PURPOSE

It is the Te Whata Ora - Health New Zealand Hauora a Toi Bay of Plenty Mental Health & Addiction Service's (MH&AS) policy intent that people who present to acute psychiatric services are provided with appropriate assessment and evidence-based interventions. These need to be continued for long enough to reduce suicide risk and improve mental health in the long-term.

OBJECTIVE

The purpose of these guidelines is to support best practice in responding to people who present following a self-harm or suicide attempt.

SCOPE

MH&AS's Referral, Triage, Assessment, Risk Assessment Treatment Planning, Service Provision, Discharge, family / whānau involvement and information sharing mechanisms for all persons who report / are referred or notified to the service with self-harm or suicidal intent and meet the threshold of Triage Categories A, B & C as per CPM.M5.34 Triage Scale

STANDARDS TO BE MET

1. TRIAGE And RESPONSE

1.1 All people who report self-harm or suicidal ideation or who present following a suicide attempt should be presumed to be at high risk of further self-harm / suicide until there is further assessment of this risk.

1.2 Response times for face to face assessment of persons who report self-harm or suicidal intent are as follows: See CPM.M5.34 Triage Scale

a) **Triage Category A:** Immediate referral to emergency services (111)
   i. Overdose/suicide attempt self-harm in progress

b) **Triage Category B**: 4 hours from referral / notification
   i. Have attempted deliberate suicide / self-harm or who present or are referred with Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression

c) **Triage Category C:** 24 hours from referral / notification
   i. Suicidal ideation with no plan and / or history of suicidal ideation

2. Assessment

2.1 A mental health assessment that follows a self-harm / suicide attempt should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material.

2.2 All people who have made suicide attempts / suicidal ideation / history of suicidal ideation / attempts will receive a comprehensive assessment See Appendix 1: Comprehensive Assessment Guideline.

2.3 All people who have made suicide attempts / suicidal ideation / history of suicidal ideation / attempts will have a Risk Assessment completed, using the risk assessment

form and guidelines, as part of their comprehensive assessment. See: CPM.M5.26 Risk Assessment

2.4 The assessment of risk will include a formulation of risk, a plan to manage clinically significant risks, and a wellness / transition plan. The wellness / transition plan is based on the formulation of risk, the management plan and developed in partnership with the person.

2.5 Whenever possible clinicians should involve whānau / family / support people / carers of the suicidal person when working with that person. At any time families / whānau can give information to the clinician without this compromising the person's privacy.

2.6 Persons possessing firearms and / or a firearms license are reported to the Police as soon as practicable following assessment if the risks of suicide / self-harm indicated that this is warranted.

2.7 If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe. In this situation the appropriate legislation to consider is the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

2.8 All assessments including Comprehensive and Crisis assessments that are not able to be undertaken or completed due to the persons level of substance induced intoxication will be undertaken at the first practicable opportunity as per CPM.M5.10 Assessment time scales.

2.9 All assessments including Comprehensive and Crisis assessments that are not able to be undertaken or completed for reasons related to differences in culture or language between clinical staff and the person being assessed should be managed in accordance with policy 1.5.1 Interpreter and Translation Services and relevant protocols (see Associated Documents section).

2.10 People assessed in emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be monitored in a safe environment until they are sober. Assessment should focus on their immediate risk with further assessment of risk when the person is sober.

3. Care Planning And Management

3.1 A MDT Review of the assessment and treatment plan of the person who has presented with self-harm / suicide will occur within 24 hours. The on-call SMO will complete this on public holidays and at weekends where the regular team does not meet. This MDT is required to be minuted by the crisis service.

3.2 Duly Authorised Officers (DAO's) and Crisis Service staff must document their clinical rationale for using or deciding to not use the MHA where there is a history of self-harm / suicide.

3.3 Clinicians involved in an assessment of a person who has presented with self-harm or suicide will document the clinical rationale for their decisions with regards to admission / discharge home.

3.4 Contact will be made with the person and their family / whānau (if appropriate) as soon as practicable after presentation to ensure safety and ongoing family / whānau involvement in support and treatment.

3.5 Every person who has presented with self-harm / suicide has follow up / safety checking within 24 hours and face to face follow-up within 72 hours following the completion of the comprehensive assessment.

3.6 A Crisis Alert / handover to another clinician, is generated for any person assessed following a self-harm attempt and / or with suicidal intent if the healthcare professional allocated to their care will be absent from normal duties.
3.7 Structured assessment tools such as The Beck Hopelessness Scale are recommended in addition to the comprehensive clinical assessment of suicide risk.

4. The Decision To Hospitalise

4.1 People who report self-harm or suicidal intent should be admitted as an inpatient when:
a) they are acutely suicidal
b) medical management of an attempt is required
c) they require more intensive psychiatric management
d) the establishment of a treatment alliance and crisis intervention fails, and the person remains acutely suicidal.
4.2 When no suitable caregivers / support people are available, respite care options may be considered as an alternative to admission. See CPM.M5.15 Crisis Respite Care. The decision should be made in partnership with the person, family / whānau / support people, and on-call SMO / Nurse Practitioner / clinical staff. Family / whānau may feel unable to cope / manage their family / whānau member and the risk that they will make another attempt.
4.3 If the person is not admitted, appropriate arrangements must be made for follow-up within 24 hours by the relevant health provider (e.g. psychiatrist, case manager, crisis service, GP, other).

5. Management As An Inpatient

5.1 People assessed as being at high risk of suicide have an initial 48 hour care plan commenced on admission that documents the level of observation required to be undertaken by inpatient staff.
5.2 Changes to closer levels of observation may be initiated by any senior clinical team member based on clinical assessment.
5.3 Reduction of the level of observation must be approved by two senior members of the clinical team.
5.4 The mental state of the individuals under observation is reviewed formally at the nursing handover at the end of each shift to ensure that the level of support and observation reflects the person's changing risk.
5.5 Senior nursing and psychiatric staff will review the level of observation at least daily when the overall management plan is reviewed.
5.6 The levels of observation and any changes are documented in the clinical notes by the appropriate clinician. The documentation will include the date, time, clinician's signature and designation, the level of observation and any changes to that level.
5.7 Where possible consistency of clinicians will be promoted between inpatient and outpatient settings to support a reduction in longer term risk.

6. Transition From Inpatient To Community Care

6.1 Standards for Inpatient Discharge Planning are provided in full in CPM.M5.17 Discharge from Mental Health & Addiction Services
6.2 All patients with Community Mental Health Case Manager involvement will receive a follow up visit within 7 days.

6.3 If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm and / or take other appropriate action e.g. contact family / whānau, call Police.

REFERENCES

- Ngā Paerewa Health and Disability Services Standard. NZS 8134:2021
- Ministry of Health Every Life Matters He Tapu te Oranga o ia tangata Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand
- Ministry of Health & NZGG The Assessment And Management Of People At Risk Of Suicide. Wellington. May 2003.

ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty Policy 1.5.1 Interpreter and Translation Services
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.5.1 protocol 1 Interpreters - Guidelines For Use
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.5.1 protocol 3 Te Reo Māori Translations – Guidelines for Use
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M7.3 CMH Intake Procedure
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Unit
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.15 Crisis Respite Care
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.25 Referral
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.26 Risk Assessment
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.27 Seclusion
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.17 Discharge from Mental Health & Addiction Services
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.34 Triage Scale
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 Protocol 3 Care Delivery – Observing Patients

Appendix 1: Comprehensive Psychiatric / Psychosocial Assessment

Assessment should include:

- identifying data: name, gender, age, ethnicity, marital status, sources of history and reliability of historian / informants
- presenting problem(s): in the person's own words
- history of present illness / episode
- past psychiatric history
- past medical and surgical history
- current medications and recent past medications
- drug allergies / sensitivities
- medical systems review
- substance use history
- forensic history
- whānau / family history
- psychosocial history
- Mental State Examination
- physical examination
- differential diagnosis
- formulation
- working diagnosis
- treatment plan.

Mental State Examination

MSE should include the assessment and documentation of:

- Behaviour
- Affect / mood
- Thought content
- Orientation
- Memory
- Insight

Family / Whānau Involvement

Seek input from the person's family / whānau / support people if appropriate. Invite them to give a description of their concerns about the person or any changes that they have noticed.

History of Present Illness

Obtain an account of the emergence, duration and severity of all symptoms, as well as any precipitating or aggravating factors, such as worsening of mood symptoms in relation to alcohol or substance use.

As illnesses such as depression are highly associated with suicidality and suicidal attempts, one needs to be alert to symptoms of:

- lowered mood,
- anhedonia,
- sadness,
- tearfulness,
- irritability; and
- hopelessness.

The latter is a frequent indicator of increased risk of suicide. Sleep and appetite changes such as early morning wakening, weight loss, psychomotor agitation and retardation, are all important indicators of underlying depression.

Differential Diagnosis
A list of all relevant possible diagnoses should be made, at least with reference to the first three Axes of DSM IV-TR.83

Formulation
The formulation synthesises the above information, drawing together an explanation of why this particular person has presented in this particular way at this particular time'. A formulation demonstrates a clinician's understanding of factors that predisposed the person to becoming suicidal (e.g. a family / whānau and personal history of depression) and factors that precipitated their present distress (e.g. grief over a relationship break up). Factors that perpetuate the person's despair are described (e.g. depressive cognitions that they are 'useless') and also any protective factors, both internal (e.g. intelligent, insightful) and external (e.g. good and helpful social supports). The formulation should put into context the current illness in terms of their past history and social circumstances. This individual's understanding complements a specific working diagnosis or diagnoses, allowing a clear management plan to be developed for the given individual to meet their needs.

Appendix 2: Levels Of Observation In Inpatient Units

Level 1: General Observation
All inpatients will have this minimum baseline of observation to monitor and report on significant changes in the patient's mental, physical and behavioural state.

Level 2: Frequent observations (NB MHS requirement for 15 minute observations)
This is required for the person who is considered to be at a significantly increased suicide risk compared with the average psychiatric inpatient, or where the extent of risk is uncertain. It is recommended that the timing of observations be varied to ensure the person cannot predict the exact time of the next observation. If a person is assessed as requiring one of the above levels of observation, details of this must be carefully and systematically documented. People who commit suicide while engaged in mental health services are likely to have had their level of care reduced before they commit suicide (i.e. to have been judged as being at decreased risk).

Recommendations
It is vital to review regularly the mental state of the individuals under such close observation. This should be done formally at the nursing handover at the end of each shift. Senior nursing and psychiatric staff should review the level of observation at least daily when the overall management plan is reviewed. The levels of observation and changes to this should be documented separately in the clinical notes, with counter-signatures from senior staff and the responsible clinician. The documentation will include date, time and signature, level of observation, stop date and role of each person signing. Changes to closer levels of observation may be initiated by any senior clinical team member. Reduction of the level of observation must be approved by 2 senior members of the clinical team.

Level 3: Same room and in sight
This is for the person at high risk of suicide who is expressing active suicidal intent but where there is less concern about impulsive self-destructive behaviour. The person 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 person.

Level 4: Constant observation and within reach 1:1
This is for the person at extremely high risk of suicide who is expressing active suicidal intent. He / she may have recently carried out an act of deliberate self-harm, have unpredictable psychotic states and / or be impulsive and aggressive. This requires observation within reach of the person for safety purposes. On some occasions, more than one nurse may be required.

Seclusion Observations
Observation and care of consumers in seclusion are subject to Health & Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008 and are fully detailed in CPM.M5.27 Seclusion in Mental Health.