Clinical Care of People Who May Be Suicidal (ImpG)

Policy Number 1.380
Policy Function Continuum of Care
Issue Date 17 October 2018
Summary This implementation guide provides information for Justice Health and Forensic Mental Health Network clinical staff on the assessment of deliberate self-harm and suicide risk to ensure that patients in custody assessed to be at risk of deliberate self-harm or suicide have an appropriate management plan in place, which is clearly documented in the patient’s health record and communicated to the appropriate staff. This policy applies to all clinical staff in Justice Health and Forensic Mental Health Network adult services who are required to assess the risk of deliberate self-harm or suicide of patients in custody.

Responsible Officer Executive Director Clinical Operations

Applicable Sites
- Administration Centres
- Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- Health Centres (Adult Correctional Centres or Police Cells)
- Health Centres (Juvenile Justice Centres)
- Long Bay Hospital
- Forensic Hospital

Previous Issue(s) Policy 1.380 (Mar 2014; Nov 2010)
Change Summary
- Amended from a policy to an implementation guide.
- Update of title names and positions.
- Update of CSNSW Policy Management of inmates at risk of self-harm or suicide.
- Forensic Hospital incorporated into the implementation guide.
- Transition from RIT and risk of harm to others sections added.
- Referral to Drug and Alcohol Services added.
- Reconfigured to align with the current policy template.

TRIM Reference POLJH/1380
Authorised by Chief Executive, Justice Health and Forensic Mental Health Network
1. Preface

Around one quarter of all deaths in prisons are self-inflicted, the majority of which are by hanging. While the rate of suicide of persons in custody has declined over recent years it remains approximately three to five times that of the general population. Suicide is still a rare event, which makes the assessment of the risk of suicide a difficult task and the custodial environment is a further confounding factor. Justice Health and Forensic Mental Health Network (JH&FMHN) clinical staff have a key role in the early detection of, and intervention with people in contact with JH&FMHN services who are at risk of suicide.

The Ministry of Health (the Ministry) Policy PD2016_007 Clinical Care of People Who May Be Suicidal applies to all JH&FMHN services and staff. Because of the special nature of correctional centres and the need to manage patients at risk of suicide in partnership with the staff of Corrective Services NSW (CSNSW), this document has been developed to guide staff in the implementation of PD2016_007 in correctional centres.

This implementation guide applies to all clinical staff in JH&FMHN who are required to assess the risk of suicide or deliberate self-harm (DSH) of adult patients in custody.

In this implementation guide, the term ‘suicidal behaviour’ includes the range of behaviours from suicidal thoughts and expressions of suicidal intent to attempted suicide and completed suicide.

For staff working in correctional centres and Police cells, this implementation guide must be read in conjunction with the following Corrective Services NSW (CSNSW) documents which are available on the JH&FMHN Intranet at Policy and Procedures>Procedures> Mental Health Procedures:

- Custodial Operations Policy and Procedures (COPP) 3.7 Management of inmates at risk of self-harm or suicide.
- ISP/RIT Management Plan - Reference Guide, and
- Risk intervention team (RIT) – Assessment interview and documentation guidelines.

The Forensic Hospital is solely a health facility and the CSNSW RIT policies and procedures do not apply there. Staff working in the Forensic Hospital must read this implementation guide in conjunction with the JH&FMHN policy 1.078 Care Coordination, Risk Assessment, Planning & Review – Forensic Hospital and Forensic Hospital Procedure Clinical Risk Assessment & Management (CRAM).

2. Policy Content

2.1 Mandatory Requirements

2.1.1 Ministry of Health Policy and Guidelines

The Ministry of Health (the Ministry) Policy PD2016_007 Clinical Care of People Who May Be Suicidal applies to all JH&FMHN services and staff.

In compliance with PD2016_007 and the Framework for Suicide Risk Assessment and Management for NSW Health Staff, all JH&FMHN clinical staff who are in contact with patients with possible suicidal behaviour must be proficient in the identification and preliminary assessment and management of patients with suicidal behaviour or at risk of DSH or suicide.

All nurses who work in correctional centres must complete the Suicide in Custody training (or equivalent), which is available on My Health Learning.

Clinical staff in the Long Bay Hospital, Mental Health Unit (MHU) should also be guided by the Ministry document Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital.

Patients in the Forensic Hospital who are identified as potentially a risk of suicide are wholly managed in accord with PD2016_007.

2.1.2 Corrective Services Procedures

CSNSW is responsible for the safe custody of patients in NSW correctional centres. In discharging these duties, CSNSW has developed a policy and procedures for the identification, assessment and management of DSH and suicide risk. JH&FMHN clinical staff must familiarise themselves with the CSNSW Custodial Operations Policy and Procedures (COPP) section 3.7 Management of inmates at risk of self-harm or suicide.

2.2 Implementation – Roles and Responsibilities

2.2.1 JH&FMHN Clinical Staff

JH&FMHN clinical staff may be required to assess a person’s risk of DSH or suicide if:

a) a person screened at reception to a correctional centre is identified as potentially at risk;

b) a current patient is identified by JH&FMHN clinical staff as potentially at risk;

c) CSNSW staff refer a person to JH&FMHN clinical staff for assessment; or

d) a JH&FMHN member of staff is participating in a Risk Intervention Team (RIT).

2.2.2 Incident Information Management System (IIMS) Report

Where a patient has attempted or completed suicide, then the JH&FMHN clinician who was involved with the assessment and/or management of the patient must log an Incident Information Management System (IIMS) report.

3. Procedure Content

3.1 Suicide and DSH Risk Assessment

3.1.1 Initial Assessment and Referral

Persons identified as potentially at risk of suicide or DSH and referred to JH&FMHN must receive an initial assessment and an interim management plan must be developed by a JH&FMHN clinical staff member before being referred for specialist psychosocial assessment, if such a referral is necessary.

JH&FMHN clinical staff who are assessing or managing the care of people who may be suicidal have an obligation to:
• provide clinical management and care in compliance with the *Mental Health Act 2007* and *Mental Health (Forensic Provisions) Act 1990*;

• undertake a comprehensive mental health assessment inclusive of risk for people with suicidal behaviour or ideation and not use risk measurement tools or checklists in isolation to determine treatment decisions;

• undertake a comprehensive mental health assessment inclusive of risk on entry to any mental health service and monitor the status of this throughout the patient’s episode of care through regular reassessment, particularly in response to changes in circumstances or care;

• develop a management plan with the involvement of the patient, their family/principal carers and key stakeholders; and

• ensure clinical records include documentation of the patient’s ongoing mental state, assessments of risk and protective factors, and actions and precautions taken as an outcome of those assessments. These include consultation with supervisors and CSNSW and the patient’s key carer network where management plans change to support ongoing communication across the care system.

### 3.1.2 Comprehensive Assessment

The assessment of a patient’s risk of DSH or suicide is dependent upon a well-documented, comprehensive evaluation of the complete clinical picture. The evaluation should include a thorough assessment of the patient’s presentation, history, and current mental state. An important element of suicide and DSH risk assessment is the identification of risk and protective factors associated with DSH and suicide. The presence of a major mental illness, that is, a psychotic illness or mood disorder, personality disorder, substance abuse and history of DSH have been linked to suicide in custody². Other factors associated with an increased risk of suicide and DSH include:

• ‘at risk mental state’ – depression, hopelessness, despair, agitation, shame, guilt, anger, psychosis, elevated/irritable mood,

• recent interpersonal crisis,

• recent DSH or incomplete suicide attempt,

• recent loss or trauma,

• exposure to known stressors,

• drug or alcohol intoxication or withdrawal,

• lack of social supports, and

• impending legal prosecution.

Potential high risk times may include:

• anniversaries,

• following sentencing,

• following conviction, and

• following incarceration (as 74 per cent of suicides occur within six months of incarceration, with 32 per cent occurring in the first week of incarceration).²
Implementation Guide: Clinical Care of People Who May Be Suicidal

The Ministry Policies PD2016_007 and PD2012_053 Mental Health Triage Policy provide further guidance on the assessment of risk.

3.1.3 Referral to specialist mental health services

Where a JH&FMHN clinical staff member has conducted an initial assessment of a patient who is suspected to be at risk of suicide and the patient has or is suspected to have a mental disorder, the patient should be referred for a specialist psychosocial assessment.

For information on how to refer a patient in a correctional centre to specialist mental health services, see JH&FMHN Policy 1443 Custodial Mental Health Referral and Case Management Policy.

3.1.4 Referral to Drug and Alcohol Services

Studies focused on NSW and South Australian prison populations have found strong correlations between psychiatric illness and substance use among prisoners who attempt suicide or who suicide. Where a patient with suicidal behaviour has been assessed and found to have current substance use issues which warrant clinical attention, the patient should be referred to Drug and Alcohol services and managed in compliance with the relevant Drug and Alcohol Procedures.

3.1.5 Cultural needs and assessment

In conducting an assessment and formulating a management plan, the clinician must consider the cultural needs of the patient. In the case of an Aboriginal patient, the clinician should refer the patient to a JH&FMHN Aboriginal service provider, wherever possible. However, it is the responsibility of all JH&FMHN staff to maintain awareness of Aboriginal difference, in line with the training framework mandated under PD2011_069 Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health and the principles detailed in PD2012_066 NSW Aboriginal Health Plan 2013-2023.

The health status and health service needs of Aboriginal people, and Aboriginal concepts of health and illness, differ from those of the general population in many ways. Improving appreciation, understanding and knowledge of Aboriginal culture, customs, heritage and protocols is of paramount importance in ensuring improved Aboriginal health outcomes. The Australian Institute of Criminology found that:

> both the Indigenous and non-Indigenous rates of deaths in custody have decreased over the last decade and are now some of the lowest ever seen (0.16 per 100 Indigenous prisoners and 0.22 per 100 non-Indigenous prisoners in 2010–11). For the last eight years in a row, the Indigenous rate of death in prison has been lower than the equivalent non-Indigenous rate. . .(However), there is a concerning trend emerging, as the actual number of Indigenous deaths in prison is rising again, with 14 in 2009-10 which is equal to the highest on record.

More recently, the Institute found that:

> While there has been – in the context of very small numbers – considerable fluctuation in the rate from year to year, the overall proportion of Indigenous suicides has not increased in line with the increased

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5 Australian Institute of Criminology, (2013) Deaths in custody in Australia to 30 June 2011: Twenty years of monitoring by the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody.
representation of Indigenous persons in the Australian prison population during the study period [of 1999 to 2013].

3.2 Management and Review of DSH and Suicide Risk

A risk assessment is not complete without the development and implementation of a documented risk management plan and the identification of a review date for that plan.

Mental health clinicians should document the risk assessment and management plan on the appropriate standardised Mental Health Clinical Documentation modules, wherever such documentation is in use.

CSNSW uses a Mandatory Notification for Inmates At Risk of Suicide or Self-Harm. This form provides for an ‘Immediate Support Plan’ and a ‘RIT Management Plan’ and is developed in consultation with JH&FMHN clinical staff and nominated CSNSW staff. As set out in JH&FMHN Policy 1.231 Health Problem Notification Form (Adults), JH&FMHN staff must use the Health Problem Notification Form (HPNF) in the Patient Administration System (PAS) to advise CSNSW staff of any actual or potential ‘at-risk’ health problems and recommendations for management of a patient.

The HPNF can also be used to remind CSNSW staff of the need to review a patient on return from court in the absence of JH&FMHN staff.

The risk management plan must address the following items:

- Placement – can the person be managed safely in their current environment?
- A monitoring regime, for example, placement in an assessment cell with camera observations, 10 minute observations. JH&FMHN staff must not recommend that a patient be placed naked in a camera cell under any circumstances.
- Immediate action required – medical referral or other physical assessment.
- Access to amenities – telephone, gymnasium, cooking utensils and certain foods.
- Treatment – does the person have an identifiable condition for which treatment is available?
- Referral – does the person require a mental health or drug and alcohol assessment?
- Review – when and by whom will the risk management plan be reviewed?

JH&FMHN staff should consider any risks in relation to the person and the person’s transport requirements should the person be transported to another centre or to court. Recommendations for special transport for health needs may be made in accord with JH&FMHN Policy 1.395 Transfer and Transport of Patients.

The ongoing management of a person’s mental health treatment requires JH&FMHN clinicians to:

- consider decisions about care and treatment in accord with the principles set out in the Mental Health Act 2007, in particular, that:
  - people receive care and treatment in the least restrictive environment possible enabling the care and treatment to be effectively given;
  - the person’s capacity to consent to treatment is considered and support is given for people without capacity to understand treatment and recovery plans;

6 Ibid, n2 above.
Every effort that is reasonably practicable is made to seek the person’s views and consent to treatment and care. The person’s expressed wishes should be incorporated into their recovery plan to the fullest extent possible;

- the views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about treatment and whether interventions are provided as voluntary or involuntary under the mental health legislation;

- people are informed of their legal rights and other entitlements under the mental health legislation and all reasonable efforts are made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand;

- engage designated carers and/or principal care providers and key stakeholders in ongoing discussions with the person about treatment and care planning including management of risk of harm and management plans.

3.3 The Forensic Hospital

Care coordination, risk assessment, planning and review are pivotal aspects of mental health delivery that reflect, support and nurture the principles of person centred care and carer participation. The process involves identification of an individual patient’s needs, implementing and monitoring progress towards meeting those needs in consultation with the patient, their carers and others as nominated by the patient. Risk assessment forms an integral part of care coordination, assessment, planning and review processes within the Forensic Hospital. A structured approach to risk assessment improves the validity of decisions regarding risk management. There are a number of approaches to risk assessment and JH&FMHN has adopted the Structured Professional Judgement (SPJ) approach endorsed in the Forensic Hospital Clinical Risk Assessment and Management (CRAM) framework, which is available at Policies and Procedures> Network Procedures and Manuals.

3.4 Additional Information for Implementation of CSNSW Custodial Operations Policy and Procedures: Management of Patients At Risk of Suicide or Self-Harm

3.4.1 JH&FMHN RIT team member

_COPP Section 3.7 at 5.1 Membership:_

The CSNSW policy states that:

_The RIT must have three members. All members of the RIT must assess the inmate together:_

- ...
- a JH&FMHN staff member.

The JH&FMHN staff member of the team will usually be a Registered Nurse from Operations and Nursing.

3.4.2 Referrals from a RIT

_COPP Section 3.7 at 6.2 Referrals:_

The CSNSW policy states:

_The following referrals should be considered by the RIT:_
• JH&FMHN (to be made by the JH&FMHN RIT member):
  - for mental health assessment and/or medication review. An inmate who is suspected of having a mental illness or who presents with any other acute mental health issue must be referred to a mental health nurse and/or psychiatrist for specialist mental health assessment and intervention
  - for a primary health medical issue.

Where a patient requires referral to a specialist mental health assessment, the referral must be made by the JH&FMHN member of the RIT. The referral should be made in accord with JH&FMHN policy 1.443 Custodial Mental Health Referral and Case Management Policy.

Where the patient has a medical issue identified during the RIT process, the JH&FMHN staff member should refer the patient to a Primary Care Nurse (PCN) or appropriate Medical Officer.

Where the patient has a drug or alcohol issue identified during the RIT process, the JH&FMHN staff member should refer the patient to a Drug and Alcohol Nurse or Medical Officer in compliance with the relevant Drug and Alcohol procedures.

Where the patient requires referral to one of the Mental Health Screening Units (MHSUs) (at Metropolitan Remand and Reception Centre for males and Silverwater Women’s Correctional Centre for females), the person should be referred to Custodial Mental Health in compliance with Policy 1.443 above.

In those centres that have a Mental Health Nurse (MHN) on-site, the RIT should refer the at-risk patient to the MHN for assessment and possible referral onto the MHSU. If indicated, staff at the MHSU will refer the patient onto the Long Bay Hospital Mental Health Unit. For further information, contact the JH&FMHN Mental Health Helpline on 1800 222 472.

Note that the MHSUs are not declared mental health facilities. Usually, the transfer of a patient to the MHSU forms part of the clinical pathway for transferring the patient into the Long Bay Hospital Mental Health Unit (MHU), which is a declared mental health facility. However, where the patient is acutely mentally ill and requires urgent treatment in a declared mental health facility (where involuntary treatment can be carried out), arrangements for an order for the patient’s direct transfer to the MHU should be organised by the completion of the two required medical certificates and compliance with JH&FMHN procedures for admission. Refer to JH&FMHN Policy 1.030 Referrals for Admission – Long Bay Hospital Mental Health Unit (Adults).

A Patient Administration System (PAS) alert must be placed by the JH&FMHN clinician who was involved with the assessment and/or management of the patient. An entry must be made identifying which of the three categories (listed below) has occurred and the RIT review date:

- report of a risk of self-harm/suicide,
- threat of self-harm/suicide,

After each RIT review the clinician must enter the next review appointment date on PAS.

If at any time a decision is made by the RIT, as part of a patient’s management plan, to accommodate the patient in a shared or group cell accommodation or an Assessment cell without hanging points then notification must be advised on the HPNF with a review date. This notification is in addition to any active RIT
alerts entered onto OIMS. All shared cell placement notifications must have a review date and must be regularly reviewed. The date of the next review must not be more than six months after the last review.

3.4.3 Transition from a RIT

Section 7.2 of COPP provides that a person who no longer needs to be managed on a RIT can be discharged:

- to a specialist unit,
- with conditions and/or referrals, or
- with no further actions.

Where a patient is discharged by a RIT from Mandatory Notification, the JH&FMHN clinician must indicate on PAS whether the patient was discharged to routine or more intensive (focused) case management and the Mandatory Notification alert must be end-dated.

Where a patient has not been referred by a RIT to specialist care, a follow-up appointment with a PCN should be made for all patients discharged from a RIT within a period of time indicated by the patient’s clinical condition but not exceeding three months.

If JH&FMHN staff do not agree with the decision of CSNSW staff for the management of a self-harming or suicidal patient, they must document this in the health record, advise their line manager, and lodge an IIMS report. A RIT cannot be ceased if all members of the team do not agree and have formulated an ongoing management plan. If the RIT members are unable to reach a unanimous decision regarding discharge from the RIT, then the RIT Coordinator should refer that matter to the CSNSW Governor (or delegate) for adjudication and provide all relevant information, which can be done in person or by telephone. Until the Governor is available, the RIT should adopt the safest option. The decision made by the Governor and the reasons for it must be noted on Management Plan paperwork.

3.4.4 Assessment of harm to others

While the present implementation guide is primarily concerned with the assessment and management of suicide risk, risk of harm to self and risk of harm to others are not mutually exclusive categories. Although rare, there have been cases in correctional centres where a person has murdered their cell mate apparently in order to then kill themself.8

Where a JH&FMHN staff member is participating in a RIT assessment and the patient is suspected to be a risk of harm to others, the RIT team should follow the assessment guidelines set out in the CSNSW Risk intervention team (RIT) – Assessment interview and documentation guidelines,9 which available on the JH&FMHN intranet at Policies and Procedures>Network Procedures and Manuals>Mental Health Procedures>CSNSW RIT Protocol.

Where a patient is considered to be a risk of harm to others and has a mental disorder or a suspected mental disorder, the patient should be referred for a specialist psychosocial assessment in compliance with section 3.1.3 above.

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8 See, for example, Inquests into the deaths of Nicholas Karayiannis and Tien Tran [2015] Coroner’s Court of New South Wales at <http://www.coroners.justice.nsw.gov.au/Documents/Karayiannis%20and%20Tran%20findings.pdf>
4. Definitions

Must
Indicates a mandatory action or requirement.

Should
Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

5. References

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<td>Framework for Suicide Risk Assessment and Management for NSW Health Staff</td>
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### Framework

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Lynemam M & Chan A *Deaths in custody in Australia to 30 June 2011: Twenty years of monitoring by the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody*. Canberra: Australian Institute of Criminology, May 2013.  