Suicide or Self-Injury Risk Assessment and Management Procedure

MHAPPM/8969

Approved by:	General Manager – Mental Health and Addiction	**First Issued:**	April 2024	
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Purpose

The purpose of this document is to clearly outline the procedural steps for Health New Zealand | Te Whatu Ora Te Matau a Māui Hawke's Bay staff when undertaking:

- Assessment and management of people with suicidal ideation or actions.

Principles

All Health NZ - Hawke's Bay documents are based on and link back to our values: **He Kauanuanu** (respect), **Ākina** (improvement), **Raranga Te Tira** (partnership) and **Tauwhiro** (care), and are detailed so all persons are provided with clear information on the way they are expected to practise and undertake tasks.

The following New Zealand Legislation and Standards are also applicable to this document:

- Ministry of Health (1998) Guidelines for Clinical risk assessment and management in mental health services
- Ministry of Health (2003) The assessment and management of people at risk of suicide

This document is to be used in conjunction with Mental Health and Addiction Group Policy - MHAPPM8953 , which outlines the shared vision and expectations for the direction, values, principles, attitudes and ways of working to deliver a values-based service.

Scope

This procedure applies to all staff working in Health NZ Hawke's Bay Mental Health and Addiction Group.

Definitions

Refer to the Mental Health Service Definitions Glossary \\FS3\share\Public\All Users\MHS Policy review\DEFINITIONS FOR WORDS AND TERMS IN USE WITHIN THE MENTAL HEALTH SERVICE.docx.

Term/Abbreviation	Meaning
Available resources	Internal and social strengths to support safety and treatment planning.
Foreseeable changes	Changes that could alter risk state.
Non-suicidal self injury	Self-harm is the direct, deliberate act of hurting or injuring your body, but without necessarily wanting to die.
Risk formulation	A concise synthesis of empirically based suicide risk information regarding immediate distress and resources at a specific time and place. It should

	capture the dynamic nature of risk and state: (a) how the tangata whaiora current risk compares to risk at previous time points, and (b) how risk might change in response to future events.
Risk status	Relative to others in a stated population and well-known, empirically supported risk factors for suicide drawn from epidemiological research.
Risk state	How current risk compares with risk at baseline or at another set point in time. A tangata whaiora recent suicidal statements and behaviour, current symptoms and stressors, and degree of engagement with helping resources all inform risk state.
Triage	The process of initial assessment to determine the need for service and the nature and urgency of the care required.

Roles and Responsibilities

Role	Responsibility
Associate Clinical Nurse Manager/ Clinical Manager (or equivalent)	Leads response in appropriate team and ensures appropriate registered health professional(s) provides and follows guideline.
Cultural Navigator / Peer Support	Ensure appropriate cultural support is available and represented.
Registered Health Professional	Provides assessment and co-ordination of care to the tangata whaiora and specialist treatment dependent on scope of practice.

Procedure

Risk Assessment

1 Risk assessment is an integral part of every clinical observation or assessment. Risk assessment does not occur on a 'one off' basis, but is ongoing, with a particular emphasis at 'critical points'.

2 All individuals presenting to, or under the care of a Mental Health and Addiction Service should be assessed for risk. The detail and specificity of such assessment will vary according to circumstance and past behaviours, but every individual should at least be screened for risk.

3 Risk assessment should follow the standards described in MHAPPM/8968 Clinical Risk in Mental Health and Addictions Assessment and Management Policy.

Assessment Procedure

4 The time frame of the initial assessment will be guided by the UK Mental Health Triage Scale (**Appendix 1**), which will be completed by the triaging registered mental health practitioner. This could be the Key Worker on notification, the Duty Worker, or an Emergency Mental Health Service Registered Health Professional.

5 A risk assessment for a tangata whaiora should be completed by registered health professional in the most appropriate confidential setting.

   a. There should be capacity for family, whānau and other supports to be part of the interview if agreed.

6 Engagement is crucial to detection, assessment and management of suicide risk. Registered health professionals should take steps to maximise engagement and provide information about confidentiality.

a. Appropriate cultural, peer and whānau support for the assessment will be offered in collaboration with the tangata whaiora.

b. The tangata whaiora should be able to participate in assessment. The assessment can be split into several sessions if there is a safe environment for the tangata whaiora.

c. If a tangata whaiora is intoxicated, that is their mood, thinking or physical abilities are notably affected by alcohol or other drugs, they should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk whilst they are still intoxicated; enduring risk cannot be judged until the tangata whaiora is sober.

7 Assessment must be based on a collection of information from all available sources including if possible, whānau/family or natural supports of the tangata whaiora, and cover all aspects of the illness, background, cultural assessment, behaviour and circumstances of the individual

8 Risk assessment will:

a. Take account of background health information including developmental history, family (both physical and mental health), physical history, psychiatric history including forensic, alcohol and other drugs past and current, and prescribed medications.

b. Take account of psychosocial circumstance including information about housing, employment, education, whānau and family, dependents, supports, culture, spiritual beliefs, leisure activities, relationships and strengths.

c. Include collateral information from whānau/family, supports, and other professionals involved where appropriate consent is attained.

d. Include questions regarding past and current suicidal behaviour (thoughts, actions and plans); intent; access to and lethality of means; and safety of others.

e. Should be completed with a current mental status examination guided by presentation during assessment: Mental State Examination - Helpful Advice.

f. Should take consideration of assessment confidence and factors affecting this such as social environment; inability to obtain collateral information; and engagement.

Risk Formulation Procedure

9 A prevention-oriented risk formulation, such as the Safeside Care Framework (**Appendix 2**) should be completed in the Comprehensive Assessment. Prevention-oriented risk formulation includes the following:

a. Enduring factors: Strengths and protective factors; long term risk factors; impulsivity/self-control (including substance abuse) and past suicidal behaviour;

b. Dynamic factors: Recent/present suicide ideation or behaviour; stressors/precipitants; symptoms, suffering and recent changes; engagement and alliance;

c. Risk status, relative to others in a stated population;

d. Risk state, relative to self at baseline or defined time period;

e. Available resources, strategies and protective factors to support safety and treatment planning

f. Forseeable changes.

10 The risk formulation should be written in partnership and shared with the tangata whaiora, and whānau (where consent is given).

Risk Management Procedure

11 **If an admission is needed**, ensure ISBAR (Introduction, Situation, Background, Assessment and Recommendation) handover of the assessment and be as clear about the intended outcome of the admission.

a. If observation for self injury during admission is required, the Engagement and Observation Policy - MHAPPM8104 should be followed.

12 If **no admission is required** consider what follow up and additional supports are required, including respite or home-based treatment.

13 Tāngata whaiora and whānau must take home a Safety Plan documented in the Go To Plan: a joint devised and agreed safety plan that includes or identifies:

a. Available resources and supports;
b. Strategies and protective factors to reduce further risk;
c. Strategies to strengthen protective factors;
d. A plan for cultural intervention as appropriate;
e. Specific circumstances that might increase risk of self-injury or suicide and actions to be taken in each circumstance, using "If…then…" statements;
f. A plan for restriction of access to lethal means;
g. Date and time, or plan, for next review.

14 Tāngata whaiora and whānau must take home a follow up plan documented in the Go To Plan with details of a short and medium term follow up plan, it may include proposed treatment for identified problems, or psycho-social interventions, and date of next review.

15 All effort should be made to engage with family, whānau and support people to review plans and interventions. All engagement and attempts to engage are to be documented in health record.

Documentation

16 Risk assessment, formulation and management plan should be documented in electronic health record and should be included in the Go To Plan and Comprehensive Assessment (refer to Health Record Standards for the Mental Health Service - MHAPPM8046).

17 Risk assessment, formulation and management plan should be discussed in multi-disciplinary meeting in accordance with Multi-Disciplinary Team Case Review Guidelines - Community Mental Health & Addictions and the outcome documented.

Risks & Hazards to Staff

Risk/Hazard	Control
Risk of aggression	Managementof Challenging Situations - EPM030 Aggresssion Action Plan – EPM030
Risk of violence	Management of Challenging Situations - EPM030 Aggresssion Action Plan - EPM030
Environmental risks	Working Safely in the Community Policy - OPM097

Measurable Outcomes

Monthly clinical quality audit of health records will monitor whether a risk assessment is completed and where risk is identifies, there is a plan to address the risk(s).

Related Documents

MHAPPM8600 - Mental Health Service Follow Up After Attempted Suicide

MHAPPM/8968 - Clinical Risk in Mental Health & Addictions Assessment and Management Policy

MHAPPM8953 - Mental Health and Addiction Group Policy

MHAPPM8958 - Nga Rau Rakau Nursing Handover Procedure

MHAPPM8046 - Health Record Standards for the Mental Health Service

MHAPPM8104 - Engagement and Observation Policy

EPM030 - Management of Challenging Situations

OPM097 - Working Safely in the Community Policy

HBDHB/CPG/044 -Nursing Clinical Handover – Transfer of Accountability and Responsibility

EPM/030 - Aggresssion Action Plan

Multi-Disciplinary Team Case Review Guidelines - Community Mental Health & Addictions

References

Refomulating Suicide Risk Formulation: From prediction to prevention

Safeside Care Framework

Mental State Examination - Helpful Advice

UK Mental Health Triage Scale

Keywords

Suicide
Self-injury
Self-harm
Risk assessment

For further information please contact the General Manager – Mental Health and Addiction Group

Risk Assessment: UK Mental Health Triage Scale

Appendix 1

UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Appendix 2

Prevention-Oriented Risk Formulation Procedure: Safeside Care Framework