Suicide Prevention Practice

Queensland Health Guideline

QH-GDL-967:2021

1. Purpose

The Suicide Prevention Practice Guideline (the Guideline) assists clinical teams and their leaders within Queensland Health Mental Health Alcohol and Other Drugs (MHAOD) services to embed best practice approaches in the identification, engagement, assessment, treatment, and transition of people at risk of suicide. The Guideline is complemented by training in suicide risk assessment and management provided by the Queensland Centre for Mental Health Learning.

Section 1 – Rationale and implementation

2. Scope

This document provides guidance based on current evidence for identifying and responding to the needs of people at risk of suicide receiving care from MHAOD services. It focuses on core aspects of practice (i.e. what to do).

Care is provided within a service context which includes local policies, procedures, protocols, and resources, including requirements for escalation of clinical safety issues. **The Guideline is not intended as an instructional guide in care processes or a substitute for skills training or supervision. Care should always be guided by professional judgement regarding an individual consumer's needs.**

3. Target audience

The Guideline is written for Queensland Health MHAOD service staff to use within their scope of practice across **all service settings and when working with all consumer population groups.** It applies to:

- employees (permanent, temporary and casual) and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors and consultants)
- clinicians, peer workers, Aboriginal and Torres Strait Islander Health Workers and other members of the MHAOD clinical team.

Effective suicide prevention requires a whole of community and whole of healthcare approach. Care pathways for people at risk of suicide routinely include contact with healthcare staff external to the MHAOD service, e.g. in the emergency department, hospital ward, general practice. Safe care of people at risk of suicide relies on close collaboration with staff across the healthcare system to ensure care is coordinated and pathways are seamless.

4. Introduction

Suicide is a significant public health issue, with reducing deaths and other suicide-related harms being a priority for the Queensland Government.

A multi-incident analysis of suspected suicides occurring in Queensland in 2015 and 2016 found that approximately one in five people who died had contact with a Queensland Health MHAOD service within one month prior to death. This highlights the opportunity for services to contribute to suicide prevention through provision of comprehensive suicide-focused care and recovery-oriented treatment.

Evaluations led by the Gold Coast Hospital and Health Service and internationally have demonstrated that repeat hospital presentations for suicide attempt and suicide deaths can be reduced when a suicide prevention pathway is implemented with a high degree of fidelity (Turner, et al., 2021) and when the pathway is supported by other organisational best practices (i.e. leadership commitment, evidence-based treatments, ongoing data collection and review) (Layman, et al., 2021).

A Queensland Health multi-site collaborative supports implementation of the Zero Suicide in Healthcare framework (Suicide Prevention Resource Centre, 2020) and a restorative just culture approach to system leadership, quality improvement and the support of consumers, carers and staff.

This includes implementation of a suicide prevention clinical pathway in participating Hospital and Health Services to provide a structured approach to the care of people at risk of suicide. The suicide prevention pathway is tailored by each Hospital and Health Service to be responsive to specific community needs and resources available in the local service system.

The Guideline supports the embedding of best suicide-focused care practices across the whole consumer care journey within and outside implementation of a suicide prevention pathway and throughout ongoing recovery-oriented treatment.

5. Implementation of this guideline

MHAOD services are responsible for supporting staff capability in working compassionately and collaboratively with people who are at risk of suicide to ensure that care is evidence-based, culturally informed and age appropriate. Hospital and Health Service's protocols and procedures should provide clarity about staff responsibilities for:

- identifying individuals with potential risk
- conducting a thorough assessment (including assessment of suicide risk)
- collaborative development of a formulation
- safety and care planning as clinically indicated.

While enforcing the message that suicides are preventable, it is critical that staff wellbeing is safeguarded. Restorative just culture, as a foundation of the Zero Suicide in Healthcare approach, builds trust among staff to implement new suicide prevention practices by creating an environment in which all stakeholders involved in a person's care can feel safe to be open to learning and improvement. Within this context, responding following a suicide is focused on compassionate leadership, facilitating a healing process for all involved and continuous quality improvement (Turner et al., 2020; Suicide Prevention Resource Centre, 2020).

Effective implementation of this Guideline is achieved through commitment and support from all levels of leadership in the Hospital and Health Service, clinical governance oversight throughout every stage of care and continuous evaluation of implementation fidelity. Implementation should be underpinned

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by collaborative partnerships with people with a lived experience of suicide, as well as people from priority population groups. Implementation is also supported by:

- promotion of the Guideline and associated resources, and other relevant policies, standards, documentation tools and population-specific resources,
- addressing local Hospital and Health Service priority populations and adapting care practices to meet specific needs, and
- ensuring staff access to appropriate and up to date training, professional development and supervision.

6. Related documents

Standards, procedures and guidelines

- *Mental Health Act 2016* and associated Factsheets and Chief Psychiatrist policy and guidelines
- National Safety and Quality Health Service (NSQHS) Standards 2017 2nd Edition
- Comprehensive care: partnerships in care and communication resources, 2020
- Managing ligature risks in Queensland public mental health alcohol and other drug inpatient units (2016)
- Recognising and managing potential environmental hazards in Queensland public mental health and alcohol and other drug inpatient units (2016)
- Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts (2019)

7. Comprehensive care: partnerships in care and communication (clinical documentation)

Accurate and up to date clinical records are vital components of clinical care and safety for a person at risk of suicide. The Comprehensive Care Documents streamline the clinical documentation process and support MHAOD staff with documentation of high quality, standardised clinical care. Supporting resources are available at the QHEPS site Comprehensive care: partnerships in care and communication.

> 📄 Suggestions for which forms to use at each stage of care for a person experiencing suicidality are included in the following sections in accordance with the Comprehensive Care Documentation Framework.

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Section 2 – Suicide prevention clinical pathway

8. Core components of a suicide prevention clinical pathway

Guided by the Zero Suicide in Healthcare framework, local suicide prevention clinical pathways incorporate the following core evidence-based components of safe care for a person with suicide risk. MHAOD service consumers placed on a Suicide Prevention Pathway are flagged via a Suicide Prevention Pathway Alert in CIMHA.

8.1.   Identify

Identification of consumers with potential suicide risk occurs from the point of referral and continues across all stages of the care journey to guide plans to mitigate a person's risk of harm. Suicide risk may exist and may even be imminent without communicated suicidal thoughts, intent or plans (Shea, 2016). Identifying suicide risk requires sensitive interviewing and attention to suicidal behaviour as many persons who die by suicide deny suicidal intent (refer Section 11).

> 📄 Suicide risk screening is documented using the Triage Screen and/or the Risk Screen form.
>
> 📄 Where a decision has been made to place a consumer on a Suicide Prevention Pathway, the Suicide Prevention Pathway Alert should be activated in CIMHA and regularly reviewed. The process for activating this Alert is detailed in the Suicide Prevention Pathways State-wide CIMHA Guideline.

8.2   Engage (risk assessment, formulation and safety planning)

All people at risk of suicide should be engaged in a collaborative assessment to inform individualised care requirements including risk management decisions, safety planning and treatment (refer Section 10). Clinicians should make a diagnosis and develop a formulation outlining an understanding of why this person has presented in this way at this time. Service providers should use prevention-oriented thinking and language to articulate the person's risk status, risk state, available resources and foreseeable changes (Pisani, Murrie, & Silverman, 2015). The analysis of risk should consider any factors potentially affecting or driving an individual's risk so that safety strategies can be targeted towards mitigating or managing sources of risk or harm.

> 📄 The assessment is documented using any of the Comprehensive Care assessment forms, supplemented where appropriate by the Aboriginal and Torres Strait Islander Cultural Information Gathering Tool. Information from the Risk Screen should be used to support completion of these forms.

A suicide safety planning intervention (Stanley & Brown, 2012) is a collaborative process between staff, the consumer and ideally their family and friends which occurs during the

engagement phase and regularly throughout the treat and transition phases of the suicide prevention pathway. The goal is to support the consumer to identify how they can manage their suicidal thoughts while also reducing access to lethal means.

The process of developing a suicide safety plan assists the consumer to identify their individual warning signs and available resources and strategies they can use to manage thoughts, emotions and circumstances that cause distress. The strategies include a list of supportive and emergency contacts and agreed steps to any foreseeable changes. The suicide safety planning intervention and documented plan should be regularly reviewed, refined and reinforced.

The suicide safety planning intervention should include counselling on access to lethal means for consumers, family and other support persons. Counselling on access to lethal means requires clinicians to assess the consumer's access to potential means (including prescribed medications and other substances) and enact strategies to remove, restrict or delay access to these means.

All persons and service providers with a role in supporting the consumer's safety should understand their responsibilities, with their names recorded on the safety plan. An agreed plan of action in the event of a crisis or escalation in suicide risk should be clearly documented.

The suicide safety plan should complement any other risk management plans and is an integral part of a comprehensive care plan for a person with suicide risk.

The consumer should hold a copy of their documented safety plan and provide one to others involved in the development of the plan and other key people and services that form their own support system. If a consumer prefers with their consent, this can also be provided by staff.

> 📄 A copy of the safety plan should be uploaded to the consumer's clinical record in CIMHA. The plan should be attached to the 'My Safety Plan' clinical note template located under the 'Emergency Planning and Interventions' category. A link to the Safety Plan should be added to the details section of relevant CIMHA Alerts. The process for uploading a safety plan is detailed in the Suicide Prevention Pathways State-wide CIMHA Guideline.

8.3 Treat (suicide specific interventions, care planning and review)

Care planning and treatment for suicidality occurs throughout the consumer's care and during care transitions. The care plan for a consumer with suicide risk should specifically address the person's suicidality as well as treatment strategies for their primary diagnosis and co-occurring disorders and strategies to support the consumer to meet their recovery goals.

Structured follow up should occur within an identified timeframe and at a frequency appropriate to the analysis of suicide risk, by services able to offer timely care at an appropriate intensity. Whenever possible, structured follow-up should commence within 24-hours of a hospital separation or discharge.

Interventions to support a person experiencing suicidality should include:

- a routine safety planning intervention (Stanley & Brown, 2012) including counselling on access to lethal means
- strategies and interventions to alleviate emotional distress and psychological drivers of suicidal thoughts and behaviours as indicated, for example:
  - Solution Focused Brief Therapy (SFBT)
  - Cognitive Behavioural Therapy (CBT)
  - Dialectical Behaviour Therapy (DBT)
  - Attempted Suicide Short Intervention Program (ASSIP)
- interventions to target psychosocial drivers of suicidality, for example relationship issues, grief and loss, financial hardship, unemployment, or other stressors
- interventions aimed at reducing hazardous or harmful substance use and associated increased risk of suicidality
- education with the person and their family, carers, and other support persons about managing risk and treating suicidality
- referral to suicide-specific aftercare services providing non-clinical support and/or peer support as an adjunct to clinical care (e.g. The Way Back Support Service), where indicated and available
- liaison with primary care providers and other services that form the support system for the consumer and their family, carers, and significant others.

> 📄 Interventions targeting the drivers of suicidality should be explicitly documented in the consumer's Care Plan, alongside treatments for any diagnosed mental illnesses and substance use disorders and other interventions aimed at supporting the consumer to achieve their recovery goals.

8.4   Transition

Care transitions occur throughout a consumer's care journey between care providers, between care settings, such as hospital and community, and between care teams and may involve handover of responsibility for a consumer's clinical care. The communication of critical safety information and information about risks when they emerge or change is used to ensure safe care (ACSQHC, 2017). Provision of continuous care to consumers at risk of suicide and their family during transition periods are essential elements of compassionate and safe care.

Care transitions are high-risk times for consumers, particularly following discharge from hospital (Chung, et al., 2018; Bickley, 2013). For people at risk of suicide, issues around their capacity to make care transitions unassisted, the level of motivation to further engage with other services, and significant delays in being able to access services can contribute to adverse outcomes (Meehan, et al., 2016; Wand, et al., 2015). To help close the gaps putting individuals at increased risk, Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care | Zero Suicide describes evidence-based practices for improving care during this critical period.

Safety should be reviewed prior to and following any care transitions. Communicating for safety is enhanced through use of structured clinical handover tools and clinical documentation, joint care review and verbal handover. Working in partnership with other service providers across health, government, non-government and private sectors enables a seamless system of care, coordinated safety planning and smooth uninterrupted transitions.

Care transitions should be supported by comprehensive care planning, clear communication with the consumer and their support system, and assertive follow-up to reduce risk of disengagement. Key elements of supportive transitional care include:

- warm hand-overs and supportive contacts–specify the contacts and supports needed throughout the transition process
- ongoing caring contacts—such as postcards, texts, or emails
- referral to services to address unmet needs, e. g. psychosocial
- active follow-up to maintain contact with the consumer until receiving services have commenced care provision.

> 📄 **For consumers transferring to another service following a referral:** risk-related and planning information is documented using triage, risk screening and/or assessment forms. Clinical information relevant to the consumer's ongoing care needs, including their suicide safety plan, should be shared with receiving services (refer Section 9.4).
>
> 📄 **For consumers transferring to another service following an episode of care:** risk-related and planning information is documented using the Transfer of Care form. The Care Plan, Risk Screen, Care Review and Longitudinal Summary should be updated prior to discharge. Relevant clinical documentation should be shared with receiving services (refer Section 9.4).

Section 3 – Suicide prevention practice principles

9.   Key principles in care

9.1   Person-centred and recovery-orientated

Suicide risk assessment is part of a comprehensive biopsychosocial assessment. Risk mitigation planning should balance safety with hope and recovery, and should:

- value self-determination and empowerment
- focus on restoring hope and purpose
- be respectful of, and responsive to the individual's preferences, needs and values
- be culturally sensitive and developmentally appropriate
- support the person and their family, carers and/or support persons to guide all clinical decisions.

9.2   Engagement and therapeutic alliance are fundamental

The quality of risk assessment is dependent on the depth and quality of the relationship between the clinical team and the individual receiving the service and their family, carers and other support persons.

In order to develop a strong therapeutic alliance, service providers should use micro-counselling skills, destigmatizing language, take time to build rapport and develop a shared understanding of the person's goals for treatment and explore ways to work together to alleviate the person's distress and build their capacity to cope.

9.3   Consumer capacity to participate in assessment and safety planning

Engagement with family members, carers and/or other support persons is essential to ensure a valid risk assessment and safety planning process. This is particularly important when the consumer's capacity to plan for their own safety is compromised because, for example, they are intoxicated or under the influence of other drugs or medication, experiencing active symptoms of mental illness such as acute psychosis, or cognitively impaired (Bergman & Silverman, 2014).

9.4   Communicating for safety, information sharing, and consumer consent

It is imperative that collateral information be obtained from family, carers and relevant others involved in a person's care to inform the assessment of suicide risk and safety planning. **Relevant risk and safety planning information should be shared** to protect the ongoing health, safety and wellbeing of consumers, their families, carers, support people and other people who may interact with the consumer.

While information sharing should occur preferably with consent from the consumer, in crisis situations consent should be attempted, but is not explicitly required to obtain clinical information that will inform the risk and safety of the consumer and/or others.

For further information on the legislative framework within which consumer information can and should be shared, and how it can be applied in clinical practice refer to Information sharing Between Mental Health Staff, Consumers, Family, Carers, Nominated Support Persons and Others.

9.5   Work in partnership with families, carers and other support persons

Service providers play a small role in an individual's life in comparison with their family, carers and/or support persons whose involvement can be lifelong, therefore playing a vital role in safeguarding and improving the mental health and wellbeing of the people they care for.

Service providers should:

- consider the perspectives of family, friends and other significant support people to be crucial to a risk assessment

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- actively involve family in all aspects of assessment, formulation, safety and care planning and, where appropriate
    - be aware of and assess a family's capacity and willingness to be involved in the person's treatment and support, including contraindications to family involvement such as family conflict, abuse, or domestic and family violence
    - protect the consumer's right to confidentiality and consent to share confidential information
- provide education to families, carers, and support persons on:
    - how to identify if the person may be at risk of suicide
    - how to safely and effectively respond when a person is distressed
    - their role in providing treatment and supporting implementation of a safety plan (including restricting access to lethal means).

For further information in relation to the rights and responsibilities of family, carers and other support persons recognised through the *Mental Health Act 2016*, refer to The Mental Health Act 2016 Fact Sheet Rights of Family, Carers and Other Support Persons.

9.6 Trauma-informed service provision supports engagement

Trauma-informed services adopt the principles of safety, trust, choice, collaboration, empowerment, and respect for diversity. They do not re-traumatise or blame people for their efforts to manage their trauma (Kezelman and Stavropoulos, 2012). They should:

- be sensitive to the ways in which consumers' presentations and service needs can be understood in the context of their trauma history
- integrate consumer needs and strengths into the assessment and formulation, and to the planning, delivery, review and transfer of care
- provide care in ways that help consumers, family members and staff to feel physically and psychologically safe
- work to deliver services in ways that prevent re-traumatisation.

9.7 Responding to diversity

Attention to cultural background, social context and diversity promotes engagement, and combats stigma and discrimination

Consider factors such as preferred language, cultural norms, family structures, histories of trauma and difficulties accessing appropriate services, especially when responding to the needs of:

- Aboriginal and Torres Strait Islander peoples
- Culturally and linguistically diverse peoples
- People who identify as sexually and gender diverse.

Consult with, value and facilitate access to relevant services such as Aboriginal and Torres Strait Islander health workers, transcultural mental health workers, interpreter services and other appropriate services to assist to meet diverse needs.

Section 4 – Practice approaches

10. Comprehensive assessment processes

The assessment of risks identified through the screening process should occur as an integrated part of a comprehensive biopsychosocial assessment to inform the development of an individualised care plan to minimise the risks of harm and promote recovery.

Sensitively assess suicidal ideation, intent, desire and planning

Asking about suicide does not increase the risk of suicide for the person. Suicidal thoughts and behaviour should be considered during every assessment. A recommended approach to clinical interviewing to explore suicidal ideation, intent, planning and behaviour is the Chronological Assessment of Suicide Events (Shea, 2009) (refer Section 11).

An analysis of risk

Risk factors interact to contribute to the person's suicide risk:

- **Static:** fixed historical factors that may have a pre-disposing influence on a person's risk of suicide
- **Dynamic:** changing factors that are having a current impact on the person's current distress and are modifiable
- **Protective:** factors that are available, accessible and valued by the person that they can turn to in a crisis
- **Future:** upcoming events that might destabilise the person and increase risk of suicide
- **Unknown:** consideration should be given to factors that are unable to be assessed or not assessed and may have significant bearing on the person's assessment and care.

When analysing risk and protective factors, service providers may consider using a theoretical model to incorporate this into their formulation. One leading theory is the Integrated Motivational Volitional (IMV) model of suicidal behaviour (O'Connor & Kirtley, 2018). This is a transdiagnostic model which seeks to understand the relationship between risk factors for suicide and how they contribute to the development of suicidal ideation, and subsequently which factors contribute to enacting suicidal behaviour. This information can be used to guide care planning.

Identification of warning signs for imminent suicide risk

Warning signs are behavioral indicators that a person may be at imminent risk of suicide ('current' and 'near future' risk of suicidal behaviour). Warning signs documented in the literature include giving away possessions, making jokes about suicide, or posting messages on social media platforms. It is important to collaboratively identify warning signs unique to the individual which should be prompts for further assessment of suicidal intent, be incorporated into safety plans and noted in clinical documentation.

Psychosocial stressors

Suicide attempts are often linked to feelings of helplessness in relation to stressful life events such as relationship difficulties, social isolation, loss of a job or income, and financial or housing stress (Potts, et al., 2016). Identification of psychosocial stressors and how these may be

affecting an individual's emotional state and driving suicidality helps to inform the collaborative development of safety strategies with the consumer, family and carers.

Mental state examination, including identification of acute deterioration in mental state

Deliberate self-harm may be preceded by observed or reported changes in a person's behaviour, cognitive function, perception, physical function, emotional state or mood that can indicate a deterioration in their mental state.

Suicide risk assessment should include an assessment of acute deterioration, including possible early warning signs and triggers or causes. Concerns about deterioration in a person's mental state and elevated suicide risk raised by the consumer, family members and/or the care system should be given due weight and followed up with timely and clear communication regarding the required risk response.

Diagnostic considerations

All mental and behavioural disorders increase the risk for suicide, with comorbidity increasing further. Therefore, robust diagnosis and treatment of mental illness and substance use disorder is a vital component of suicide prevention. However, it is important that neither specific diagnosis nor level of lethality of past and current suicide attempt alone determine access to comprehensive assessment and treatment as most suicides occur in people with lower lethality attempts and no pre-existing diagnosis of mental illness or substance use disorder.

Suicide risk assessment should be informed by knowledge of the risk factors and warnings signs associated with different diagnostic profiles. For example, for persons diagnosed with psychotic disorders, suicidality may manifest as a direct result of delusional content or as part of a reactive depression secondary to developing insight about their diagnosis (Castelein, et al., 2015). Accordingly, the assessment of depressed mood, anhedonia and its severity, feelings of hopelessness, 'voices' about suicide, and suicide-related behaviours are critical components of analysis of suicide risk (Kjelby, et al., 2015). The assessment of interpersonal conflict as a contextual stressor for escalating suicide risk is essential, with particular relevance for people with borderline personality disorder.

Assessment of co-occurring substance use disorders and other mental health disorders

Up to 50 per cent of individuals are recorded as experiencing problematic substance use prior to death by suspected suicide and a third have evidence of a drug dependence at the time of death (Bugeja, Milner, & Pirkis, 2015).

An integrated assessment is recommended to address the intersection between substance use disorder, other mental health disorders and suicide risk. This includes a detailed review of past and current patterns of substance use, sudden changes in usage and chronic heavy use, as well as interactions with physical health, cognitive ability, functional capacity and mental state. Warning signs for elevated suicide risk include regular periods of intoxication, withdrawal symptoms and effects of rapid reinstatement of drug use after abstinence.

Assessment of physical health and multimorbidity

Assessment should include consideration of physical health conditions, particularly those that are chronic, complex or life-limiting. Multimorbidity, the co-existence of multiple chronic

conditions in an individual, is associated with increased suicide risk. Chronic pain is one such chronic condition and is separately associated with increased risk.

Risk of abuse from others and/or violence towards others

The identification of signs of abuse and risk of harm from and/or to others including domestic and family violence is essential when assessing suicide risk, especially in relationships where there is an expectation of trust and the potential victim has partial or sole dependency on the alleged abuser, such as children and young people or adult children and elderly parents. There is an increasing focus on the aging population's vulnerability to elder abuse, which is associated with higher levels of depression and suicide risk.

11. Clinical interviewing to explore suicidal intent, planning and behaviour

Consumers may not communicate suicidal intent when directly asked (Shea, 2016). Withholding suicide intent is common and may arise because a person is in so much pain, they are highly motivated to take their own life or they may be worried about negative consequence such as involuntary admission, loss of job and social stigma. This makes assessing suicide intent a complex and challenging clinical skill.

To understand a person's 'real suicide intent' service providers should consider the following aspects of the presentation:

1) **Stated intent**: the details the person discloses about their suicidal thoughts, plans, desire and intent.
2) **Reflected intent:** additional information that can be gleaned from the clinical interview, observation or collateral sources, that can reveal the depth of thought and planning associated with the person's experiences of suicidal ideation.
3) **Withheld intent:** the possibility that some people may not disclose their true suicide intent.

Where a person has not previously reported suicidal ideation, or they are denying suicide planning or intent, sensitive screening questions should be asked.

Screening questions (Shea, 2016):

Normalisation	*"Some of the people that I have worked with who are going through what you are, have told me that they have had thoughts of killing themselves. I am wondering if you have been having thoughts like that?"*
Shame Attenuation	*"Given how depressed you have been feeling and the pain that you have been going through, I am wondering if you have been having thoughts of killing yourself?"*

Where suicidal ideation is identified, a comprehensive history of the person's suicidal ideation, plans, behaviour and intent should be explored using a structured approach and documented as part of the assessment. The Chronological Assessment of Suicide Events (CASE) approach explores the presenting, recent and past suicide events as well as the person's immediate and current suicidal ideation, intent and plan.

Service providers should consider specific detail that is revealed during the enquiry that might increase the likelihood of a death by suicide occurring. Specific details of note include: lethality of the method, level of access to means, behaviours that indicates rehearsal or preparation for a suicide attempt (for example, whether the person had the means in hand during the suicidal crisis) and factors that might increase risk of transitioning from suicidal ideation to suicide attempt such as impulsivity, drug and alcohol use during the crisis, mental imagery, 'if/then' suicide plans.

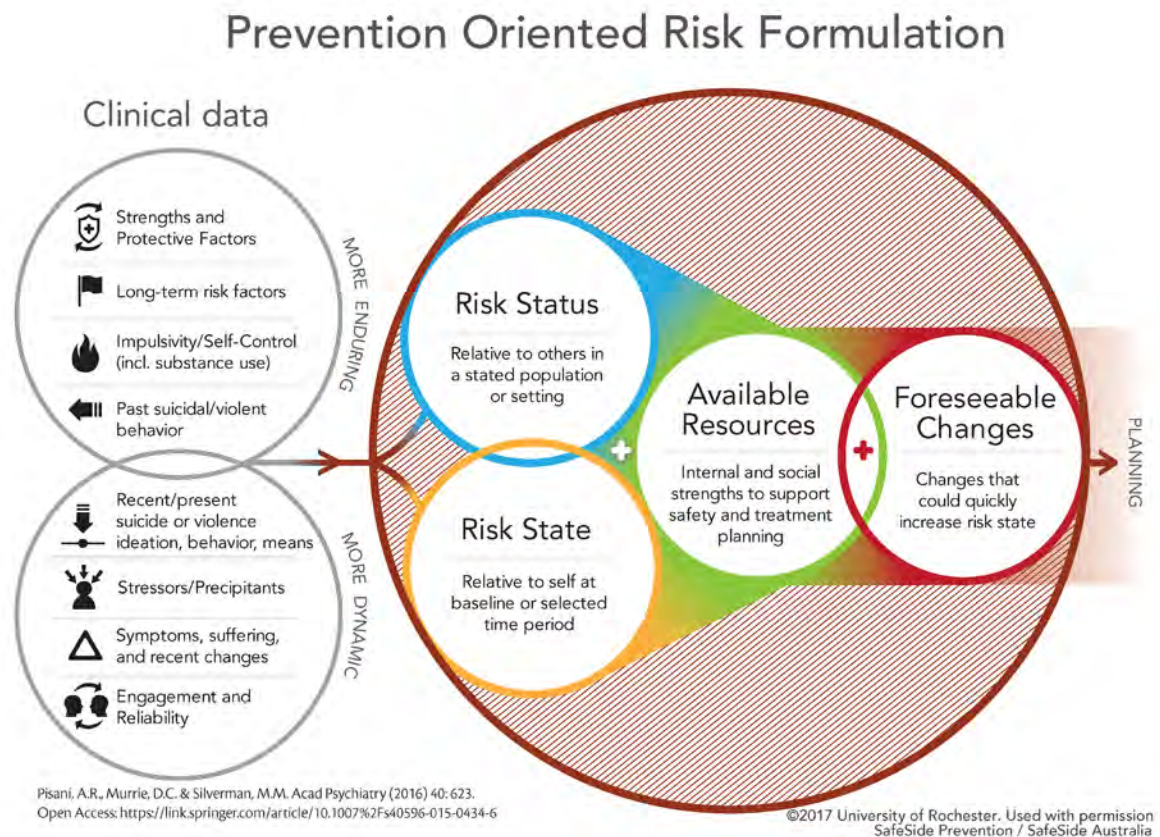## 12. Formulation focused on prevention and planning, not prediction

Suicide is a complex, multi-faceted behaviour which cannot be predicted (Steeg, Gunnell, & Kapur, 2018) or meaningfully stratified into categorised risk (high, medium, and low) (Large, et al,. 2017) to determine allocation of health resources (e.g. inpatient bed allocation).

The clinical formulation is a working hypothesis coproduced with the consumer, their carers and the multidisciplinary team, which explains the relationship between the consumer's historical and current contexts, causative and maintaining factors, and various risk domains. It also identifies the person's strengths, support systems, recovery goals and needs, and drives personalised care planning, including risk management strategies.

The comprehensive care resources provide further information on approaches to formulation: https://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs. Although different terminology may be used at times in relation to formulation and risk there is a shared focus on prevention oriented risk management across multiple domains of risk including suicide.

Integrated within the clinical formulation, the Prevention Orientated Risk Formulation (Pisani, Murrie, & Silverman, 2015) (see Figure 1) is a recommended approach to considering and communicating a consumer's risk.

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Figure 1: Prevention Orientated Risk Formulation

This approach brings together the following elements:

1) **Risk status** = *Risk compared to WHO?* Risk status is a description of risk relative to others in a treatment setting or a stated population (such as inpatient, acute care or community mental health settings). A person's risk status can be described as "higher than", "similar to" or "lower than" a particular setting, with a clinical rationale for this conclusion. Risk status may guide the intensity of care required within a particular service and assist services to communicate risk between settings.

2) **Risk state** = *Risk compared to WHEN?* is a description of the person's current risk that is anchored in their own life. Risk should be described as "higher than", "similar to" or "lower than" relative to a designated time point such as: the last contact with the service, discharge from hospital, the person's last suicide attempt. Risk state may also be described in relation to a person's own baseline with a clinical rationale to support this conclusion.

3) **Available resources** = Strengths and protective factors that are accessible, available and valued by the person. These are more than protective factors; they are resources that the person can meaningfully draw on in a crisis.

4) **Foreseeable changes** = Future factors that may occur that could destabilise the person and trigger a crisis. It is important that contingency plans are documented for identified foreseeable changes.

When describing risk status or risk state, "higher risk" does not necessarily indicate an inpatient admission. It is a term that is used to prompt consideration of treatment needs and consideration as to whether the person's available resources, contingency plans for foreseeable changes and risk mitigation strategies (such as safety planning), care planning and follow up actions are sufficient to address the identified risk.

13. Consider the most appropriate treatment setting

There will be factors indicating that a person's risk for suicide cannot be managed in a community setting and an inpatient admission should be considered. These might include:

- previous suicide ideation and/or attempt
- presence of warning signs or indicators that a person may be at imminent risk of suicide
- specific suicidal intentions with high lethality and availability of means
- limitations in available resources and likely foreseeable changes that may increase risk state (e. g. isolation, homelessness, transience)
- a level of impulsiveness or impaired judgement which places the person at significant risk of misadventure, being harmed by others, significant deterioration in mental state, health status or changes in pattern of substance use
- a need for diagnostic clarification
- reduced capacity to engage in assessment and safety planning process
- low levels of clinical team confidence in risk assessment due to difficulty engaging the consumer and inability to obtain collateral (e. g. consumer withheld consent or unable to contact sources).

Risk management and safety planning with consumers during care transitions is of paramount importance when managing changes in a treatment setting (refer Section 8.4).

For information and resources related to the *Mental Health Act 2016* service providers should refer to the following website: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act

14. Further advice, information and support

- Zero Suicide in Healthcare framework
  https://zerosuicide.edc.org/

- The Chronological Assessment of Suicide Events
  https://suicideassessment.com/the-case-approach/

- Prevention Orientated Risk Formulation Approach -
  https://www.safesideprevention.com/approach/care-framework

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- Inconvenient truths in Suicide prevention : Why a Restorative Just Culture Should be Implemented Alongside a Zero Suicide Framework
https://journals.sagepub.com/doi/pdf/10.1177/0004867420918659

- BeyondNow Suicide Prevention Safety Planning
https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

- Guidelines for Best Practice Psychosocial Assessment of Aboriginal and Torres Strait Islander People Presenting to Hospital with Self-harm and Suicidal Thoughts
http://www.menzies.edu.au/icms_docs/310034_The_BestPrAxIS_study.pdf

- Manual of Resources in Aboriginal and Torres Strait Islander Suicide Prevention
https://cbpatsisp.com.au/

- Queensland Centre for Mental Health Learning
https://www.qcmhl.qld.edu.au/

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ACSQHC. (2017). *National Safety and Quality Health Service Standards (Second Edition)*. Sydney: Australian Commission on Safety and Quality in Health Care.

Bergman, A., & Silverman, M. (2014). *Suicide Risk Assessment and Risk Formulation Part II: Suicide Risk Formulation and the Determination of Levels of Risk.* Suicide and Life Theatening Behaviour, 432-443.

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