality.

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.

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

- empathic, non-judgemental clinical staff with a good knowledge about suicide;
- having emotional distress recognised and responded to;
- 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; and
- in the case of minors, including the parents / guardian in safety planning.

New South Wales Health's reference guide, *Mental Health for Emergency Departments 2015* states that *"All patients with self-harm, suicide attempt or marked suicidal ideation require mental health consultation before discharge is considered."* The Victorian Department of Health's guide, *Working with the Suicidal Person 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."

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 life-time. 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.

Mental health services, in partnership with EDs, have an obligation to 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 the development of these protocols:

- Patient safety.
Waiting times should be minimised for people who present to an ED after a suicide attempt or self-harm. They need 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 require a consultation with a mental health professional before discharge. This ideally would be face-to-face, but 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; and
 - handover and referral processes to transfer care to mental health services.
- Discharge plan
Before discharge, a discharge plan needs to be developed involving the individual and, where at all possible, their family 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 his/her condition and advice about when to return to the ED. The individual and where possible, their family and personal support person should be provided with a copy of the plan, advised to remove lethal means (e.g. firearms) and monitor sudden changes. Patients should not be discharged alone and staff should ensure that 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 assertively 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 family member / personal support person) if a person fails to attend his / her 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 (self and next of kin), or through their GP, mental health services or the police.

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

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 management, 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 have an obligation to support clinicians to provide best practice risk assessment and safety management 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 that 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 experienced 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.”

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 of experienced clinicians and this fact is to be recorded in the related entry in the clinical notes. Where this is not possible, the reason must be clearly explained in the clinical notes.

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 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 and Contracted Health Entities have statutory requirements under the *Mental Health Act 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 and Contracted Health Entities, supplied to the Department of Health and made widely available to help shape policy and improve services.

The National Confidential Inquiry into Suicides and Homicide by People with Mental Illness 2015, 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 Western Australia 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 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, family, personal support person and other consumers who may have been involved in, or have developed relationships 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 referral 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, clinical supervisor and, where necessary, referral to the Employee Assistance Program. Consumer debriefing may be required, particularly following death of an individual in an inpatient setting.

9. DOCUMENTATION AND SHARING INFORMATION

All significant assessment and safety management 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 requirements of the *Mental Health Act 2014* and the *Health Services Act 2016* regarding confidentiality.

Currently a minimum requirement is that clinicians document care using *State-wide Standardised Clinical Documentation* for mental health services, OD 0526/14. This includes the use of the Risk Assessment and Management Plan (RAMP), a section of which addresses the risk of suicide. However, 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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