Science.
Compassion.
Action.

Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings

Black Dog Institute
BETTER MENTAL HEALTH

Published November 2017
Revised August 2023

Acknowledgements

Our thanks go to those who participated in the research that led to the development of the 2017 guidelines, and to those who participated in the 2023 review process. We hope this report honours your contribution. We would also like to thank the team at Black Dog Institute who contributed to this document: Nicole Hill, Lyndal Halliday, Nicola Reavley, Fiona Shand, Laura Vogl, Jo Riley, Isabel Zbukvic, and all the behind-the-scenes staff.

Suggested citation

Hill N.T.M, Shand F, Torok M, Halliday L, Reavley N.J (2023). Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings. Sydney, Black Dog Institute.

Contents

Better mental health for all

We all know mental health in Australia needs to be better. That's our goal at Black Dog Institute. As a global leader in mental health research and the only medical research institute in Australia to investigate mental health from childhood across the lifespan, we know there is no one-size-fits-all solution to the challenges we're facing together.

Our research findings give us hope for the future. By rapidly translating our research into evidence-based programs, services, and products, that hope can become reality. We want to put the best information we have available into the hands of the people who need it. Our goal is to assist them, their loved ones, their students, their workplaces and their communities.

The Institute is proud to be a trusted partner of government, clinicians, First Nations leaders, industry, workplaces, schools, and philanthropists across the country. We know that through hard work, continuous knowledge sharing, and being led by the evidence, we can help to provide better mental health for all Australians and transform the mental health system.

Our areas of strength include suicide prevention, digital mental health, workplace mental health, new treatments, and mental ill health prevention in young people. We connect research answers, expert knowledge, and the voices of lived experience to deliver better solutions across the healthcare system for patients and practitioners alike.

We're for better for mental health through:

Science

Our research identifies the scientific foundations on which we can develop practical, real-world programs. We're always searching for new and better ways to do things and we won't stop there.

Compassion

We listen and learn from those with lived experience of mental illness – who know first-hand the mornings, the nights, the moments when someone just wants to feel better, just wants to have a better day. This guides and informs everything we do.

Action

We connect the dots to turn research into better treatments, programs, policies, workplaces, classrooms, understanding of community, and ways for reconciliation and healing.

Message from the Executive Director

The quality of care someone receives from the emergency department (ED) following a suicide attempt can influence their risk of attempting or dying by suicide in the future.[1-4] This means that crisis support from the ED and follow-up care can be life-changing for the person, as well as for their loved ones.

For many experiencing a suicidal crisis, the ED is the best option to obtain the essential safety and support they need at that time. It may also be the person's first point of contact with professional help. This is true whether they are referred by a health professional, emergency service, or loved one.

At Black Dog Institute, we have heard a clear call from those with lived experience of suicide that the care many receive in the ED inadequately addresses their needs. We have also heard from clinicians that suicide risk assessment, the current focus of care in many acute settings, offers insufficient guidance to inform treatment and support planning. The development and implementation of best practice guidelines aims to address these concerns and more, providing new guidance for the health system and supporting a life-affirming experience for every person who presents to the ED in suicidal crisis.

Professor Samuel Harvey
Executive Director and Chief Scientist, Black Dog Institute

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Overview

Providing trauma-informed care, especially in emergency department's is a critical component of supporting people in suicidal distress. High-quality psychosocial assessment and a relational, warm and emphatic approach are key: care should acknowledge the person's distress; be compassionate and respectful; and be free of stigmatising beliefs about suicide, such as that suicide attempts are attention seeking, that people who are serious about dying by suicide don't talk about it, or that suicide or a suicide attempt are selfish acts.

Understanding and responding effectively to suicidal distress

The biggest shifts in Australia's suicide rates over the last 100 years have occurred in response to major social, environmental, and economic events. It is clear that these determinants play a key role in driving suicide attempts and deaths. Each year, the Australian Bureau of Statistics analyses the coronial files of people who have died by suicide to determine the leading factors involved in suicide deaths for that year. While there is variation by age and sex, these factors consistently include disruption of family by separation or divorce, problems in relationship with spouse or partner, having a personal history of self-harm, and for older adults, limitations to activities due to disability.

Perhaps the most substantial background contributor is childhood trauma. People who have experienced childhood trauma can have a heightened response to stress. They are also at risk of being retraumatised as a result of losing control, experiencing unreliable behaviours or judgement from others, or having their emotional experiences dismissed.

Trauma-informed approaches seek to avoid re-traumatisation by supporting individuals in decision making; creating safety and trust, choice and collaboration; and building strengths and skills in personal problem solving and mental health (SAMHSA 2014b).

Our response, if it is to be effective, needs to be trauma-informed and free of myths and stigmatising attitudes, such as the idea that a suicide attempt is attention seeking, or that people who are serious about dying by suicide don't talk about it. People who talk about suicide are often thinking about taking their life, and talking about it is an indication that they need help. People who have suicidal thoughts may have a range of emotional responses to thoughts, from fear to relief. Another myth is that suicide or a suicide attempt is selfish. People who attempt suicide are experiencing overwhelming distress and cannot see another way out. As such, suicide can be seen as an escape from intolerable emotional pain.

People who experience suicidal crisis want to receive care that is free from judgement and to access private spaces for confidential conversations with their care teams. Many highlight the importance of having a support person with them who can advocate for them, help them navigate the system and provide them with emotional support. Above all, they emphasise the need to have their distress acknowledged with compassion and respect, undergo psychological assessment that uncovers their unique drivers of distress, and receive a treatment plan that addresses these drivers effectively. While there is limited evidence to guide treatment within the ED, high-quality psychosocial assessment and a relational and emphatic approach are key elements of an effective response. A warm and timely handover to aftercare services is also vital. Effective aftercare has been shown to reduce the risk of subsequent suicide attempts.

> *'People should think "I've landed in the right place". If what is going on right now is a really scary or frightening thing, if you can give the person a sense of relief that they are here… no one knows what's going to happen to them, but if you create a place where people feel relieved to be and then validate and acknowledge what they're saying, I think that's a brilliant start to a conversation.'*
>
> – Mental health nurse

> *'I don't think people should be getting reviewed and asked to talk about their deepest, darkest fears and insecurities… when everyone around them can hear it.'*
>
> – Psychiatric registrar

> *'99.9% of us and the medical staff are all more confident with the psychological [cases] because we're highly trained in that.'*
>
> – ED nurse

Changes to our response to suicidal crisis

Since these guidelines were first released in 2017 hospitals across Australia have made significant efforts to improve outcomes and care for people who present to the ED and other acute settings in suicidal crisis. There has been a national increase in the availability of high-quality aftercare services; the use of telehealth as a viable service delivery model; the availability of peer support in existing services and in standalone helpline and telehealth services; and the inclusion of lived experience voices in planning, implementation and service delivery. However, while the research increasingly points to the value of peer support as a vital component of suicide response, barriers remain, particularly in creating a work culture, systems, and supervisory structures that support peer workers to integrate with clinical teams and carry out the difficult work of supporting and advocating for patients in large, complex health services.

In many jurisdictions, new suicide prevention service models are emerging. These include the establishment of safe spaces as an alternative to the ED for people experiencing suicidal crisis, a commitment to the implementation of the Towards Zero Suicides in Healthcare framework, and piloting of health-centred outreach approaches such as the Police, Ambulance and Clinician Response (PACER) program and other outreach models.

Newer assessment treatment approaches to supporting a person in suicidal crisis are also being implemented in Australian services. Most services are moving away from risk categorisation to more comprehensive risk formulation approaches that are supported by safety planning.

On the flipside, the COVID-19 pandemic has increased the strain on an already stressed healthcare workforce and more clearly exposed flaws in the approach to caring for people experiencing suicidal crisis. During our consultations to update this document, a lack of workforce capacity was the most commonly identified barrier to achieving the goal that every person leaves the ED feeling safe and supported.

Challenges in the emergency department

An environment characterised by constant demand, the ED poses unique challenges for providing care to persons presenting in suicidal crisis. For clinical staff, it can be challenging to adequately address complex needs within tight organisational and legal boundaries. Very public consult settings and short treatment times can make building patient-clinician rapport difficult and some Australian ED clinicians report a lack of confidence in assessing and managing suicide related presentations[6]. Ensuring processes are consistent with best practice can also be difficult when general resources are stretched, such as staff availability at certain hours or across geographic areas. An essential focus on managing acute presentations often means that ED care doesn't integrate smoothly with community-based care pathways.

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5. NHMRC Centre of Research Excellence in Suicide Prevention (C.R.E.S.P). Care after a suicide attempt. 2015.
6. Jelinek GA, Weiland TJ, Mackinlay C, Gerdtz M, Hill N. Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: findings from a national qualitative study. International Journal of Emergency Medicine. 2013;6:2-2.

The emergency department as part of a care pathway

Many people who experience suicidal crisis never present to the ED. While some people receive no support, many can be safely supported by family or friends, community-based health professionals, safe spaces (also called safe havens), first responders, and phone support services such as LifeLine. As health professionals, frontline staff, and community members become more skilled at providing out-of-hospital support, pathways into the ED may change. Nevertheless, EDs are likely to remain a widely used option for people who are unable to remain safe in the community. There are opportunities to improve communication between non-hospital health practitioners referring to the ED and ED clinicians so that all have greater clarity about the short and long-term plans to support the people in crisis.

While there are many pathways into the ED, there are more referral pathways out of the ED, which can leave ED clinicians unclear about care planning options, particularly given the restricted capacity and opening hours of many community-based support services. Equally, there is enormous variance in existing models of care through the ED and beyond. This means that implementation of these recommendations will look quite different in each location and that each ED will have different starting points and priorities.

There remains a very clear role for ED staff to support people experiencing suicidal crisis. Some states and territories provide guidance to help hospitals and health districts establish their own care pathways. In New South Wales, for example, the Agency for Clinical Innovation provides a step-by-step process that guides local health districts, specialty health networks and other stakeholders to co-design care pathways that meet the needs of local communities.

For many people, receiving care in the ED is the first step on their journey to recovery. The transition from ED to aftercare for suicidal crisis can have powerful effects on someone's future risk of self-harm[7]. For this reason, access to high-quality aftercare represents another essential element in any suicide prevention initiative.

The following guidelines address the steps to be taken by ED staff to arrange, in conjunction with the patient and (with the person's consent) their family or support people, referral and follow-up prior to clinical handover.

Setting the benchmark with best practice recommendations

Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings provides evidence-based recommendations for best practice care of people who present to the ED and other acute settings in suicidal crisis. It also addresses the issues that can lead to low patient and carer satisfaction with ED care and lower engagement with ongoing care. Developed as part of the LifeSpan systems approach to suicide prevention, these recommendations build on previously published recommendations and jurisdictional guidelines, while also including the perspectives patients, consumers,

7. NICE Guideline [NG225]: Self-harm: assessment, management and preventing recurrence. National Institute for Health and Care Excellence (NICE); 2022.

family members, support people, or carers who have lived experience of suicidal crisis in an ED setting. Including this perspective provides vital insight into what is most valuable for recovery and is the reason that *Lived experience inclusion at every level* is a core component of the LifeSpan approach to suicide prevention. These recommendations and lived experience perspectives have been combined with insights from clinicians that reflect what is most critical, practical, and feasible in the ED.

The recommendations provide a full picture of requirements for quality care including information for administrators and managerial staff as well, as well as a clinical summary focused on practical steps to be implemented in real time. By taking the uncertainty out of how to create change on the ground, this guide will make it easier for administrators to determine appropriate resourcing, as well as for clinicians to provide the highest quality care.

The research behind the recommendations

These recommendations were produced using the Delphi method, an internationally recognised process standard for developing empirically-based expert recommendations. This method involves asking panels of experts to rank items in terms of importance until the highest level of consensus is reached.

In this case, items were included if they related to care for suicidality in an acute setting or following a suicide attempt. Items were collected by systematically searching international literature (including websites, reports and journal articles). This resulted in a collection of recommendations from guidelines developed in the UK, Canada, and Australia, which were added to statements from people with experience working in crisis settings or aftercare services, as well as people with a personal experience of suicide. Only those items considered significant by all panel members were included in the final guidelines. This resulted in a core set of best practice guidelines from over 400 original items.

A total of 89 individuals participated on the panel, including 50 people with lived experience and 39 professionals representing ED staff or employees in acute settings, health care providers, employees of a crisis response or aftercare service, academics, and people employed in the non-profit community outreach sector. The revision of the guidelines was a consultative process, including one-on-one meetings and workshops with consumer groups, peak bodies, and associations to highlight areas needed for change and improvement.

The full Delphi study has been published following peer review.

'You can't hear my silent screams and you can't see all of the wounds inside my tortured body and my mind. Maybe, just maybe, you can see the hopelessness etched deep inside my eyes. The things you say to me and the way you react to me will be critical to my ability to live. Do not prejudge me for you may never know what drove me to this point in my life.

These words could apply to many who present at an emergency department after attempting to end their own life, or to those who are considering ending their own life. I know that is how I felt, and how many others whose lives have been affected by a suicide attempt or suicidal thoughts have felt. You can't underestimate the importance of being treated with compassion and respect when seeking help during a suicidal crisis; it connects you back to life and hope.

ED staff play a key role in giving a person something they are desperate to find again — hope that they can recover and overcome the issues that drove them to this terrifying point in their lives. Hope helps create a plan for the care and support they need to move through their crisis and into recovery. Once the plan is in place, it's critical to follow up to make sure the person remains supported and stays on track with the plan. If done well, it's like helping them to build a bridge back to life and offering to walk with them out of the darkest place they have ever known.'

Allan Sparkes CV, OAM, VA
Lived experience speaker, author, and advocate

'Family or friends are usually the main source of support for a person in suicidal crisis and are desperate to do all they can to help to keep their loved one safe. It's an extremely challenging and frightening time but it helps to be equipped with relevant information and actively involved in support planning. These guidelines set the standard for ensuring everyone who presents at emergency, including their family or friends, are treated with dignity and respect, [and] receive practical support and appropriate referrals to the care they need to recover.'

Bronwen Edwards
CEO, Roses in the Ocean, and lived experience advisor

'In recent years, clinicians became fixated on "risk assessment" when trying to understand and assist people who raised concerns about suicide. Now that it is clear that suicide risk assessment offers no useful assistance in this task, many clinicians are asking for aid in helping the suicidal patient. These guidelines offer a comprehensive framework to approach patients with the aim of developing a good understanding of their predicament and negotiating with them and their families the best way to achieve the outcomes they want and [to] live the lives they strive for.'

Dr Christopher Ryan
Clinical Associate Professor and Consultation — Liaison Psychiatrist, University of Sydney and Westmead Hospital

'There are very clear opportunities for improving the way in which we respond to a person in suicidal crisis. From our interviews with people who had experienced the health care system following a suicide attempt, the message was clear: an empathic, compassionate response to a person in distress is not an add-on to treatment, it is intrinsic to the treatment. There is a clear association between patients' satisfaction with the first response they receive from health services and their willingness to seek further help. Hospital staff need to be supported to work effectively with at-risk patients in order to reduce the risk of further suicide attempts.'

Dr Fiona Shand
Associate Professor, Black Dog Institute

Detailed guidelines

Description

These Recommendations outline the team structure, skills, and actions that staff can take when responding to a suicidal person in acute settings such as hospital EDs and psychiatric emergency care centres. The following guidelines were developed using the Delphi consensus method. Two expert panels, one consisting of health care professionals and the other consisting of people with lived experience of suicide, rated each action according to how important they believed it to be for inclusion in the guidelines. Only those items that were endorsed as essential or important by at least 80% of both panels were included. The following guidelines are intended for use by those working in acute settings to guide the response to people who have made a suicide attempt or are experiencing thoughts of suicide.

1. Scope of the recommendations

These recommendations seek to promote best practice suicide crisis response in the ED and other acute settings. For the purposes of this document, the term 'suicide response team' (SRT) refers to hospital-based mental health teams who are trained in suicide prevention and responsible for coordinating the hospital's response to suicide presentations. The team may be comprised of multiple members with designated roles, or a single clinician such as a mental health nurse who is trained to perform multiple roles in response to suicide presentations. The term 'a person at risk of suicide' refers to a person who has attempted or is having thoughts of suicide.

2. Administrative and managerial roles and actions

This section covers areas of work for which administrators are responsible, such as staffing, resourcing, contracting arrangements, data collection and systems, and room allocation arrangements. These responsibilities may be split across hospital administrator/s and clinical administrator/s.

2.1 Staffing

The manager/s responsible for staffing should ensure that the SRT is staffed 24 hours a day or that caseworkers are available after-hours to respond to crises (for acute settings without an SRT see 2.1.1 below). They should accommodate for known high-demand periods by increasing the number of staff with the skills and experience to assess and treat people at risk of suicide. In order to understand when rates of people at risk of suicide presenting to the acute setting are highest, a designated member of staff in the acute setting should be responsible for collecting, analysing, and communicating the following data:

a. Number of presentations
b. Time of presentation
c. Date of presentation
d. Number of people who did not wait for treatment
e. Time waiting for consultation by the suicide response team (SRT).

2.1.1 Staffing the acute setting without an SRT

Where no SRT is available, the member of staff responsible for staff scheduling should ensure the hospital is staffed by doing the following:

- Hiring additional providers who have the clinical and other skills and experience to work with people who are at risk of suicide
- Contracting agencies in the community who can provide services such as monitoring, assessment, referrals, and follow-up
- Ensuring that an after-hours therapist, such as a clinician, peer worker, or mental health nurse, is available to assess people at risk of suicide presenting to the acute setting outside regular hours
- Ensuring that a psychiatry registrar or psychiatry liaison is available on call at all times
- Ensuring that a person trained in comprehensive psychosocial assessment, supportive counselling and intervention is available 24/7
- Allocating providers from other departments in the hospital during periods of high demand.

2.2 Providing a safe environment

Staff in acute settings should create a safe environment for people at risk of suicide by providing a comfortable and private place for them to sit and wait for consultation or to complete assessment procedures. A signed and dated environmental safety audit should be kept on record in the acute setting. This should cover removal of ligature points and access to means of suicide.

2.3 Training

Nursing directors should ensure that all staff members who have contact with a person at risk of suicide are trained to deliver effective care. The manager responsible for training and education in the acute setting should assess the training needs of staff and should ensure that training is provided to the following staff:

- Paramedics (including ambulance staff)
- Social workers
- Peer workers
- Youth workers
- Security staff
- Other allied services that provide care in the acute setting

In acute settings where no SRT is present, the responsible manager should ensure that staff receive comprehensive training in suicide and mental health. The manager should ensure that staff members working with people with suicidal behaviour have the opportunity for:

- supervision
- peer discussion and support
- self reflection
- case review meetings and opportunity for supervision
- access to appropriate clinical and other supervision, consultation, and advice from a senior clinician at all times.

Suitable training programs are listed on the Suicide Prevention Australia Website.

2.3.1 Core competencies

The following is a list of core competencies that SRT members should possess:

2.3.1.1 Knowledge

Knowledge of:

- hospital policies, protocols, and guidelines
- medico-legal issues in the delivery of mental health care as well as requirements of common law and legislation
- the different presentations of suicidal behaviour in different age groups and the stressors that lead people to suicide
- comorbidities and their impact on suicidal behaviour (e.g. alcohol and drug disorders), including brief interventions and detoxification programs
- the sequence of care in the acute settings
- mental capacity and its application in the acute setting
- procedures for engaging partnering services who have shared governance of a person's care
- local evidence-based resources relevant to the support of service users
- the impact of cultural differences on influencing symptomatology, perception of symptoms, help-seeking behaviour, and clinical judgment and the ability to provide culturally safe care
- procedures to notify police of firearms or weapons present in the home
- procedures for contacting child protection services.

2.3.1.2 Skills

Ability to:

- perform detailed evaluations of suicidal behaviour and management of self-harm
- perform mental state assessments and comprehensive psychosocial assessments

- solve problems using a variety of techniques
- recognise and respond to frequent attenders
- recognise and respond to acute behavioural disturbances
- manage treatment adherence
- triage in line with symptom severity
- perform culturally relevant and sensitive assessments
- generate and implement management/care plans
- assess hostile or guarded people
- formally assess a person's decision-making capacity when they disagree with treatment recommendations or if they decide to leave the acute setting before completion of the assessment
- inform a person of their treatment options, particularly if they have limited judgment
- use corroborative information to aid diagnosis, assessment, management, and discharge planning
- provide means restriction counselling that informs the person's carer, family, or friends about the dangers of access to medication and other lethal objects.

2.3.1.3 Skills in person-centred care

Ability to:

- engage the person as partner in the design of their care
- listen and talk to the person, explain actions, and provide reassurance
- provide person-centred engagement, reflective practice, and capacity to build a therapeutic alliance
- respond respectfully in a non-stigmatising, non-discriminatory manner
- understand the impact of emotions and feelings on interactions with others, including regulating emotions and feelings
- understand the impact of attitudes and judgments on help-seeking behaviour
- act in ways to make people feel validated and listened to
- offer comfort, reassurance and hope to the person.

2.4 Facilitating collaboration

The managers responsible for facilitating collaboration and coordination across health and social care services should ensure that the following are in place:

- a standardised form for communicating with partnering community services
- processes to exchange health care records and coordinate services with community partners
- joint education opportunities such as inter-professional education programs
- opportunities for care providers to present at formal professional development events
- joint staffing meetings with inpatient units and acute psychiatric care departments
- mentoring programs
- telepsychiatry or videoconferencing tools to close provider gaps if local resources are limited
- risk management training
- feedback and communication streams for service issues
- designated time for mental health providers from other hospital departments to assess and treat a person presenting for suicide behaviour

- processes for efficient and standardised data collection processes across sectors
- routine screening processes for physical and mental co-morbidities
- space and resources (rooms, computers) for co-located services.

2.5 Service evaluation

A mental health data collection and monitoring framework that assesses service activity and quality should be created and integrated with existing health data collection systems. This should include a process for asking people with lived experience for feedback on their service experience, although not necessarily at the time of suicidal crisis. These data should be used to identify care processes that require improvement and to evaluate whether changes to these processes have the desired effect.

The SRT should keep records of the following data on each person who presents to the ED or acute setting in suicidal distress:

- average number of contacts made per individual
- whether the person was admitted to hospital or inpatient care
- whether the person accessed referral services or other services
- demographic information (including indicators of LGBTI, Aboriginal and Torres Strait Islander status)
- whether the person attended the acute settings alone
- whether the person required a translator.

The member of staff responsible for data collection should record the numbers of people who:

- are treated after a suicide attempt (in the past year)
- re-present with suicidal behaviour
- are admitted
- receive aftercare and follow-up
- enter the acute setting and are discharged within four hours or within other relevant hospital access targets
- return to the acute setting within 28 days of discharge
- attempt suicide or experience suicidal thoughts and receive a comprehensive psychosocial assessment. Waiting times for a comprehensive psychosocial assessment should also be recorded
- receive a referral to an appropriate aftercare service
- receive a notification that an appointment has been made with an appropriate ongoing care agency
- receive a follow-up referral and appointment within 24 hours of discharge
- leave the acute care setting against the advice of the clinical team.

3. Resources needed for patients, carers, families, and clinicians

Staff should ensure that comprehensive aftercare information is available to people waiting for consultation, as well as to their family and friends. This information should be provided in writing and should include details of:

- referral and aftercare services available to the person through the hospital and/or the community
- ED processes, including procedures to rapidly escalate a patient deterioration, identify concerns, or make a complaint
- alternatives to inpatient admission (e.g., community crisis houses, day hospitals, home treatment, respite)
- community support groups and other relevant local community programs
- a person's rights in health care
- available mental health crisis services (e.g., mental health drop in clinics)
- any non-clinical services that may alleviate isolation and promote hope.

3.1 Community referral resource manual

The SRT should develop and maintain a resource manual of local outpatient mental health providers and community services to assist with referral, follow-up, and continuity of care. This should include:

- a description of the service provided
- a description of eligibility criteria
- relevant skills of the agency/service
- specialisations of the service provided
- contact information
- referral information.

4. Clinician and suicide response team roles and actions

4.1 Team roles

The SRT should have members co-located in the department where people at risk of suicide receive acute care (for acute settings without an SRT, see 4.2 below). The member of staff who is responsible for overseeing the operations of the mental health team should ensure that all SRT members receive appropriate training in the care of a person at risk of suicide. The SRT should include people trained in liaison psychiatry; delivery of psychosocial assessments; crisis intervention; the provision of follow-up care; discharge, formulation of the discharge care plans and transfer of care; and referrals to internal and external services. If the SRT liaison psychiatrist is in training, they should have 24/7 access to a consultant psychiatrist. When providing care to a person in suicidal distress, SRT members should:

- ask the person whether they prefer to wait in a private place, ensure that the person is not left unsupervised, and provide the person with regular updates on waiting times and next steps
- have a protocol for a person that presents to the acute setting alone
- notify key hospital workers or case-managers previously involved with the person's care
- link the person to hospital services (e.g., drug and alcohol services) that address co-morbidities
- refer the person to inpatient care when necessary (e.g., in cases of people with command hallucinations or ready access to lethal means)
- provide follow up if the person is transferred to a different hospital ward (e.g., following surgical intervention) to ensure they receive a comprehensive psychosocial assessment
- provide emotional support and help to carers, family, or friends accompanying the person who are experiencing high levels of stress and anxiety
- provide carers, family, or friends with information about caring for someone with suicidality
- establish a protocol for contacting the person's GP to obtain relevant medical history
- refer carers to local services and support groups
- identify people who frequently attend the acute setting
- arrange the comprehensive psychosocial assessment
- Complete discharge care planning and refer the person to follow-up with aftercare services.

4.2 Acute settings with no/limited SRT

Some acute settings may not have a fully staffed mental health team and many will not have a 24 hour SRT. In this instance, the member of staff responsible for coordinating the mental health team should arrange for a 24-hour mental health telephone triage service that offers instructions and advice to people in suicidal distress. They should also arrange for partnerships with allied health professionals, ambulatory care services,

community-based services (e.g., local NGOs, outpatient services, and social services), and services that provide cultural support services for Aboriginal and Torres Strait Islander people. Links should be established with a community-based team to assist with aftercare and follow up.

4.3 Initial contact

Initial contact is the point at which a person at risk of suicide, or their carer or clinical practitioner, first makes contact with medical services. A person who has received the required medical treatment for any physical issues they have presented with should then be referred directly to the SRT. Staff in acute settings should offer to contact a family member or friend of the person.

4.4 Provision of peer support

Acute settings with peer support workers should have supervision and governance structures in place to support them and should receive appropriate training.

4.4.1 The role of the peer support worker

Peer support workers should assist the person at risk of suicide in the following ways:

- working with the clinical team to support access to other services, including safe spaces, and to develop a safety plan with the person
- advocating for the person to be treated with dignity and respect
- connecting with the person and offering support and comfort, including basic physical comforts such as blankets, towels, meal trays, reading materials, and water
- offer to accompany the person while they wait for consultation with the SRT
- offer to help the person communicate with staff in the acute setting
- offer to liaise with the person's carer, family, or friends.

4.5 The comprehensive psychosocial assessment

Comprehensive psychosocial assessment refers to the evaluation of a person's mental, physical and emotional health, as well as their ability to function in the community. Assessment is not aimed at categorising risk; rather, its purpose is to guide treatment planning for the individual. This assessment plays a central role in helping to improve the aspects of the person's life that have contributed to their risk of suicide and offers an opportunity for clinical staff to show compassion and understanding. A SRT member should administer a comprehensive psychosocial assessment to everyone who is referred for a suicide attempt or thoughts of suicide and should assess the needs of carers accompanying the person at risk of suicide. If the person refuses a comprehensive psychosocial assessment, the SRT liaison psychiatrist should attempt to explore the reasons, including possible assessment of the person's mental capacity.

The SRT should ask treating health professionals and people in the person's social network to provide information on their beliefs about the current presentation, behavioural changes in the person, and access to means of suicide such as firearms or stockpiles of medication. They should also assess the needs of carers, family, or friends accompanying the person.

4.5.1 Content of the comprehensive psychosocial assessment

The comprehensive psychosocial assessment should prioritise assessment of the key

factors that brought the person to their current crisis.

Suicidality

Assessment of:

- the physical injury, its severity and the potential lethality of the chosen method
- the person's subjective view about the lethality of their attempt
- the circumstances that led to the suicide attempt, including suicidal ideation and persistence of suicidal ideation
- the motives underlying the suicide attempt
- current/ongoing suicidality (thoughts, plan, lethality of plan, level of intent, access to means)
- preparatory behaviours and planned precautions to prevent discovery or interference of the person's suicide attempt
- the person's mental state
- negative feelings, including depression, hopelessness, helplessness, loneliness, feeling trapped, and continuing suicidal intent
- ambivalence about living or dying
- covert suicidal ideation (e.g., making a will, paying debts, hinting – 'you won't have to worry about me anymore').

Medical and psychiatric history

Assessment of the person's:

- suicide attempt and self-harm history
- mental health symptoms
- current physical health symptoms and diagnoses
- medication and substance use history
- ability to maintain sufficient hydration and nutrition.

Psychosocial history and life stressors

Assessment of the person's:

- support resources
- dependents
- exposure to domestic violence, neglect, or abuse
- ability to fulfill family and occupational responsibilities
- exposure to someone else's suicidal behaviour or suicide death.

Presence of risk factors for suicide

Assessment of the person's:

- circumstances that led to the suicide attempt including suicidal ideation and persistence of suicidal ideation
- perception that they are a burden to others
- trauma history and treatment needs
- veteran status and war trauma
- membership of a cultural or minority group (e.g., Aboriginal and Torres Strait Island people, LGBTI)
- impulsiveness and risk-taking behavoiurs and acknowledegment of self-destructive behaviours, if applicable.

Ability to recover in the community

Assessment of the person's:

- protective factors; e.g., family support, coping skills
- ability to seek and access help and identify any barriers to accessing services including an assessment of financial barriers
- ability of the person to enter into a

therapeutic alliance/partnership including the persons engagement with help

- positive coping and problem solving skills
- family and social connectedness
- ability to interact with others
- core values, beliefs, goals, and strengths
- openness to different problem-solving strategies
- concerns about stigma
- immediate, medium, and long-term mental health needs
- Immediate and long-term social needs.

The psychological assessment should also include psychological first aid and problem-solving counselling that addresses the persons needs and is aligned with strategies that the person has identified and is open to.

4.5.2 Using the comprehensive psychosocial assessment to guide treatment

The SRT should use the results from the comprehensive psychosocial assessment to complete the following:

- develop a treatment care plan
- educate the person about their condition and treatment options
- provide a referral for psychiatric consultation, if applicable
- provide referrals to other hospital or outpatient services such as mental health treatment, substance abuse treatment, family counselling, and other social services
- educate carers, family, or friends about the person's condition and treatment options.

Where a clinical decision results in a person being discharged, the SRT should organise a follow-up assessment through relevant care coordination programs. They should request the person's consent before sharing information from the comprehensive psychosocial assessment.

4.6 Crisis management plans for frequent attenders to acute settings

People who frequently attend the acute setting for mental health-related behaviours should be encouraged to develop a crisis management plan that sets out their preferences for future medical treatment. This should be done when the person is well. This approach gives the person the opportunity to work with health professionals to decide the type of treatment they would like to receive in a time of crisis.

5. Referral and follow-up arrangements

Referral describes the transmission of a person's personal or health information from one agency to another for further assessment, care, or treatment. Follow-up, which is also known as aftercare, describes the continuity of care following discharge from acute settings.

5.1 Arranging referral

The SRT should arrange referral and follow-up services based on the needs identified by the comprehensive psychosocial assessment. The SRT is responsible for the following:

- confirming that the person's referral has been received by the relevant aftercare service
- arranging a follow-up referral to the person's GP
- documenting referral outcomes
- arranging referrals to local services and support groups for carers, family, or friends and to postvention and bereavement services for carers, family, or friends of a person who died by suicide after entering the acute setting.

The SRT should contact relevant agencies prior to making a referral to ensure the agency can accommodate the timely implementation of the referral request. They should ensure that aftercare referrals are established within 24–72 hours for all cases. However, referrals to services involving the person's immediate needs should be prioritised as urgent, meaning referral cannot wait and must occur the next day.

5.2 Arranging follow-up

The SRT should arrange follow-up services for everyone who has presented to the acute setting due to suicidal distress or a suicide attempt. Follow-up support should be negotiated with the client to ensure they get the care and support needed without breaking confidentiality. This can be done face-to-face or by using 'crisis cards' that list emergency phone numbers and safety measures. The SRT member responsible for follow-up should have access to relevant patient administration systems. Rural and remote communities should partner with other organisations (e.g., Red Cross, Lifeline, police, etc) to provide follow-up contact via phone, telehealth/ video call, email, or home visits.

The SRT should have a protocol to manage the care of a person who does not give consent for communication with aftercare and follow-up services. Staff should be trained in understanding the difference between requesting and requiring consent and the importance of mitigating harm.

5.3 Clinical handover and transfer of care

5.3.1 The clinical handover plan (discharge plan)[1]

The purpose of clinical handover/discharge planning is to ensure a safe and successful transition from the acute setting to an inpatient service or to the community. It provides a means of synthesising assessment

[1] The terms clinical handover plan and discharge plan can be used interchangeably as required. Both refer to the transfer of care of the individual from one provider to another.

information and agreed strategies and is particularly important for people with multiple and complex needs. It specifies the steps that must be taken and assists the person to come to a decision that is appropriate for their needs, wishes, values and circumstances.

The clinical handover plan (CHP) should contain strategies that are accessible, available, and valuable to the person, their family and/or care. It should be written using non-stigmatising language (e.g., it should avoid the use of terms such as 'non-compliance') and should include culturally appropriate assessments and referrals, as well as developmentally appropriate language. The CHP should include the following:

Treatment and support recommendations

- Recommendations and actions that address needs identified in the comprehensive psychosocial assessment
- Instructions for the person's medication including frequency, dosage, and side effects
- A schedule of appointments for follow-up and aftercare including contact details of all the aftercare services included in the person's referral
- Contingency arrangements for contacting specialists
- Arrangements to overcome barriers to accessing aftercare services
- Housing support recommendations and action needed to secure accommodation, if applicable
- Recommendations to reduce social isolation and engage with a support network
- Relapse prevention recommendations
- Specific steps to seek help and support if symptoms re-occur or worsen or the situation deteriorates following discharge
- Follow-up procedures following failure to attend aftercare appointments
- Education about warning signs of possible relapse and what to do
- Strategies to support coping and mitigate intolerable distress, pain and suicidal thoughts at home
- A harm minimisation plan for alcohol and drug use, if applicable
- Emergency contact details
- Details of the person's nominated support network and related contact details
- 24/7 mental health emergency contact details (including phone support services such as Lifeline)
- Contact details for crisis assistance and community mental health services.

5.3.2 Providing the clinical handover plan to the person

The SRT should provide a CHP to everyone who presents to an acute setting in suicidal distress. Team members should work with the person to develop the CHP.

The SRT should provide the CHP to the person before they are discharged or transferred from the acute setting, although they may provide a brief CHP to the person when arrangements have been made to develop the care plan in the community during a scheduled appointment. In such cases, the SRT should make arrangements for a more extensive CHP within 24 hours of discharge. The SRT should engage in more extensive discharge planning for people with multiple needs identified by the psychosocial assessment.

The CHP should be provided to the person

in written format, verbally, and in any other format the person prefers (email, mail). The SRT should also provide a written copy of the CHP to the person's GP or aftercare service within 24 hours of the discharge and, with the person's consent, to their carer, family, or friends.

5.3.3 Discharge eligibility

For a person eligible for discharge, the SRT ensures that:

- the contact details of the person, their GP, as well as those supporting them in the community, are updated in the hospital's electronic records
- the person has received the following:
    - the CHP
    - medication and a prescription supply, if applicable
    - information stating the benefits of follow-up and treatment adherence
    - information such as crisis cards, business cards, and brochures from community services and partners
- the person has adequate arrangements to be transported to a safe location at discharge
- phone hand-over to the relevant agency (during regular business hours) has been performed.

5.3.4 Transfer of care

If appropriate and with the person's consent, the SRT should assist with finding a substitute treatment setting, including inpatient, sub-acute or private hospital beds, respite care, or special accommodation. In such cases, the SRT is responsible for handover and for providing all acute setting notes and a copy of investigation results to the staff in the new setting.

During discharge, the SRT should carry out the following procedures:

- notifying the person's GP
- notifying community-based services used by the person (with the person's consent)
- arranging support for dependents and carers, family or friends
- exchanging information between service providers (with the person's consent)
- arranging reviews and reassessments

If possible, the SRT should make arrangements with aftercare services before the person is discharged.

5.3.5 Clinical handover

The SRT provides a clinical handover that includes:

- details of the person's condition/ diagnosis/crisis
- the person's reason for attending the acute setting
- a summary of the assessments performed
- a list of interventions undertaken by the SRT
- a list of interventions arranged by the SRT
- recommendation for the person's GP if the person needs additional support.

The SRT provides the discharge summary to the following people:

- the person
- the person's GP
- the person/service responsible for follow-up
- all services involved with the person's aftercare (including follow-up and outpatient services)

The SRT should provide the clinical handover summary within 24 hours of discharge. The person can request the clinical handover summary is provided in a format best suited to them (e.g., email).

5.3.6 Providing the clinical handover summary to carers, family, or friends

The SRT should ensure that , with the person's consent, the discharge information is shared with the person's carer, family, or friends. This consent should be documented. Information given to carers, family, or friends includes:

- safety measure advice including means restriction counselling (i.e., securing medications)
- harm minimisation techniques
- healthy strategies to help with person cope with distress
- encouragement to support the person being discharged
- specific risks related to the person
- crisis and emergency contact numbers
- explicit contingency arrangements so the carer can contact specialist services if they need to
- advice about how to handle situations in which the person is unwell but avoiding or resisting help.

5.3.7 Case management

The SRT or a community-based service can provide follow-up care or case management. In the latter case, the SRT should liaise with service providers to ensure that aftercare referrals have been actioned. Effective case management involves:

- expressing concern and support to the person and explaining the purpose of the follow-up contact
- discussing the person's clinical handover plan, checking their progress, and assessing whether the discharge care plan has been useful
- facilitating engagement with relevant services and providing additional referrals to community supports, if applicable
- determining whether treatment has been sought, organised, and delivered
- reviewing barriers to treatment adherence and developing alternative strategies that encourage the person to return to treatment
- providing telephone reminders of appointments
- assessing the success of the person's transition back into the community and discussing future case management planning
- establishing a more suitable therapeutic plan in collaboration with the person and health services, if applicable
- conducting a mood check
- discussing solutions to problems and the management of stressors
- explaining when the schedule of follow-up contact will end
- inviting the person to stay in touch and call whenever they feel they are in crisis.

First follow-up contact should occur within seven days.

5.3.8 Assertive follow-up

Some people may require assertive follow-up when discharged into the community. This includes people:

- with a suspected or diagnosed mental illness
- at risk of becoming homeless
- in situations of domestic violence

- who cannot be sure they can keep themselves safe
- presenting for suicide risk for the first time
- with a reported history of poor treatment adherence.

Assertive follow-up should involve more frequent contact with the person, home-visits, intensive case management, and out-reach support. First follow-up contact should occur within 24 hours.

5.3.9 Linkage with community services and aftercare

Community mental health services include urgent community-based assessment and short-term interventions for people in suicidal distress; intensive long-term support for people with prolonged and severe mental illness and associated high-level disability; and non-urgent continuing care services for people with mental illness and their carers, family, or friends.

Inter-agency linkage

The SRT should arrange for inter-agency protocols that link the acute setting to community agencies, NGOs, and community services. The protocol should cover:

- aftercare referral arrangements
- follow-up arrangements
- assessment arrangements
- treatment arrangements
- shared care arrangements
- agreement to allow some people to receive priority treatment when referred from the acute setting based on clinical need
- access to clinical mediation and advocacy (e.g., social workers in aged care who can assist person to decide on treatment options)
- outreach arrangements for hospitals that lack the capacity to employ in-house services
- collaboration with GPs
- the responsibilities of each aftercare service when the person has multiple aftercare needs
- an agreement for accessing secondary consultation on request
- agreement between community agencies that people with certain comorbidities (e.g., alcohol misuse) will not be excluded from aftercare services
- information sharing arrangements.

Appendix

Clinical summary

Referral options and collateral information	Person presenting in suicidal crisis	Carers/family/friends
• Notify key hospital workers with prior involvement	**Triage/refer to suicide response team (SRT) or mental health team (MHT)**	
• Refer to inpatient care when necessary • Link to hospital services that address comorbidities (e.g., drug and alcohol) • Referral for psychiatric consultation (if appropriate) • Referral to other hospital/ outpatient services (e.g., mental health treatment, substance abuse treatment, family counselling, social services)	**Conduct comprehensive psychosocial assessment**	• Provide emotional support and help • Provide information about caring for someone with suicidality • Provide referral options to local services/support groups
	Create treatment care plan — inpatient/outpatient	• Information about the person's condition and treatment options (with the consent of the person presenting in suicidal crisis). • Arrange referral to local services and support groups • Arrange referral to postvention/ bereavement services for a person who has died by suicide
	Arrange referral and follow–up services	
	Provide Clinical Handover Plan (CHP)	Discharge information given to carers/ family/friends should include: • safety measure advice — means restriction counselling • harm minimisation techniques • healthy strategies to help person cope with distress • encouragement to support the person being discharged • specific risks related to the person • crisis and emergency contact numbers • explicit contingency arrangements to contact specialist services • advice on how to handle the situation if the person is unwell and resisting/ avoiding help.
	Follow-up care/case management	

Clinical summary
Further details

Triage/refer to suicide response team (SRT) or mental health team (MRT)

- Provide safe comfortable environment with appropriate supervision/monitoring
- Offer to contact family member/friend
- Follow-up patients in different wards
- Provide peer support worker if available

Conduct comprehensive psychosocial assessment

The CPA is a broad assessment of a person's mental, physical and emotional health, as well as their ability to function in the community. It should support the person to understand what contributed to their suicidal crisis. It does not need to be carried out in a prescribed order.

IMPORTANTLY, the CPA is an opportunity to build rapport and show compassion and understanding.

Assessment of Suicidality

- the physical injury, its severity and the potential lethality of the chosen method
- the person's subjective view about the lethality of their attempt
- the circumstances that led to the suicide attempt including suicidal ideation and persistence of suicidal ideation
- evidence of preparatory behaviours and planned precautions to prevent discovery or interference of the person's suicide attempt
- the person's ambivalence about living or dying
- the person's covert suicidal ideation (e.g. making a will, paying debts, hinting –'you will not have to worry about me anymore')
- the person's suicide attempt and self-harm history
- the person's impulsiveness and risk taking behaviours, and acknowledgment of self-destructive behaviours, if applicable
- the perceived burden on others
- negative feelings including depression, hopelessness, helplessness, loneliness, feeling trapped, and continuing suicidal intent
- current suicidality, including the motives underlying the suicide attempt
- current/Ongoing suicidality (thoughts, plan, lethality of plan, level of intent, access to means).

Medical/mental health assessment and history

- A comprehensive mental state examination
- A review of mental health symptoms
- A review of current physical health symptoms and diagnoses
- Medication and substance use history
- Ability to maintain sufficient hydration and nutrition
- Psychosocial history and life stressors
- Current life stressors (e.g. financial, social, familial, occupational etc.)
- Whether the person has any dependents and parenting skills
- Ability to fulfil family and occupational responsibilities
- Trauma history and treatment needs
- Exposure to domestic violence, neglect or abuse
- Exposure to someone else's suicidal behavior or suicide death
- Veteran status and war trauma
- Whether the person is part of a cultural/minority group (e.g., Aboriginal and Torres Strait Island people, LGBTI).

Coping resources and support

- The person's support resources
- Assessment of protective factors e.g. family support, positive coping skills and problem solving skills
- An assessment of family and social connectedness
- Identify the core values/beliefs, goals and strengths of the person.

Ability to recover in the community

- The person's ability to seek and access help - identify any barriers to accessing services including an assessment of financial barriers
- The ability of the person to enter into a therapeutic alliance/partnership including the persons engagement with help
- Identify problem solving strategies the person is open to
- The person's ability to interact with others
- The person's concerns about stigma
- Immediate medium and long term mental health needs
- Immediate and long term social needs.

Create treatment care plan — inpatient/outpatient

- Develop a treatment care plan
- Provide education about person's condition and treatment options

Arrange referral and follow–up services

In collaboration with person:

- For every patient going home, organise follow-up assessment and obtain consent before sharing information
- Confirm referral has been received by relevant aftercare service
- Confirm all referrals can be established within 24–72 hours of discharge and urgent cases the next day
- Arrange a follow-up referral to the person's GP
- Document referral outcomes

*Follow-up can include face-to-face, crisis cards etc.

Clinical summary
Additional details

Provide clinical handover plan (CHP)

Aim: To ensure safe successful transition from acute setting to community.

CHP should include:

Treatment and support recommendations

- Recommendations and actions that address needs identified in the CPA
- Instructions for medication including frequency, dosage, and side effects
- A schedule of appointments for follow-up and aftercare including contact details
- Contingency arrangements for contacting specialists
- Arrangements to overcome barriers to accessing aftercare services
- Housing support recommendations/action needed to secure accommodation, if applicable
- Recommendations to reduce social isolation and engage with a support network

Relapse prevention recommendations

- Specific steps to seek help and support if symptoms re-occur or worsen or the situation deteriorates following discharge
- Follow-up procedures following non-compliance or failure to attend aftercare appointments
- Education about warning signs of possible relapse and what to do
- Strategies to support coping and mitigate intolerable distress, pain and suicidal thoughts at home
- Harm minimisation plan for alcohol and drug use, if applicable

Emergency contact details

- Details of the person's nominated support network and related contact details
- 24/7 mental health emergency contact details (including phone support services such as Lifeline)
- Contact details for crisis assistance and community mental health services

Discharge eligibility:

- Update hospital records (details of person, GP, those supporting in community)
- The person has: clinical handover summary, medication and prescriptions, information on benefits of follow-up and treatment adherence, crisis cards, business cards, brochures of community services
- Arrange transport to safe location at discharge
- Perform phone handover to relevant agency

Follow-up care/case management

- Express concern and support/explain purpose of follow-up contact
- Check progress and usefulness of discharge plan and update as required
- Facilitate engagement with relevant services/provide additional referral to community supports, if applicable
- Determine whether treatment has been sought, organised, and delivered
- Review barriers to adherence and problem-solve strategies to encourage return to treatment
- Provide telephone reminders of appointments
- Assertive follow-up required (see below for priority populations)

Role of peer support worker

Offer to:

- advocate for the person's needs to be met where they feel unable to do so themselves
- provide basic physical comforts (e.g. blankets, towels, meal trays)
- accompany person while they wait for the SRT/MHT
- help the person communicate with staff in the acute setting
- liaise with the person's family/friends/carer (with the person's consent).

Content of CHP

- Condition/diagnosis/crisis
- Reason for attending the acute setting
- Summary of assessments performed
- Interventions undertaken by the SRT or MHT
- Summary of the discharge care plan
- Interventions and referrals arranged
- Recommendations for the person's GP if the person needs additional help

Populations requiring assertive follow-up

- With a suspected diagnosed mental illness
- At risk of becoming homeless
- In a situation of domestic violence
- Who cannot be sure they can keep themselves safe
- Presenting for suicide risk for the first time

Assertive follow-up includes

- Frequent contact with person, home-visits, intensive case management, and out-reach support
- First contact should occur within 24 hours


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