COPSETI

FACT SHEET 2

Initial Assessment and Clinical Care of people who may be suicidal

CLINICAL CARE OF PEOPLE WHO MAY BE SUICIDAL: EDUCATION AND TRAINING INITIATIVE

The Clinical Care of People who may be Suicidal PD2016_007 outlines the roles and responsibilities of mental health services and clinicians across all settings.

This fact sheet is the second in a series of three. It provides a snapshot of the 2016 Policy Directives in relation to the initial assessment and clinical care of people who may be suicidal. Information on this sheet is covered in detail in COPSETI Online Module 2.

A significant proportion of people who die by suicide have had contact with a health professional in the weeks prior to their suicide.

- Health staff should identify people at risk and prevent suicide by referral to relevant services for further assessment and expert support.
- Mental health services and clinicians have responsibility and skills in assessing, advising and implementing strategies to prevent suicide, including facilitating access to appropriate care.

The person's immediate safety

The person's immediate safety is a priority. Further observation needs to take place or be arranged whilst awaiting assessment, where access to means of self-harm has been removed.

There should be a procedure identifying who should be notified if the person wishes to leave prior to, or during the assessment. Patient safety is the over-riding consideration.

A comprehensive mental health assessment

Mental health service clinicians in all settings are responsible for undertaking a comprehensive mental health assessment inclusive of psychiatric, psychosocial and risk assessments. The assessment process must be sensitive to the distress of the person and be conducted in a trauma-informed, recovery-oriented manner. The assessment will:

- identify and assess symptoms, mental state and history
- explore what stressors the person experiences, as well as significant changes or events
- identify any risk factors and strengths, including coping skills and interpersonal connectedness
- make a clinical judgement about the impact of the above on the person's immediate and longer term safety
- inform an initial plan that outlines issues related to safety, interim strategies, next contact and review.

Risk measurement checklists or tools should not be used in isolation to determine treatment decisions.

All mental health clinicians must use the Mental Health Clinical Documentation modules to document care and consultation outcomes.

If the person is known to have access to a firearm, and there is an assessed level of risk to self or others, clinicians must complete a Notification to NSW Police and Firearms Registry Form.

A holistic approach to risk assessment

A person's ability to cope with stressors relates to their life stage, coping capabilities and personal support systems. Mental health clinicians should recognise and respond effectively to the possible suicidal behaviour in different age groups and diagnostic categories.

If the patient is under 16 years of age, a parent, designated carer, guardian or principal care provider must be contacted. Children under 14 years of age cannot consent to treatment.

Appropriate approaches should be considered to address specific needs of people presenting who have specific cultural, linguistic, religious or other needs (e.g. the person identifies as an Aboriginal person, Torres Strait Islander, is from a culturally and linguistically diverse background (CALD) or is lesbian, bisexual, gay, transgender or intersex (LGBTI) etc.).

… young people are still learning about the world, they're still learning about themselves. They've effectively still got P plates on when it comes to relationships, and for them, every experiment with the relationship is very intense.

Dr Philip Hazel Director, Child and Adolescent Mental Health Services | Conjoint Professor of Child and Adolescent Psychiatry, Sydney Medical School

The key difference between an adult and an older person … is the pattern of risk. The older person has a much higher risk of completion of suicide following an attempt - no matter how trivial that previous attempt might be.

Dr Rod McKay Director Psychiatry and Mental Health Programs, HETI Mental Health Portfolio

Specialist workers or services (e.g. child and adolescent; older people mental health services, Aboriginal mental health workers, interpreters etc.), should be engaged wherever possible, in all stages of assessment and management, and particularly on discharge.

Clinical care of the suicidal person

The person's recovery-oriented plan will support people who may be suicidal, by using a person-centred approach. It will provide care and treatment in the least restrictive environment possible that enables the care and treatment to be effectively given.

The person's recovery plan will consider a person's experiences, culture, location, ability, sexual orientation, socioeconomic status and any other specific personal attributes. It will include the person's expressed wishes to the fullest extent possible.

When making decisions about treatments and voluntary or involuntary interventions, clinicians are required to seek the person's views and consent to treatment and care. They will involve the person, their family / principal carers and key stakeholders in decision making.

People experiencing ongoing suicidality require clear strategies to support their recovery, which respond to changes in risk over time and ensuring that services have strategies to contain their emotional distress. Designated carers and / or principal care providers and key stakeholders should be engaged in ongoing discussions with the person about treatment and care planning.

Clinical supervision

Central to the assessment and clinical care of a person at risk of suicide, is the judgement of the mental health clinician. Consultation with, or the advice of, a senior colleague should be sought - particularly where the decision to not admit someone with a suicide risk is made.

All mental health services are required to ensure that clinicians have access to appropriate supervision, consultation and advice from senior / peer clinicians at all times.

Transfer of care and discharge

Changes in the environment or care team can be stressful transitions for some people, which may lead to increasing distress and greater risk. Transfer of a person's care across settings requires planning and collaboration with all key stakeholders.

There should be clear protocols, developed collaboratively by Mental Health Services and Emergency Departments, for providing care for people presenting to Emergency Departments at risk of absconding.

Safe transfer of care into the community requires planning and early engagement with all stakeholders. After discharge from settings other than an acute care facility, assertive contact needs to be made as indicated in the Transfer of Care Plan.

Transfer of care from an acute psychiatric admission is a period of greatly increased risk. Determinations on leave decisions must be considered by a multidisciplinary team and fully documented, prior to approval by the treating psychiatrist. Identified family or carers should be engaged / advised prior to discharge in high risk cases. Direct contact must be made with patients discharged from an acute facility within 7 days.

Mental health services have a responsibility to follow up persons at risk of being lost to care.

NSW GOVERNMENT Health

The NSW Ministry of Health commissioned the HETI Mental Health Portfolio to deliver the Clinical Care Of People who may be Suicidal: Education and Training Initiative (COPSETI). Mandatory training requirements apply to NSW Public Mental Health Service medical officers and clinicians. COPSETI Learning Pathways and resources can be accessed from My Health Learning: http://myhealthlearning.health.nsw.gov.au. The Clinical Care of People who may be Suicidal PD2016_007 is available from the NSW Health website: www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_007.pdf

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