GUIDELINES ON THE MANAGEMENT OF SUICIDAL PATIENTS

Mental Health Services, Ministry of Health

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INTRODUCTION

These guidelines are issued by the Ministry of Health for the guidance of clinicians and to establish minimum standards of care that mental health services are expected to achieve in the management of suicidal patients. They were produced by a working party set up by the Ministry of Health which comprised representatives from mental health services and community agencies involved in the care of suicidal patients. The members of the working party and those who made submissions on the draft version of the guidelines are detailed in Appendix 1.

Suicide is the second most common cause of death by injury in New Zealand. There has been a dramatic increase in the number of young people, especially young men, dying by suicide in recent years in our country. Internationally, there has been concern that the rate of suicide is increasing among psychiatric inpatients and recently discharged patients. These changes are of particular concern. While the increase in young people dying by suicide probably reflects a number of social pressures, the alleged increased rate among patients known to the mental health services requires a review of current management strategies.

Over the last two decades there has been a move from custodial care in our larger psychiatric institutions (with a considerable emphasis on the physical safety of patients) towards a system that places greater emphasis on the dignity and autonomy of patients. While some might argue that this has been at the expense of patients' safety, the working party considers that effective prevention of suicide is based on the development of effective treatment alliances between mental health professionals and patients and the vigorous treatment of mental illness. Management of suicidal behaviour must involve a partnership between the mental health professional and the patient. It is hoped that these guidelines will be of assistance in promoting these aims.

Although the causes of suicide are complex and a number of factors may combine to lead any individual to take their own life, it is generally accepted that at least 94% of people who die by suicide were suffering from a mental illness at the time of their death. Most commonly this is depression, alcohol use disorders or schizophrenia. Active treatment of these conditions generally leads to suicidal urges disappearing and allows the individuals to return to their families, homes and jobs. It is also acknowledged that patients may feel suicidal in the absence of a specific mental illness due to a variety of other reasons.

While these guidelines focus on preserving the safety of suicidal patients, they cannot be used in isolation and must form part of an overall management plan for the treatment of the patient's underlying mental illness in the context of their social, cultural and economic environment. If these guidelines are to be an effective tool, they must also be accompanied by adequate training and resources. The current trend toward deinstitutionalisation and increased community care of patients means there is a need to ensure adequate resources, support and information are available in the community setting for effective management. Mental health services are provided in a number of different models throughout the country and an attempt has been made to ensure that the guidelines are applicable to these different settings. However, the working party was mindful of the need to establish some minimum standards which should be the entitlement of New Zealanders afflicted by suicidal despair.

It should also be recognised that despite the best efforts of any therapist or treatment team, some patients will still kill themselves. Suicide is a complex issue, and no set of management guidelines will prevent all suicides. Nevertheless, there are a number of principles and practical procedures which should contribute to greater safety both within the hospital setting and in the wider community.

REFERRALS FOR ASSESSMENT

It is particularly important to ensure that suicidal patients and those caring for them have ready access to mental health professionals or advice and assessment on a 24 hour basis. The sometimes complex structure of mental health services can be very confusing for those not familiar with the system. It is vital that a call from a suicidal patient, or someone caring for them, should not be referred on to another service or worker. The health professional who receives the initial call for assistance should be responsible for ensuring that the person seeking help is linked to the appropriate mental health professional. Self-referral by a patient indicating suicidal intent must be treated as a psychiatric emergency.

Information provided by the referrer is of considerable assistance to the emergency psychiatric services. The information outlined below is of particular assistance.

Table 1. Useful referral information (which might be readily available to a worker for a community agency).

Vital information

- Client's name, including aliases.
- Address/ phone number.
- Whether an interpreter is required (including interpreters for the deaf).
- A description of the current situation (and its causes) and what is causing the referrer concern.
- The nature of the suicidal behaviour (e.g. a feeling by the carer, indirect or direct hint by the client, a direct statement of suicidal ideas, a direct statement of intent, a current plan, the extent to which the plan has been carried out).
- Does the patient have the expertise and the means to carry out the threat?
- Current medication, if known, or substance abuse.
- Whether there is a risk of violence or other vital need to call the police.
- The caller's involvement with the client and ability to offer ongoing support.

Additional valuable information

Age/ gender.
Race.
Name of GP if known.
Whether subject to provisions of the Mental Health Act (compulsory patient?).
Whether any other mental health agencies are currently involved (and whether they are aware of the present situation).
Mental health agencies involved in the past (if known).
Have they made previous suicide attempts (and if so, how many, what happened, and what was the outcome).
The resources available in the person's environment (e.g. support/ transport).
Whether the duly authorised officer* should be involved to consider invoking some aspect of the Mental Health Act.

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* A duly authorised officer is a person appointed under the Mental Health (compulsory assessment and treatment) Act 1992 to provide (among other duties) information and assistance under the Act, in relation to the assessment of people considered to be mentally ill and in need of involuntary treatment.

ASSESSMENT

It is vital that any suicide attempt is taken seriously. Suicidal thoughts and behaviour are closely associated with mental illness. Therefore the evaluation of such symptoms should always include a full psychiatric assessment. In general, this should be carried out by an appropriately trained team of mental health professionals. A multidisciplinary team offers a greater range of skills to meet the differing needs of patients and also can provide supervision and support to its members in a particularly demanding aspect of mental health care. However in some situations, such as after hours or in private practice, it will not be possible for a multidisciplinary team to provide an initial assessment of a patient. In all circumstances there must be clear lines of clinical responsibility for each client or patient.

By the end of the assessment, there must be a clearly documented treatment plan which specifically includes the level of assessed risk to the patient and steps to be taken to ensure their safety. This should be developed in partnership and collaboration with the patient as far as possible. (The clinician must consider whether the patient's judgement is impaired due to mental illness. Where involuntary treatment is being considered, this can only proceed under the provisions of the Mental Health (compulsory assessment and treatment) Act 1992.)

Family members and whanau can, and often wish to, provide important input into such assessments. Where the patient gives their permission for such contact, this assistance should, in general, be actively sought. In a small number of cases, this may not be appropriate if the family is a contributing factor to the patient's risk of suicide. Difficulties can arise if the patient refuses permission for the assessing person to speak to their relatives, particularly when the patient is an adolescent under 17 years.

The legislation related to seeking information about the patient, as opposed to giving out information about the patient, is not straightforward. The principles of confidentiality and respect for the patient's wishes and rights must be adhered to. However, there will be situations where a comprehensive assessment cannot be completed without additional information from the family. This is particularly likely to be the case if the person is from Maori or Pacific Island cultures, or where a person is assessed for the first time and is reluctant to provide information In these cases decisions must be made in the interest of patient safety.

In an emergency, information should be sought if it is "necessary to save the patient's life, to prevent serious damage to the health of the patient or to prevent the patient from causing serious injury to himself or herself or others" (S.62, Mental Health (compulsory assessment and treatment) Act, 1992). This may be the case where information is sought on the medication that a patient has used to overdose or about possible access to firearms, etc.

The patient should always be informed of the steps which need to be taken for their safety. A decision to contact their family should also take into account the likely impact on the patient's current and future relationships. When a patient is unwilling for their therapist to contact their relatives, it may be appropriate for another member of the therapeutic team to be available to the family to try and assist with issues of concern to them, while preserving confidentiality about information relating to the patient.

Possible conflicts about confidentiality issues need to be resolved early in the assessment and the limits of confidentiality established in each situation.

The influence of cultural factors must always be considered. The assessing professional may need to contact the patient's family, appropriate community resources, church, or alternative health providers to gain an understanding of the patient's difficulties. Again, issues of confidentiality and the rights of the individual need to be carefully considered. There may be conflict between the presumed right of the family to know about their ill member, to contribute to decision making and to be involved in treatment, and the wishes of the patient, particularly among second generation Polynesians. The use of cultural experts can be valuable in resolving such conflict.

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A more detailed schema for the assessment of a suicidal patient is provided in Appendix 2. However, the points listed below are of particular relevance to the assessment of the degree of suicidal risk.

Table 2. Information required for the assessment of suicidal risk.

- Mental health status- depressed, psychotic, intoxicated.
- History of previous attempts, previous suicidal ideation.
- Family history of impulsive/ destructive illness or other mental illness.
- Supports or contacts.
- If a suicide attempt has been made, the patient's understanding of what they did and what they expected to happen.
- Recent events contributing to the decision to attempt suicide.
- The patient's degree of 'future orientation' and hope of improvement or degree of hopelessness (assessing both direct and indirect evidence).
- The interviewer's clinical judgement about the quality of the patient's responses.
- Whether there is any risk to others associated with the patient's suicidal plans.
- The patient's current suicidal ideation, plan/action, and the means available.

Another factor which should be taken into account in the assessment of suicidal risk is whether the patient has been sexually or physically abused. One recent New Zealand study of persons who had attempted suicide showed that over 1/3 had been sexually abused. This is a sensitive issue and the assessing person must decide the most appropriate stage to explore this area with the patient.

The use of specialised risk scales, such as the Beck Hopelessness Scale, may be a useful supplement to clinical judgement but should not replace a thorough psychiatric and psychological evaluation.

It must also be recognised that suicidal ideation in particular, and mental state in general, can fluctuate considerably over relatively short periods of time. It is therefore necessary to assess their stability in any individual patient and to determine the need for reassessment over the next few hours, days and weeks.

MANAGEMENT AS AN INPATIENT

The level of concern about a patient's safety will be a key factor in determining whether a patient is managed in the hospital or in the community. This will be influenced by the severity of the patients' illness, their level of insight, degree of impulsivity and the availability of social supports. In general, the most acutely suicidal patients are best managed as inpatients.

The most important aspects of the treatment plan are:

- to ensure the safety of the patient
- to establish an effective therapeutic relationship
- to institute effective treatment of any mental illness

Merely providing some form of observation will do little to assist the patient in the long term. Close observation should not be a passive procedure. Such close contact between a nurse and the patient allows a valuable opportunity to develop a therapeutic relationship. It should be highlighted that high levels of observation, while completely necessary, are only a component of an active treatment plan.

The treatment plan should also include a conscious assessment of the degree to which the patient can accept responsibility for themselves. Distinction needs to be drawn between the times when the clinical staff need to take primary and major responsibility, and when it is more helpful to the patient to pass greater responsibility to them. This requires a calculated risk by the multidisciplinary team.

The treatment plan of patients with continuing high risk of suicide (requiring at least "same room and in sight" observation) must be reviewed at least once each 24 hours by multidisciplinary team members involved with the patient. It should be discussed with the patient and outcomes documented.

If the patient continues to present with a high risk of self-harm, there should be at least a weekly case conference, to review current care, progress, and management of safety. The review should include psychiatric, psychological and behavioural assessment.

While treatment of psychiatric disorders will not be discussed here, it is noted that it should be good clinical practice that such severely ill patients have the right to the best quality clinical care. Although there may be an apparent improvement in a patient's illness, it cannot be assumed that suicide risk is similarly decreased, particularly if the patient's circumstances remain the same.

Quality management will include a coordinated treatment plan that allows for evaluation at frequent intervals by appropriately skilled clinicians and appropriate modification of treatment as a result. It is essential that there is a commitment to a multidisciplinary approach that utilises all of the individual team members' clinical strengths in the care of patients who have a high risk of suicide/selfharm.

Close observation of patients who are seen as being at high risk of suicide is a widely supported form of management. While this is usually a nursing role, due to resource issues, it would be desirable for all members of the multidisciplinary team to be able to carry out this level of observation after suitable training. Wide acceptance of this responsibility would enhance the functional role of the team, and facilitate the achievement of therapeutic rapport with the patient. Patients may have specific requests in terms of the gender and race of nursing staff assigned to provide such special observation for them, and these should be taken into account.

It is suggested that the defined levels of observation outlined below be adopted in an effort to avoid misunderstandings between staff on different shifts and in different units about the meaning of poorly defined or locally defined terms.

Table 3. Levels of Observation. There should be three special levels of observation over and above the level required for all psychiatric patients.

- **Within Reach**

  This is for the patient at extremely high risk of suicide who is expressing active suicidal intent. He (or she) may have recently carried out an act of deliberate self-harm. They may have unpredictable psychotic states and/or be impulsive and aggressive.

  This requires observation within reach of the patient for safety purposes. On some occasions, more than one nurse may be required.

- **Same Room and In Sight**

  This is for the patient at high risk of suicide who is expressing active suicidal intent but where there is less concern at impulsive self-destructive behaviour. The patient may have recently carried out an act of deliberate self-harm or have unpredictable psychotic states.

  This requires constant visual observation on a 1:1 basis, with the nurse in the same room and in sight of the patient.

- **Frequent Observations (Specify maximum interval in range of 10-20 minutes)**

  This is required for the patient who is considered to be a significantly increased suicide risk compared with the average psychiatric patient, or where the extent of risk is uncertain.

  It is recommended that the timing of observations be varied to ensure the patient cannot predict the exact time of the next observation.

All such special observation must be documented logically and systematically in a standard format.

Review of Levels of Observation

It is vital to review regularly the mental state of patients under such close observation. This should be formally discussed at the nursing handover at the end of each shift. The level of observation should be reviewed at least daily by senior nursing and psychiatric staff when the overall management plan is reviewed. The levels of observation, and changes to them should be documented separately in the clinical notes, with counter signatures from senior staff and the Responsible Clinician. The documentation will include date, time signature, level of observation, stop date, and role of each person signing.

In principle, changes to closer levels of observation may be initiated by any senior clinical team member. This would be communicated to the Responsible Clinician at the earliest opportunity to confirm the need for closer observation.

Reduction of the level of observation must be approved by two senior members of the clinical team, one of whom is the Responsible Clinician.

Good communication should also be maintained with families regarding the progress of the patient and the management plan, mindful of course of the patient's rights to confidentiality. As far as possible patients should continue to contribute to this process.

Contracts

Written contracts with patients incorporating a "no suicide" component should be used cautiously. Contracts can be detrimental to patient safety if undue emphasis is placed on them by mental health professionals in a complex situation. The usefulness of such a contract will depend on the patient's capacity to take responsibility for themselves. It is more helpful to provide the patient with a written statement of the treatment plan, to increase their involvement in, and understanding of, their treatment.

Environment

The patient's environment should be made as physically safe as possible, with potential hazards identified and controlled if they are unable to be removed. This applies not only to the inpatient psychiatric ward, but also to other environments the patient may encounter, such as general medical wards and overnight 'holding' wards, police and prison cells, and the patient's home if he or she is being managed in the community. Where it is necessary to search a patient's belongings, this should be carried out with the cooperation of the patient where possible. Sections 110 and 111 of the Mental Health Act provides for such searches to be carried out for patient protection during an assessment fo compulsory treatment under the Act. The following measures are helpful to reduce the risk to the patient in a given environment.

- It is helpful to identify a specific means of self-harm or plan that a person may use, to allow for management that will minimise risk by avoiding that situation, or preventing access to that means.
- It is necessary to identify those areas of an existing environment which present a higher risk (ie. lockable toilet areas, stairwells, as in a general hospital setting).
- Once the environment is assessed it may be necessary to restrict a patient's access to a smaller, more manageable, safe environment or area, and identify that area for management of that individual's potential/actual self-harm attempts.
- The specific area identified, which is used to manage patients with the potential for self-harm, must meet certain criteria to minimise risk. Criteria would include :
- easily observable location (proximate to areas where staff resources are highest).
- uncluttered easily checked area or room.
- minimum of double laminate safety glazing.
- flush fittings which do not allow for the attachment of lengths of cloth, belts, etc (ie. curtain rails should be safe plastic and easily detach under weight of a person.
- all belongings stored in the area should be checked for potential hazard to the patient. Items to be checked for, and to be removed, include:
  - any sharp objects (metal or glass).
  - any length of cloth, rope, belts.
  - any stored/hidden medication.
  - any glass.
  - liquids that may be utilised for self-harm.
  - any object likely to block airways (cotton wool).
  - objects which may be used as a weapon.
  - money/cheque books/tickets/car keys.
  - lighters and matches.
  - items of jewellery.

Further details of procedures to increase the safety of the patient's environment are given in Appendix 3 and guidelines on the safe layout and design of psychiatric facilities are given in Appendix 4.

Another aspect of the patient's environment is governed by the human resources available for his or her care. Clearly adequate numbers of suitably trained staff with high morale are necessary to implement effective supportive observation and treatment. Recognition of such requirements by health service managers and the commitment to provide these is also essential to a satisfactory standard of care for patients.

Limited use of a secure or locked facility within a ward can provide flexibility in the management of self-destructive patients and may reduce disruption for other patients. It also signals that the patient's condition is being taken seriously. At times a patient on the highest level of observation, "within reach", may find this overly intrusive and may prefer to be in a more secure setting such as a locked facility where a lower level of observation, such as "same room and in sight", may ensure a similar level of safety. The option of a locked facility should not be used as an alternative to developing a positive management plan and is an unacceptable alternative to providing adequate staffing levels.

It is important that issues such as transference and conflict within teams managing particularly challenging behaviour are addressed within case conferences. This allows issues of support for staff to be identified as part of overall patient management and care.

The practice of requiring patients to wear pyjamas during the day provides a disincentive to leave the ward without permission. However it may also have a negative impact on patient self-esteem. This practice is unnecessary and unacceptable if there are adequate levels of observation, and a safe, secure environment.

Cultural Factors

In certain cultures, particularly Maori and Pacific Islands cultures, the family may consider they have a right to be involved in decisions relating to the management of the patient and to remain with the patient in hospital. It is important to be sensitive to these needs and to keep open the lines of communication even if the patient/family reject the treatment offered or if there are conflicts regarding management decisions. At times, alternative treatment settings are available or can be arranged which are more acceptable to patients and their families. Consultation with cultural advisers, appropriate community health workers, alternative health providers and ministers may help avoid such conflict or assist in its resolution. Interpreters should be chosen carefully in order to ensure their expertise, acceptability to the patients and their independence from emotional involvement in the patient's illness.

Throughout the period of a patient's treatment, it is important to consider issues of cultural responsiveness, acceptability and safety.

Maori cultural factors

The reality for many Maori is that good health is not merely the absence of disease or illness. The Maori concept of good health embraces the (physical) Tinana; (spiritual) Wairua; (emotional) Hinegaro and (family) Whanau dimensions. The interaction between Maori and mental health professionals in the health sector can sometimes result in conflicting views about the underlying causes and possible ways of treating mental illness.

For mental health professionals to be effective in this relationship, the process of assessment and treatment must be transparent and flexible enough to involve the person and their whanau. Health professionals must be prepared to work in partnership with Maori health practitioners and healers, particularly for the person who identifies as Maori.

A process of informed consent is essential to ease the tensions that may arise between Maori cultural needs and the needs of the health sector. To achieve informed consent the involvement of a mediator or an interpreter may be required. Written information prepared for the specific needs of Maori will serve as an effective buttress to good verbal communication.

Health care organisations need to recognise the social structures which support Maori. Some Maori will identify strongly with their iwi, tapu or whanau. Others may have associations or networks which are not readily identified. The involvement of iwi health workers or family will assist in identifying and working with these networks. Some people may have no networks.

Training should include education on issues for Maori people and anti-racism workshops.

Pacific Island cultural factors

While consideration of Pacific Island culture and custom is always important in the consideration of any illness of a Pacific Island person, it is vital when the patient is affected by a mental disorder. Pacific Islanders have their own cultural perspective on mental illness which leads to a different formulation of the underlying causes.

Suicide is seen as very shameful by families and is considered to bring a curse on the survivors. Specific action is necessary to release the family from this shame and guilt. The spiritual being of the person concerned must be addressed if suicidal behaviour and the illness causing it is to be prevented. It is therefore very important

that a person who has a good understanding of Pacific Island culture is involved throughout the assessment and treatment of a suicidal Pacific Island patient. Members of the family should be involved throughout as well. The services must accommodate Pacific Island approaches to these problems.

Leave

Leave should be granted to suicidal patients cautiously, as a high proportion of suicides occur when the patient is on leave. Particular care should be taken when the conflicts associated with the patient's suicidal behaviour arise from the home setting and remain unresolved, or when the precipitants for an episode of deliberate self harm remain unclear. It is important that the timing of any leave, during the week, or at the weekend, coincides with when the most support is available.

Plans for leave should be reviewed regularly as part of the patient's management plan. All decisions about leave should be documented. This should record: who made the assessment and decision to grant leave; what safety provisions have been made; who is responsible for care during the leave period; date and time of contacts or return; and clear plans for what should happen if contact or return is missed.

Discharge planning

Because patients are at an increased risk of suicide in the period immediately following their discharge, this transitional phase from hospital back into the community needs to be planned carefully in conjunction with the patient. During pre-discharge planning the patient should be offered information about medication, contact persons or services and coping strategies to deal with continuing problems, as appropriate. Prior to discharge, the hospital mental health professionals should meet with the professional staff who will have primary responsibility for assisting the patient in the community after discharge. The patient should be invited to join this discussion. Relevant information should be passed to community mental health services.

Subject to the patient's consent (preferably in writing), there should also be communication with key workers from community agencies involved in providing accommodation and care. Relevant information should also be passed to community agencies involved in the care of the patient. The patient should also receive a copy of this information. The main matters to be considered are outlined in Table 4.

Table 4. Information of value to community groups caring for a previously suicidal patient.

- Summary of diagnosis/illness and problems.
- Medication on discharge.
- Current state of the patient.
- Indicators of possible future high risk factors including warning signals and combinations of circumstances likely to lead to increased risk of suicide.
- A contact person(s) in the mental health services.

OUTPATIENT TREATMENT/ COMMUNITY CARE

When there is a decision to manage the patient in the community, it is vital to ensure that adequate resources are available. Care of the patient should follow the same principles proposed for inpatient care. The following matters should be considered.

- Carers must have information on the current mental state of the patient, medication, precipitants of the suicide act and the degree of risk of suicide. The patient's GP should have details of treatment.
- Carers and patients must have a contact person or organisation for further urgent support on a 24 hour basis.
- Carers must be advised about the level of supervision which the patient requires.
- There should be ongoing professional assessment of the patient by a multidisciplinary team, with specific appointments for review. Outpatient follow-up for patients indicating chronic suicidality should be a priority.
- The carer should be able to respond to changes in the state of the patient. They should be aware of the Mental Health Act which can be used as a resource to set boundaries for the patient and that the police may be called in emergencies.
- The patient's physical environment should be safe.
- Support should be available for the carer, given the stress associated with their responsibilities.

Community agencies may not have sufficient resources to provide 24 hour specialised care for suicidal patients. They often experience difficulty in obtaining access to additional support. Their principal function is to offer accommodation and rehabilitation, with the aim of increasing their clients' independence and facilitating their reintegration into the community. Not only do limited staffing resources mean that the provision of extra staff to assist a suicidal patient is difficult, but the presence of an acutely ill patient in a community house is distressing and unsettling to other residents and may adversely affect their own mental health. The addition of an unfamiliar staff member can, at times, add to this distress. It can also be difficult to remove potentially harmful precipitants from the environment.

GROUPS/ SITUATIONS REQUIRING SPECIAL ATTENTION

Patients Who Repeatedly Either Self-harm or Make Suicide Attempts

Some patients present repeatedly to mental health services following actual or threatened episodes of deliberate self-harm. While some of these patients are suffering from inadequately treated or difficult to treat major psychiatric illnesses, others may have major personality difficulties and associated problems with social circumstances. This latter group are often in contact with several different agencies and there may be a degree of reluctance by individual workers to provide a continuing therapeutic relationship. It is recognised that such patients benefit more from a consistent relationship with an experienced key worker and that good ongoing liaison between the various agencies involved is essential in providing consistent support to help the individual patient gain greater autonomy. Cooperation between various agencies is essential, particularly in relation to the transfer of patient information. Working with such patients can be very demanding and it should be recognised that individual mental health professionals will only be able to provide quality care for a limited number of patients. It is also important that appropriate inpatient care is available for these patients as they are at increased risk of suicide.

Alcohol and Drug Abuse/ Co-morbidity

Greater recognition needs to be given to the fact that drug and alcohol problems are often associated with psychiatric disorders such as depression. The presence of co-morbidity greatly increases the risk of suicide. Treatment for drug and alcohol problems needs to include assessment and management of any associated mental disorders by a mental health professional. It is recommended that mental health services provide liaison with groups involved in the treatment of alcohol and drug abuse, including training.

Elderly

Although the suicide rate in the elderly has always been higher than in the general population, the risks can often be overlooked. The increasing losses and infirmities of later life and concomitant depression are probably factors in this increased level of risk. It is uncommon for an older person to present with deliberate self-harm and any such attempts must be taken seriously. The elderly can and should be treated for depression. It is important that those agencies involved in care of the elderly are trained to recognise mental health disorders and that facilities are provided for their treatment.

Children/ Adolescents

Suicidal ideas in young children and adolescents are common and mostly transient and without intent. However, even though rare in young children, suicidal attempts and successful suicides do occur and increase significantly with increasing age. The risk is considerably higher in older adolescents. This group is more likely to act impulsively when struggling to deal with problems (such as the break-up of their first relationship), where they may have neither the knowledge nor the experience to deal effectively with the situation.

For those children and adolescents who present following a suicidal attempt, it is important to regard all attempts as being serious, even though it may be "only a gesture". The foremost concern is assessing those factors that relate to the safety of the child or adolescent.

There are particular areas that must be enquired into when assessing the suicidality of a child or adolescent, in order to make a clinical judgement about the degree of risk and to make subsequent clinical decisions. In order to gather this information, additional sources, such as family and school, should be approached.

It is important to ask if a child has thoughts of hurting himself and of killing himself, because hurting oneself and killing oneself are not necessarily the same. Answers in the affirmative should be further explored by questioning how strong the feelings or ideas are, the degree of intent and if there is a plan. It is also important to establish the motives and the surrounding circumstances at the onset of these thoughts and the duration of these ideas. Almost all completed suicides are associated with a psychiatric disorder. Particular attention

eeds to be paid to symptoms and behaviour relevant to depression, behaviour disorders, substance abuse, sychosis and organic brain disturbance. The individual should be questioned as to possible delusions or allucinations. For example, he could have a strong belief that he will save the world if he died or be hearing oices telling him that he should kill himself. The child or adolescent's ideas of death, and the result of killing neself need to be examined. Many report fantasies that in some way they will still be around observing the esults of the suicide, or think only of the consequences to others, or only that they will be getting out of a ifficult situation. Access to the means of suicide, such as a hand gun, and the degree of sophistication about he lethality of the proposed method much be assessed.

)ther general risk factors that should be enquired about are:

- knowledge of anyone they know who has attempted or committed suicide.
- death of parent, sibling or close friend.
- recent suicide in school (even of someone they do not know).
- recently viewing movie or TV regarding actual or fictional suicide.
- the child and adolescents perception of the severity and pressures of current stressors, eg. family, school, and social issues (rejection by a club, breaking up with boy/girl friend, or experiencing other significant losses, conflict over sexual orientation, etc.).
- History of physical or sexual abuse.

Major factors indicating increased risk of suicide are a patient:

- who expresses intent.
- who is impulsive.
- who has made a previous suicidal attempt.
- who is depressed and has either a conduct disturbance or substance abuse and has become more withdrawn.
- who has a high degree of hopelessness.
- who has a high degree of stressors and low amount of family and other support.
- who suffers concomitant medical conditions (acute or chronic).
- who has an overall history of poor judgement and poor coping skills.
- to whom suicide means something pleasant and not permanent or there is a belief that there will be a rejoining with a loved one.
- who is not well known nor is there rapport or co-operativeness.
- who has access to lethal means.
- who has a history of or current physical or sexual abuse.

And where a recent suicide attempt has been made:

- if the attempt was planned.
- where there has been a very strong attempt at not being discovered.
- if the attempt was with a more objectively lethal means.
- if the child believed the method was lethal.
- if regret is expressed at having been saved.

A particularly high risk patient would be a male adolescent who has a depressive disorder and additionally a conduct disorder or substance abuse disorder, and recent stressors such as a break-up with a girlfriend, or arguments with parents; a previous suicidal attempt; suicide in a family member or close friend; recent suicide in school or recent representation of actual or fictional suicide on TV or in other media; who has poor social support.

As much as possible, an evaluation of the family as to the source of stress and as to the degree it can provide for the safety of the child and adolescent and participate in the treatment plan, is necessary in determining the disposition of the child or adolescent who has made a suicidal attempt. One would particularly look for current depression or other significant problems in other members of the family (such as alcohol or drug abuse) that could impede their ability to provide safety for the child or adolescent. One should also attempt to assess if

There is significant hostility toward the child or adolescent and how much she/he is perceived as a burden to be rid of. Does the family take the child or adolescent seriously? Are they willing to participate in the treatment plan? Consideration should also be given to the possibility of physical or sexual abuse.

Treatment plans for suicidal children and adolescents need to bear in mind the level of risk, based on the above factors, and should weigh the relative merits and risks of different treatment options. This is a clinical judgement and, as far as possible, should be made by mental health professionals experienced with children and adolescents, or in consultation with them. The treatment plan and the reasons for arriving at it should be clearly documented and discussed with the family and the patient.

Attempts are made with suicidal children and adolescents to avoid hospitalisation, especially into an adult psychiatric unit, but to provide a safe and structured programme within the community. In order to do this, it is important to have available Child and adolescent mental health professionals who can formalise treatment relationships with others in the community to participate in the treatment plan along with the family, while taking into account confidentiality issues. These others could include GPs, paediatricians, public health nurses, school teachers and counsellors, Open Homes, day programmes, "safe houses", and other community agencies. The proposed development of adolescent health services may offer another resource for these people. Effective liaison between these services is essential.

If a potential child or adolescent patient is judged to be able to co-operate and participate in an outpatient programme, within specific guidelines and directions for the family, and it is believed that there would be therapeutic benefits to outpatient treatment, then a closely monitored and structured programme should be undertaken. This would include frequent therapist contact by phone and by visits, along with utilising family and other supports in the Community.

If it is believed that the family cannot provide sufficient support for the safety of the child and participate in a treatment programme, or if the risk of the individual is so high that even a stable, supportive and caring family would not be able to ensure safety, then admission to a psychiatric ward is indicated, in a child or adolescent facility if available.

As the suicide potential diminishes then clinical judgement will dictate the lessening of the intensity of the outpatient programme. In cases where the patient is admitted to a Psychiatric Hospital there may be a significant risk following discharge particularly within the six months immediately following hospitalisation. It is therefore necessary to have regular outpatient follow up.

Conflicts over the confidentiality of information provided by young persons have already been discussed. It is necessary to inform the patient and family from the outset as to what is confidential and what is not. An exception to confidentiality is a danger to oneself or others. Being unable to involve the parents, if indicated, hampers the treatment of the patient and raises the risk of suicide. In cases of difficulty, there is a pre-eminent duty to ensure the safety of the child or young person.

Parental consent is necessary for the treatment of children. Sections 85-90 of the Mental Health (compulsory assessment and treatment) Act 1992 refer to special provisions relating to children and young persons. The Guardianship Act 1968 and the Children, Young Persons and their Families Act 1989 also apply, in that if the parents refuse permission or are considered to be neglecting the needs of the child, guardianship orders, court orders or care and protection orders can be made.

Pregnant and Post-partum Women, the Seriously Medically Ill, People with HIV and AIDS

These groups are all recognised to be at higher risk of mental illness and suicide. A consultation liaison psychiatry service should be available to meet the needs of such patients.

The Intellectually Handicapped

Although the rate of suicide in the severely intellectually handicapped is said to be low, presumably because of difficulties forming intent, the risk is higher in the mild/ moderately handicapped and where there is concomitant psychiatric disorder. It is difficult to recognise and diagnose psychiatric problems in this group as communication may be difficult. Their lack of a clear appreciation of the lethality of certain actions and

npulsivity leaves them at risk of suicide when this may not have been their intent. Mental health services hould provide special training for mental health professionals involved in assessing these patients, although ie lack of resources at a national level in this area is acknowledged.

uspected Deliberate Self-Harm Patients in Medical Wards/Accident and Emergency

All patients involved in an act of self-harm should be assessed by a mental health professional as soon as ossible and appropriate arrangements made for further care. At times the medical condition of the patient vill necessitate their transfer to a general medical ward or a 'holding ward' associated with the Accident and Emergency Department. In such cases, patients should be managed as close as possible to the nursing station o facilitate observation. Where special observations are required, this must be particularly clearly specified nd will require close liaison between the mental health and general medical or surgical services, either hrough the emergency psychiatric service or through the liaison psychiatry service. There should be one ward which is prepared for the treatment of such patients. This ward should be on the lowest available floor of the building and efforts should be made to make this as safe an environment for suicidal patients as possible. There should be at least one room where the windows are glazed with safety glass.

Rural Services

The management of patients at risk of suicide is more difficult in rural areas where there are limited resources and limited choices for treatment. Primary health care providers eg. general practitioners, public health nurses and iwi health workers carry a greater responsibility for providing mental health services than in urban situations. There is a need for effective systems of communication to ensure that services are responsive and coordinated. Resources must be made available to ensure that primary health care staff have opportunities to develop and maintain the skills necessary for them to practice safely in this environment. Access to specialist mental health services backup is crucial. Rural communities should have access to visiting psychiatric outpatient, community and domiciliary mental health services. The shortage of specialist child and adolescent services in these areas means that crisis intervention teams and community mental health teams in these areas should have special training in child and adolescent crisis intervention and suicidal assessment.

MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

This is a resource available for the management of mentally ill suicidal patients if their mental disorder falls within the definition of mental disorder in the Mental Health (compulsory assessment and treatment) Act 1992. Duly Authorised Officers are available to provide information and assistance to patients and their families where compulsory assessment or treatment under the Act is being considered. If the patient is voluntary, whether in the community or in hospital application can be made under section 8. If the resulting examination under section 10 of the Act finds that the patient should undergo compulsory treatment, then treatment can take place even if the patient cannot or will not consent, subject to the provisions of the Act. If the person is in the community, the duly authorised officer may seek police assistance if necessary (section 41). Similarly, if the police are called to a situation where a person "is acting in a manner which gives rise to reasonable belief that he or she may be mentally disordered", the police may take the person to a hospital, police station or surgery for the purpose of a psychiatric assessment. This may lead to a section 8 application under the Act.

Should a person who is voluntarily in hospital give cause for concern due to their mental disorder, they may be detained by a registered nurse for up to 6 hours to allow for a medical examination to be arranged.

PROCEDURES FOLLOWING SUSPECTED SUICIDE

Cultural considerations in handling the body of the deceased must be respected.

Legal requirements

The Coroners Act 1988 section 4 states that every death that appears to be suicide must be reported, as must any deaths of people in institutions pursuant to section 9 of the Alcoholism and Drug Addiction Act 1966 or the death of any special patient or patient being compulsorily treated in a hospital. Such deaths are reported to the Coroner, although in practice suspected suicide is always reported to the police who coordinate the reports to the coroner. Section 5 of the Coroners Act states that anyone finding a body must report this to the police.

Debriefing

Where a suicide is suspected, there should be provision for a debriefing of all those involved with the care of the patient who suicided. One example (see appendix 5) would require an initial debriefing followed by a more in depth debriefing within a week.

An immediate debriefing should attempt to meet the following needs:

- Support for those related to the patient who suicided. This may involve visits to the family.
- When a young person of school age has died, support for classmates and other members of the school community.
- Support for other patients, both as a group and individually.
- Support for staff involved with the patient.
- Support for those involved in care outside the immediate treatment team eg community agencies.

Attendance by staff and patients at the funeral should be facilitated, subject to the wishes of the family and whanau.

It is recommended that the later debriefing should consist of two parallel debriefings: one which is completely confidential for staff to achieve their own emotional and psychological closure; and another which is a formal review from a quality assurance viewpoint. The interaction between these two reviews can be determined by individual units and management structures. It is essential that any consideration of disciplinary matters arising as a result of the suicide be carried out separately and independently.

TRAINING

There is a need for appropriate training for all those involved in the assessment and management of patients at risk of suicide. Mental health services should be responsible for adequate training of its own staff including regular "refresher courses". The aims of such training should be to ensure high quality assessment and management of suicidal patients. Those responsible for emergency psychiatric services and others who carry out assessments of suicidal patients should ensure that their staff formally review their training needs in this area on a yearly basis and that these training needs are then met.

Training needs also include:

- Specialist skills for those caring for high risk patients in inpatient units, including close observation and appropriate documentation.
- Cultural factors to be considered in the assessment and treatment of patients.
- Treatment of confidentiality issues particularly in relation to obtaining information from a patient's family

Training should also be provided for community agencies who are involved in the care of patients at risk of suicide. This should provide a greater understanding of the:

- Assessment and management of suicidal patients
- The role of the agencies in the process.

Similar training should be available for school counsellors/ teachers. Interpreters who are regularly called on to assist mental health services should also receive some basic training in common types of psychiatric symptoms and interviewing the seriously mentally ill. All of this training should be the responsibility of the principal funded mental health service and should be provided at no cost or on a cost recovery basis only. Mental health services will be able to discuss the provision of training with Regional Health Authorities as part of their contracts. The Ministry of Health will be responsible for quality assurance and monitoring standards.

There is a need to train mental health professionals working in prison or police facilities in the management of suicidal patients. This should include a requirement for those people to satisfy themselves that the facilities, observation, and staffing are adequate. This would heighten awareness that a locked door does not equate with safety. Seriously suicidal patients should be cared for in hospital, not cells or prisons.

It is acknowledged that the police are the first point of contact for some suicidal patients. There is a clear need for appropriate training so that they are skilled to assist such patients. Details of such training are beyond the brief of these guidelines. The families of suicidal patients will also require information about the management of their relative, particularly if they are participating in his or her care. This should be provided as part of a joint management plan, subject to the wishes and rights of the patient.

QUALITY ASSURANCE

Reporting and Review of Adverse Incidents (including suicide and self-harm)

There should be mechanisms for the effective recording and review of suicides and episodes of deliberate self-harm among known patients on a local basis to identify ways in which the management of suicidal patients can be improved. The procedures outlined in the Protocol on Reporting and Review of Incidents should be followed.

APPENDIX 1

Membership Of The Working Party On The Management Of Suicidal Patients

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The report of the Working Party was edited by Christine Bartley and Pete Ellis.

APPENDIX 2

Schema for psychiatric assessment of the suicidal patient

CRISIS
What has made the patient present at this particular point in time?

If a suicide attempt has been made:
- was there a note - what did it say?
- what was the patient's understanding of what would happen?
- what means is available to carry out an attempt?
- how specific is the plan?

HISTORY OF PRESENTING PROBLEM
a) Background and development of signs and symptoms:
- life circumstances at time of onset.
- how has it affected their life.
- details of dysfunction.

b) Precipitating Stresses:
- relationship between onset of symptoms and particular events and factors in their life.

c) Functional Enquiry:
Changes in biological functioning and person's subjective opinions (including duration of changes).
- mood (depressed, elevated, labile).
- sleep (increased or decreased).
- appetite (weight change).
- energy.
- motivation.
- concentration.
- memory.
- irritability.
- level of ability to enjoy usual activities.

d) Other symptoms
- anxiety, social phobia, panic symptoms, obsessional ruminations, compulsive rituals, agoraphobia.
- psychotic phenomena
  - hallucinations (auditory, visual or somatic).
  - delusions (paranoid, ideas of reference, somatic, hypochondriacal, grandiose, religious).

RELEVANT PHYSICAL FACTORS
eg: asthma, heart disease, diabetes, epilepsy.
If present, enquire further: ie. treatment, duration, extent of incapacity.

PAST PSYCHIATRIC HISTORY
- extent of incapacity.
- types of treatment.
- names of hospitals.
- last admission date.
- length of illness.
- effect of treatment.
- past suicide attempts.

ALCOHOL AND DRUG HISTORY
- accurate history of current alcohol and drug use : ie. frequency, amount, types and duration.
- past history: ie. past use and details of any treatments.

FAMILY PSYCHIATRIC HISTORY
- as with past psychiatric history, but with family members.
- enquiry extends to immediate family including grandparents (include enquiry on suicide and alcohol and drug history).

PERSONAL HISTORY
Review of patient's early life, subsequent development and experiences to:
- gain understanding of patient's personality and the influences that moulded it.
- detect any particular areas of vulnerability.
- identify factors which may have led to patient's problem.
- identify any clear patterns of behaviour and experience.Includes:
- family background, ie. siblings, relationships within the family.
- personality as a child.
- educational history.
- work history.
- social relationships.
- history of behavioural problems.
- forensic history.
- traumatic experiences, ie. sexual molestation, rape, significant losses (including anniversary reactions).
- relationship history including marital.

CURRENT SOCIAL SITUATION.
- living situation.
- current employment and financial situation.
- social supports.
- involvement of any social agencies.

MENTAL STATUS EXAMINATION
- sum total of examiner's observations and impression derived from the initial interviews.
- assessment of <u>current</u> state of mind.

a) <u>Appearance</u>: appropriateness of dress, grooming, posture, gait, physical characteristics : ie. size, physical health, apparent versus chronological age.

b) <u>Behaviour:</u> psychomotor activity, eye contact, facial expression, mannerisms and attitude towards interviewer.

c) <u>Emotion:</u> mood is a pervasive and sustained emotion experienced by the patient. How does the patient say they feel?
- duration, fluctuations; affect, outward manifestation of mood, predominant feature, variability, intensity, lability: appropriateness (interviewer's objective evaluation).

d) <u>Thought</u>

<u>Form:</u> Thought form refers to the way ideas are put together.
- productivity, speed, amount, spontaneity.
- nature of thoughts.
- logic, tangential, circumstantial.
- associative processes flight of ideas, loose associations, clanging, word salad, neologisms, thought blocking.

<u>Content:</u> Thought content refers to ideas the patient communicates.
- delusions, phobias, obsessions, ideas of reference, grandiosity, self-condemnatory beliefs, preoccupations.

e) <u>Perception:</u>
- Hallucinations, illusions, dissociations.

f) <u>Cognition:</u>
- The Mini Mental Status Examination is suitable for more detailed screening.

g) <u>Insight</u>:
- the way they perceive themselves and their problems.

SUICIDE ASSESSMENT
Occurrence and extent of :
- Thoughts of death, prolonged sleep, suicide.
- Plans.
- Potential for action.
- Deterrents to action.

How far along the suicidal continuum has the patient progressed?
- Thoughts of prolonged sleep to escape.
- Thoughts of death to escape.
- Thoughts of self-harm.
- Thoughts of suicide.
- Vague plans for suicide.
- Definite plans for suicide.
  - Where is plan to be enacted.
  - Availability of means to carry out plans.
  - Is plan dependent on external events or due to general sense of hopelessness.
  - What needs to happen to change decision to carry out plan.

Are there conditions present which will facilitate the impulsivity of the patient?
- Intoxication.
- Delirium.
- Drug withdrawal.
- Brain damage.

VIOLENCE/HOMICIDE ASSESSMENT
Same as for suicide.

PROVISIONAL DIAGNOSIS

SUMMARY
- Summary of current reasons for presentation, current symptomatology, current diagnosis and formulation (Why <u>this person</u> has presented with <u>these problems</u> and symptoms at <u>this time</u>).

MANAGEMENT PLAN
Based on:
- Provisional diagnosis.
- Assessment of patient's situation/ current support.
- Understanding of patient as a person.
- Services and treatment options available.
- Risk/ benefit analysis.

APPENDIX 3

Guidelines for providing a safer environment for suicidal patients

An awareness of the level of risk of suicide should include identification of plans to self-harm, involving specific means, so that the means to carry out likely methods of self-harm can be removed. These measures should be taken as far as possible with the cooperation with the patient. Where this is not possible, action can be taken under the Mental Health Act.

Once specific means are identified and where possible excluded, further strategies to consider are:

In the home environment:

- Preventing access to weapons and, where possible, removing these from the house, in particular firearms.
- Ensuring that all medication is accounted for and supervised and/or locked away with minimum amounts stored.
- Prescriptions for medication are for minimum amounts.
- Taking medication is, where possible, supervised (eg. Domiciliary Nurse /carer supervision).
- Removing alcohol from the house.
- Preventing easy access to transport (ie car keys) so that an individual's movements and access to means to self-harm are limited, and contact with carers in promoted.
- Removing cords, ropes, and any other obvious means to self-harm in the immediate environment.

In the non-psychiatric inpatient setting:
It is not possible to make a whole ward safer for a patient who is suicidal, in a general hospital setting. It is the heightened awareness by the health professionals, within the total setting, that will assist toward safe management of the patient in the wider ward environment.

- Staff need to be aware not to leave or place potentially hazardous material within easy access of a suicidal patient.
- A room that is used for patients at risk should be identified and made much safer than the general environment.
- The patient should have clearly defined restricted access to areas within the ward.
- If the level of risk is thought to be high this should, in conjunction with other interventions, include restriction to their own room. This should be explained to the patient and communicated to all staff.
- There should be absolutely no ordinary glass in the room. All glazing should be at least some laminate and, if not on the ground floor, should be triple laminate with recessed frames. If windows can be opened, this should be restricted and safe.
- There should be no cords, string, or material which could be made into a rope.
- There should be no sharp objects at all.
- Where risk is assessed as high then attention should be paid to appropriate cutlery (safe plastic) and to the use of plastic or paper plates and cups.
- Medication should be administered/taken with supervision.
- The room should be uncluttered and easily searched for stored objects which may be used for self-harm.
- Clothing and belongings should be checked for potential objects of self-harm. Belts should be removed. Belongings should be checked for hidden medication, for notes re self-harm attempts, etc. Belongings and clothing should be checked for means to leave the ward ie. money, vehicle keys, etc.
- Cleaning tools, liquids, and routine sterilising liquids need to be removed from the area.
- Electrical cords and appliances need to be removed where possible.
- No electric equipment should be left in the room with the patient unobserved.
- Light fittings should be flush ceiling mounted. Areas of the room which present a risk should be identified and the room used in the context of an assessment of an individual's potential risk to themselves and the potential for some areas of a room to be used to self-harm. A general hospital is not an acute psychiatric unit with a psychiatric unit's resources, but where possible all corners should be rounded, all coverings moulded and sealed at joints.

In the acute inpatient psychiatric setting:

Consideration of the need for safety, within the environment, starts on admission for a patient who is assessed as having a potential for suicide.

The initial response is to:

- Check all belongs and property (in particular, belts, glass, razors, etc.) with respect for the individual's cultural and social rights, and to remove all items that may be used to self-harm. Check all belongings brought in and discuss this with relatives.
- Identify an area in the unit which allows close observation of movement, especially if the patient is under special observation.
- Check the total environment for safety and identify areas that may present as an increased risk ie. stairwells. It may be appropriate to restrict access to those areas by negotiating with the patient and instituting special observations to confirm this eg. "within reach" observation.

- Check the room the patient uses for:
- glass.
- any metal objects especially those with a sharp edge.
- belts.
- lengths of cloth.
- discarded/hidden medication.
- any sharp objects/sharp fragments of any material.
- any object that might be used as a weapon.
- any objects that might be used to block an airway if swallowed ie. cotton wool.
- any liquid storage container of potentially harmful liquids.

APPENDIX 4

Guidelines for safe layout and design of areas to manage potentially self-harming patients.

The layout of a unit and rooms should enhance high levels of observation.

The layout of rooms should ensure that there are no areas that a patient may use to obscure themselves or hide in. In bedrooms this means that locker space is easily accessed and observable and that placement of beds is such that there are no hidden spaces created ie. between a bed and wall. Ensuite facilities should achieve a balance between privacy and being able to be easily checked if necessary.

In checking the layout for potentially hazardous features, it is necessary to concentrate the need for the highest degree of environmental safety in:

- Areas of patient activity that do not allow easy observation ie. toilets and showers, bathing facilities
- Areas where patients will spend large amounts of time and may not always be observed (bedrooms)
- Areas which are designed for the treatment of people with the highest level of risk (intensive care seclusion rooms)

All of these areas share the need to be a similar standard in regard to the following:

- All fittings must absolutely flush and able to withstand deliberate attempts to damage them.
- There must be no object that can allow a length of material or rope to be attached which will support a person's weight.
- All fittings and contours of the room must be moulded, rounded at corners, and seamless.
- All fittings and contours must be visible on inspection ie. picture rails must be moulded at the top edge to prevent hidden objects (ie. small razors) being placed there.
- All door locks or snibs must be able to be opened from outside (ie. toilets), all doors must open outwards and not intersect or be close to other doors.
- Glazing must be at least double laminate in the Unit and "Omnilite" standard in intensive care seclusion rooms. There must be no ordinary glazing, including picture covers. Mirrors must be safe plastic or other safe material.
- All beading must be tested for fixing to ensure it is not removable ie. beading around toilet fixtures and basin. All plumbing must be flush to the wall. Where possible all facilities, controls, and access to them, should be in a roof space or place other than inside a room.
- Intensive care seclusion facilities should have external controls.

APPENDIX 5

A Format For Debriefing After Suicide Or Sudden Death

Debriefing should be available to all those employees who are involved with a serious incident, members of the debriefing team, group manager, patients, next-of-kin and witnesses to the incident.

Debriefing should ensure that all people involved with suicide, serious suicide attempt or sudden unexpected death of a patient have an opportunity to express their thoughts and feelings concerning the incident.

Both an immediate debriefing and a review debriefing should be arranged for those people involved with a suicide, a serious suicide attempt or the sudden unexpected death of a patient.

The immediate debriefing is aimed to meet the needs of the people involved at the time the death occurred or was discovered.

The review debriefing aims to be a closure of debriefing work after the event/incident has occurred.

The degree of confidentiality of the information provided by participants must be clear from the outset. The following procedures are suggested:

Immediate debriefing.

- Immediate debriefing will be arranged at a time suitable for those involved and shall be of an informal nature. It shall include only those involved and their immediate controlling officer.
- At the request of the group a facilitator may be arranged to conduct the meeting.

Review debriefing.

- Review debriefings will be held for any staff who has been involved with the patient.
- A facilitator who has not known the patient will conduct the review briefing. An independent observer should be present to observe the process and identify anything missed or needing further attention (Perhaps other members of the debriefing team).
- Review debriefings will seek to :
  - arrive at an understanding of the suicide/event.
  - enable staff to express their feelings.
  - bring attention to specific problems to be addressed or improved.
- It is NOT the function of Review debriefing to assign blame or guilt, or provide a scapegoat or act as a quality assurance procedure.

APPENDIX 6

Reference material

The working party were greatly assisted by a literature review on the assessment and treatment of suicidal behaviour (Suicide - a literature review) prepared for them by Janet Randell-Johnson. This is held by the Mental Health Section of the Ministry of Health.

The working party were also influenced by the following guidelines prepared for use in Britain: Persons at Risk of Suicide-Guidelines on Good Clinical Practice. Professor H Gethin Morgan and Dr John H Owen. Boots Pharmaceuticals, Nottingham.

Related Publications by the Mental Health Section of the Health Department

Guidelines for reporting and review of incidents.

An annotated inventory of mental health services for youth.

Youth suicide prevention project phase two.

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Procedural guidelines for the use of seclusion.

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