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NSW Health suicide care pathway

A framework for clinicians

June 2022

Zero Suicides in Care is a NSW Health Towards Zero Suicides initiative

NSW GOVERNMENT

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AGENCY FOR CLINICAL INNOVATION

1 Reserve Road St Leonards NSW 2065

Locked Bag 2030, St Leonards NSW 1590
T +61 2 9464 4666
E *aci-info@nsw.gov.au* | *aci.health.nsw.gov.au*

SHPN: (ACI) 220222

ISBN: 978-1-76023-135-4

Produced by: ACI Mental Health Network

Further copies of this publication can be obtained from
the Agency for Clinical Innovation website at *www.aci.health.nsw.gov.au*

Version: 1.0 **Trim:** ACI/D22/576

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Contents

Content warning

While the authors do not anticipate that this content will cause distress, we encourage you to consider not reading it if you think you may become distressed. If you find yourself becoming distressed, please seek support and exercise your self-care strategies.

Suicide care pathway guides clinicians

The NSW Health suicide care pathway provides a framework and guidance for providing comprehensive identification, assessment, intervention, and transition of care for all individuals who enter NSW Health facilities with suicidal ideation and suicidal behaviours.

It outlines the key components of care required to support a person who is, or may be, suicidal. It guides clinicians, consumers, carers, and families on what is effective care. It also helps to minimise variation in service delivery.

This document provides guidance to clinicians, local health districts (LHDs) and specialty health networks (SHNs) on the key functions of a local suicide care pathway.

Underpinning the pathway is the fundamental importance of establishing a good therapeutic relationship with the person when addressing suicidality. It is essential to provide care that is person-centred, trauma-informed and recovery-oriented. The components are based on the latest evidence and reflect current best practice.

Based on international framework

The pathway aligns with the internationally renowned Zero Suicide Framework developed in the United States.[1] The NSW Health pathway is supported by NSW Health policies and Australia's National Safety and Quality Health Service Standards.

The NSW Health suicide care pathway is a structured universal intervention designed to ensure every person with suicidal ideation and suicidal behaviour receives a minimum set of interventions. It moves away from stratifying suicide risk and providing suicide prevention interventions only to those considered to be at high risk or with a specific psychiatric diagnosis. Instead, it follows the principle of delivering high-quality, evidence-based care to everyone who presents to health services with suicidal ideation and suicidal behaviours.

Developing a suicide care pathway ensures there is consistent, high-quality care provided by a health service to a person experiencing a suicidal crisis.

How to use this framework

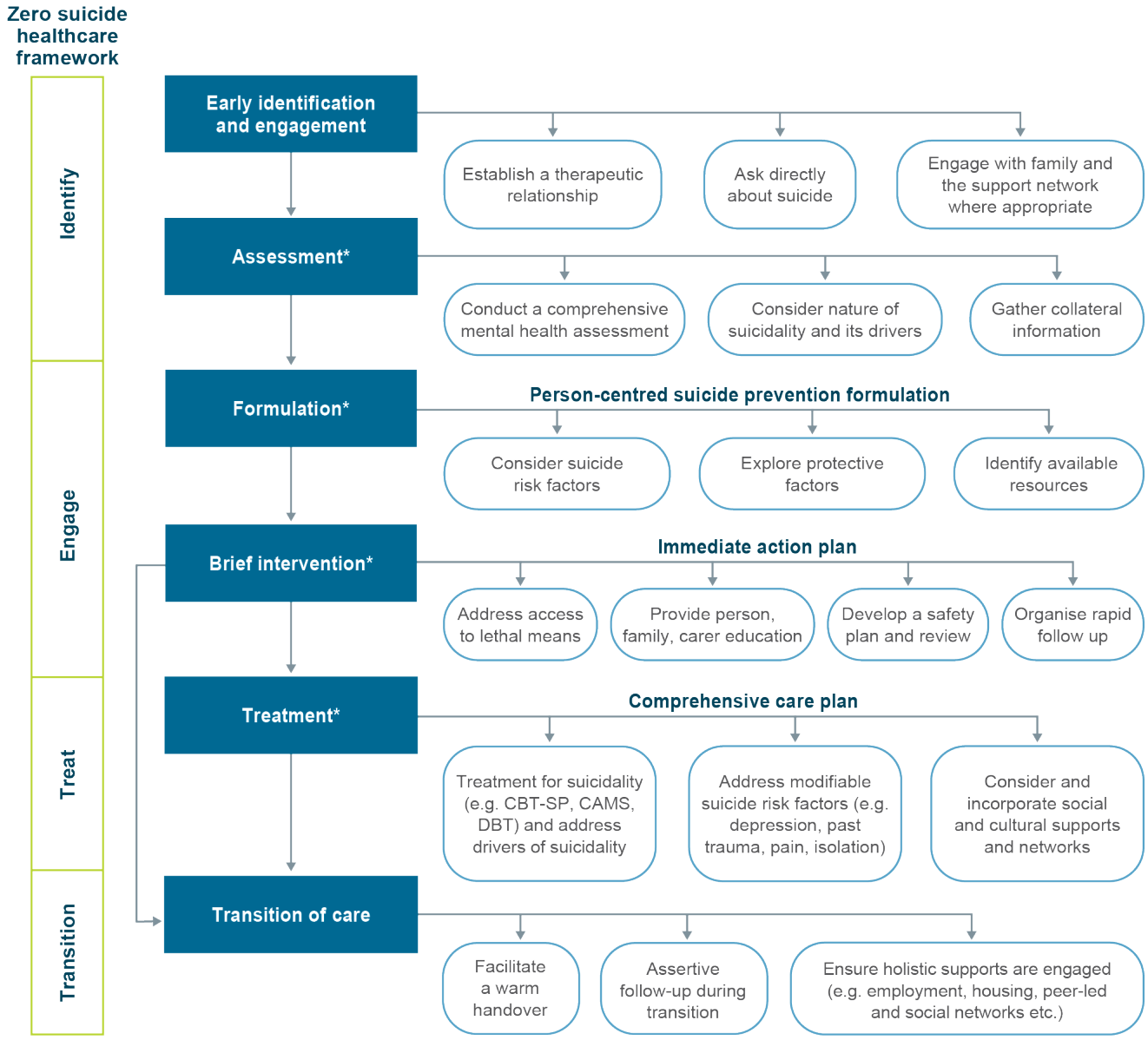
LHDs and SHNs should consider following the framework when drafting their local suicide care pathway. This document consists of:

- a flowchart of the NSW Health suicide care pathway
- details of who, what and how to deliver a local suicide care pathway.

As LHDs and SHNs develop their pathway, this framework will ensure the essential components of care are incorporated into services and that local policies and procedures reflect best practice.

The suicide care pathway should also be used by LHDs and SHNs in staff training to ensure a consistent message on best practice across all NSW Health mental health services.

NSW Health suicide care pathway



***Note:**

The pathway is not a fixed linear process. Movement between components of the pathway should occur in response to changes in the needs and circumstances of the person.

Glossary:

CBT-SP - cognitive behaviour therapy for suicide prevention
CAMS - collaborative assessment and management of suicidality
DBT - dialectical behaviour therapy

Principles of care – developing a good therapeutic relationship

Why this is important

It is essential to build a good therapeutic relationship with a person who is experiencing suicidal ideation.

Research shows a strong link between the quality of the therapeutic relationship and therapeutic outcomes.[2] The development of a good alliance between the clinician and the person in the early stages of therapy is vital for therapy success.[3]

An empathetic and compassionate approach by the clinician will build important trust and rapport.[4]

A good therapeutic relationship should include:

- trust, care and respect
- agreement on the goals of care
- collaboration on the care plan and tasks to be undertaken.

The principles of a good therapeutic relationship need to be embedded during every interaction at each stage of the suicide care pathway.

Key components

- **Person-centred** – places the person at the centre of the service. The focus is *not* on their condition or disability. Support focuses on the person achieving their aspirations and is tailored to their needs and unique circumstances.[1]
- **Collaborative** – describes the partnership between healthcare providers, the person, and their family in shared decision-making, coordination, and cooperation.[2] Every person working in the health system plays a valuable role that contributes to achieving the best possible outcomes for the person.[1]
- **Respectful** – means respect for the abilities, knowledge, skills and achievements of all people who work in the health system.[3] It includes a commitment to providing services that acknowledge and respect the feelings, wishes and rights of patients and their carers.[3]
- **Trauma-informed** – requires re-thinking traditional approaches to health service delivery. Trauma-informed care requires that services acknowledge the high rate of trauma throughout society.[4] Trauma-informed services are sensitive to the dynamics of trauma rather than simply treating trauma.[5]
- **Culturally safe** – requires healthcare professionals and their organisations to examine themselves and the potential impact of their culture on clinical interactions and healthcare service delivery. This requires ongoing self-reflection to acknowledge and address biases, attitudes, and assumptions, that may affect the quality of care provided.[6]
- **Non-judgmental** – not judged or judging based on one's personal standards or opinions.
- **Inclusive** – aiming to provide equal access to opportunities, resources, and care for all people.
- **Recovery oriented** – this approach includes understanding that each person is different and needs to be supported to make their own choices. Each person is the expert of their own life. They should be listened to and treated with dignity and respect. Support should assist them to achieve their hopes, goals, and aspirations. Recovery will mean different things to different people.[7]
- **Trauma-informed practice** – avoids the potential for people to exclude themselves from services because of trauma-related distress triggered by contact with staff and services.[4, 8, 9] Trauma-informed

services change the question from 'what is wrong with you?' to 'what has happened to you?'.[9, 10] This approach acknowledges that those in most need may also be the hardest to reach and most unlikely to engage effectively with services.[4, 8]

Early identification and engagement

Why this is important

Studies show most people who die by suicide have had contact with a healthcare provider in the months leading up to their death.[11] However, many people do not talk about suicidal thoughts and plans unless asked directly. Even then, it may be difficult for the person to discuss it.

Asking directly about suicide is critical to identifying and supporting a person who may be contemplating suicide. The evidence shows asking someone if they feel suicidal will not make the situation worse or 'put ideas in their head'.[12, 13] Identifying suicidal ideation or suicidal behaviour early allows a person to be linked in with the supports they need to manage a suicidal crisis.

To provide the basis of collaborative care and a safe environment in which suicidal thinking can be discussed, you need to:

- ensure the principles of care are adhered to
- establish a good therapeutic relationship.

Engaging early with family and support networks is important. They can provide a view about the current situation because they have known the person for a longer period of time.[14]

Key components

Establish a therapeutic relationship – based on respect, trust and empathy. Recognise and seek to understand what has brought a person to the service. Then, work with them to identify what will help them most now. Even when contact is fleeting, a good working relationship can be established if a person feels seen, heard, and understood.

Ask directly about suicide – screening for suicidal ideation and all forms of suicidal behaviour (including suicide attempts, aborted or interrupted attempts and preparatory behaviour) is essential to the early identification phase.

Asking about suicide early ensures that information is gathered during assessment. If a person indicates they are suicidal, find out what is happening for them. This information underpins formulation about a person's suicide risk. It also addresses how to support their safety and capacity to navigate crises, for example, to engage in formulation with a focus on suicide prevention.

Engage with family and the support network where appropriate – talk to family members and carers about the person's suicidal behaviours.[14] They may have opinions and provide information about other supports and how to activate them. Working with the family and a broader support network creates a stronger safety net during periods of crisis.

How to implement

Establish a therapeutic relationship

Asking about suicide will be most helpful when there is trust, understanding and compassion. The following are essential when establishing a therapeutic relationship during the early engagement phase:

- provide a physical environment that is comfortable and does not cause distress to the person
- actively listen and engage in a non-judgemental, respectful manner
- value collaborative discussions and decision making and provide time for this process.

Ask directly about suicide

Everyone who presents to health services with mental health problems should be asked, directly and gently, if they have thoughts about suicide.[14] Remain alert to the possibility that a person may be suicidal even when suicidality is minimised or no thoughts of suicide are reported. Take notice of your gut feelings. Clinicians should detect distress early in the engagement and assessment of an individual's situation. Allow for ongoing conversations about suicide and ensure the person is connected to the appropriate supports.

For mental health services, early identification may occur during a comprehensive psychosocial assessment. This is where suicidality is routinely assessed so that screening tools are not the only, or primary, way suicidality is identified.[14, 15]

Engage with family and the support network where appropriate

Ask the person if they have any family members or other people who support them during difficult times. This will allow you to explore whether any support people will be helpful in assessment and treatment planning activities. But ensure you have the person's expressed consent to share information with their family and support network before you provide it.

Document a collaboratively developed escalation process and make it available to the person, their family, carers, support network and relevant health professionals. Review the document at every step of the suicide care pathway.

It is important to collaboratively establish escalation processes with the person and their support network early in the engagement phase. These processes are to detect and respond to a deterioration of a person's suicidality and for raising concerns regarding care.[16] The *R.E.A.C.H* pathway provides an example of a process for health services to create clearly defined avenues for families and carers to escalate care as required.[17] This pathway provides a graded approach for the person and their family to activate escalation:

> **Recognise**: acknowledge that patients and families can often recognise signs of deterioration before they are clinically evident.
>
> **Engage**: encourage patients and families to engage with their treating team if they are concerned that 'something is not right'.
>
> **Act**: enable patients and families to act by requesting a 'clinical review'.
>
> **Call**: provide patients and families with an independent avenue to call for a rapid response if they are still concerned and other avenues are exhausted.
>
> **Help**: patients and families should be assured that help will be on its way in the form of a rapid response team.

Assessment

Why this is important

A comprehensive mental health assessment is the base of effective care planning. It includes assessing suicidality, medical and psychiatric history, psychosocial history, life stressors, presence of risk factors for suicide, and a person's ability to recover in the community.[18] Effective assessments have been shown to reduce the risk of future suicide attempts and improve engagement with care.[14, 19]

Key components

Conduct a comprehensive mental health assessment – a mental health assessment includes gaining information on the presence of acute mental ill-health, physical illness, and substance misuse.

The assessment also includes exploring an individual's current life stressors, as well as understanding their strengths, supports and protective factors.

Ask whether the person has thought about hurting themselves (self-harm) and ending their life. Ask these questions even when there are no indications of suicidality.[14, 19]

Consider nature of suicidality and its drivers – it is important to identify factors that contribute to a person's distress, thoughts about suicide and their capacity to navigate suicidal crises. Where suicidality is identified, the assessment should explore the severity and frequency of suicidal ideation. Check whether this has changed over time and the contextual factors that may be impacting the person's current presentation.[20]

Gather collateral information – where possible, mental health assessments, including assessment of suicidality, should include the views of family and carers and incorporate information from other health professionals who support the person.[14, 18, 21]

How to implement

A range of frameworks exist to organise assessment information. Assessments should not be conducted in a rigid, checklist-like style. A narrative style of interviewing is best to develop a good therapeutic relationship. It also helps you to fully understand the person's experience.[22, 23]

You need to be sensitive to the distress the person may be experiencing. Assessment of suicidality means the person is making a significant disclosure. The assessment should be conducted in a manner that is trauma-informed and recovery-oriented.[14] It also needs to examine both individual risk and protective factors. Assessment should identify which of the personal risk factors are of concern to the person, rather than the assessor making this determination.

Conduct a comprehensive mental health assessment

A comprehensive mental health assessment should occur as part of any new contact with the mental health service. There also needs to be a periodic review over the course of a service request.

The mental health assessment should be recorded in the service's chosen electronic medical record system in documents such as mental health current assessment and mental health review.[24]

Consider nature of suicidality and its drivers

People experience suicidal thoughts and urges in different ways. It is important to get a sense of the nature of suicidality for each person. Learn whether it is a more general sense of 'I don't want to be here anymore' or 'I just want to sleep'. Or, has the person identified how, and when, they may take actions to end their life?

Gather collateral information

After an initial discussion with the person and their family members, contact the person's broader support network. While you need to have these discussions in line with privacy and confidentiality legislation, speaking to other people can be valuable. They can shed light on the person's current situation, risk, and available supports.

Formulation

Suicide prevention formulation refers to the process of synthesising information collected during an assessment that is relevant to a person's suicide risk. It includes identifying stressors as well as protective factors. It aims to capture how a person's history and context interact to produce and mitigate suicide risk.[25, 26]

Why this is important

Developing an accurate and thoughtful suicide prevention formulation allows for the most appropriate and valuable support, treatment, and care to be activated.

Suicide risk stratification (categorising suicide risk as high, medium, or low) is not an effective or appropriate way to determine the treatments or support that should be offered to a person.[25, 27-35] Meta-analysis indicates that half of all people who die by suicide have been identified as being at low risk of suicide. The vast majority (95%) of those identified as being at high risk will not die by suicide in the short- or longer-term.[28]

Person-centred suicide prevention formulation provides the best way to ensure that the most effective and suitable care can be tailored to a person's needs.[15, 36] Suicide prevention formulation should sit within a broader consideration of what is happening for a person in their life. This ensures all concerns that may need to be addressed are identified.

Key components

Person-centred suicide prevention formulation should directly inform the care and support required to reduce suicide risk and promote recovery.[18, 19, 25] It should drive the nature and type of care offered to a person experiencing suicidality. This is because it ensures that the care provided is tailored to a person's needs, and circumstances, and their recovery goals.

A person-centred suicide prevention formulation should:

- consider the suicide risk factors a person presents
- identify which risk factors are modifiable and can be addressed
- determine the nature of an individual's protective factors and how they can be strengthened
- detail the resources (internal and external) available to help a person steer through times of crisis.

How to implement

The assessing clinician consults with the person and their carer to develop the suicide prevention formulation. The person's broader support network will also be consulted, if relevant. Where possible, formulation is best done in consultation with a multidisciplinary team.[36] Suicide risk formulations should be reviewed regularly and updated with any significant changes in presentation, context or availability of support. Suicide prevention formulation should be documented in electronic medical records.

Structure of a suicide prevention formulation

There are different ways to structure a suicide prevention formulation. Two recommended approaches are the *SafeSide prevention-oriented suicide risk formulation model* and an *ISBAR* (introduction, situation, background, assessment, recommendation) format.[26,37] A suicide prevention formulation should document risk and protective factors that a person presents with and the internal and external resources available to them to navigate distress.

The suicide prevention formulation provides the basis for brief interventions and ongoing treatment. It provides essential information for a comprehensive care plan that seeks to:

- address modifiable risk factors
- mitigate the impact of long-standing risk factors
- consolidate and build a person's strengths and available resources.

Brief intervention

Why this is important

Brief interventions refer to activities that can be enacted immediately to help ensure a person is safer and better able to manage suicidality. A good therapeutic relationship, and ensuring the person feels listened to and respected, are fundamental to brief interventions.[38, 39]

Brief psychological interventions can be effective in reducing suicide and suicidal behaviours.[40-42] These can, and should, be combined with longer-term treatment options as appropriate. (Refer to the *Treatment section* for further information on longer-term treatment options.)

Brief interventions can be used early in the therapeutic engagement process – as early as first contact. This enables timely support to be provided and immediate needs to be addressed, while also promoting ongoing engagement with care.

Key components

Brief intervention is guided by an immediate action plan that incorporates the following activities that should be routinely used when a person identifies they are suicidal.

Address access to lethal means – suicidal thoughts may come and go and some suicidal acts are impulsive.[43] Minimising easy access to lethal means can delay a person's ability to act on suicidal thoughts until they subside, or care can be provided.[44, 45]

Provide person, family and carer education – the person, their family and support networks need to be given information relevant to the person's experiences and the supports available to them. This will empower the person to make informed decisions about their recovery.[46]

Develop a safety plan and review – this is a tailored list of coping strategies and sources of support a person wishes to use when they experience a suicidal crisis. Safety planning includes:

- exploring warning signs of an impending suicidal crisis
- internal coping strategies
- use of social contacts and social settings
- seeking help from friends and family members
- engaging professional help
- addressing access to lethal means.[47]

Effective safety planning incorporates a process of engagement, exploration and collaborative planning in partnership with the person. It is not just the creation of a checklist plan.[48, 49] It is essential the plan includes escalation concerns and processes in case the person deteriorates.

Organise rapid follow-up – all people identified as at risk of suicide should be followed up, ideally within 24-48 hours.[18, 50, 51]

How to implement

Address access to lethal means

Regardless of whether a person has identified a specific means of suicide, access to lethal means should be explored. Discuss whether the person has considered a way to end their life. Then develop collaborative and explicit plans to minimise access to the identified means.[15]

When addressing access to lethal means it is best to include the person and their supports.[52] However, there may be circumstances where acute concern about the safety of the person may warrant notifying about access to lethal means without the person's consent.

The intent is not to confiscate or involuntarily remove access to means. Rather it is to develop a plan together to reduce access or establish stopgaps that may delay the person using the means during times of distress. The person's collaboration on, and ownership, of the strategies is critical.

Include the availability of drugs and alcohol when discussing lethal means. Drugs and alcohol could indirectly facilitate death because they reduce inhibitions of the person to act on suicidality. Drugs and alcohol also increase the capacity to cause death by other means such as overdoses.[53]

Clinicians also have a duty of care regarding firearms under Section 79 of the Firearms Act 1996 and Section 38 of the Weapons Prohibition Act 1998.[54, 55]

If a health professional is made aware that the person they are treating has a firearm, and the clinician is concerned that the person may pose a risk to public safety or the person's own safety, the clinician is required to provide a *Disclosure of Information*.[56]

Follow-up may be required to ensure all agreed strategies for reducing access to lethal means have been enacted.

Counselling on Access to Lethal Means (CALM) is an online course that provides some guidance and resources for addressing access to lethal means.[57] However, given the North American origin of the course and its focus on the use of firearms, consideration should be given to translating the content to the local context.

Addressing access to lethal means is a key part of safety planning and ideally should be discussed and documented as part of the safety planning process.

Provide person, family and carer education

Information packs that include localised advice, support services and crisis contacts should be developed and provided to the person, family members and support networks. Wherever possible materials should be co-designed to ensure relevance of content.[46]

Develop safety planning and review

Safety planning is a collaborative process between the person and clinician, incorporating family and carers where possible.[19] A safety plan should be put in place as early as possible and be reviewed regularly as circumstances change, including after a crises or suicide attempt.[47]

Contingency planning should be considered in the event of acute deterioration of an individual utilising a defined escalation process, such as *R.E.A.C.H.*[17]

The safety plan should be documented in a format that is appropriate and readily accessible to the person. This could include a physical copy or a digital plan. *The Beyond Now* app and website is a good resource to support this.[58]

Organise rapid follow-up

Schedule rapid follow-up as soon as possible, ideally including face-to-face contact within 24-48hrs.[18, 50, 59] Follow-up needs to reinforce the connection between the person and care and be linked with a higher intensity of scheduled care contact in the initial weeks after presentation.[59,60]

If possible, the same healthcare worker should provide follow-up. Where this is not possible, ensure a thorough handover of information to the new healthcare worker.[59]

Provide the person and their supports with a clear process and contacts if they find themselves in crisis before the next appointment. This would be outlined in the safety plan.[61]

Treatment

Treatment refers to the care, therapies and resources that support a person to address their suicidality. It considers the drivers and precipitators of the suicidality and the other factors that may contribute to or reduce their suicide risk.

Why this is important

Effective treatment allows a person to manage and reduce suicidal ideation and suicidal behaviours now and in the longer term. Effective evidence-based treatments may lead to benefits being realised quickly and with longer lasting impacts.[62, 63]

A strong foundation for recovery and reduction of longer-term risk can be found by addressing drivers of suicidality and modifiable risk factors directly, such as:

- mood disorders
- psychosis
- anxiety
- bipolar disorder
- substance misuse
- pain
- physical illness
- isolation.

The foundation for recovery also needs to consider supportive holistic care such as:

- a person's social connections
- housing
- employment.[15]

Involvement of the person and their support network is essential in treatment and care planning and is associated with improvements in symptoms, better engagement with treatment, reduced stigma, and stronger provider-person relationships.[14]

Key components

Treatment should be guided by a comprehensive care plan that incorporates the following components.

Treatment for suicidality and address drivers of suicidality – should include therapies that specifically aim to reduce suicidality; as well as treatments or interventions that address the drivers of the person's suicidality, for example, isolation.

Address modifiable suicide risk factors – conditions, experiences or situations that are known to contribute to suicide risk. This could include underlying mood, psychotic and other mental disorders, substance misuse, physical illness, pain syndromes, past trauma, or isolation. These risk factors apply even if there is no direct causal link between the experience and the suicidality for a particular person.[64] Treatment for modifiable suicide risk factors is also an important part of the care plan.

Consider and incorporate social and cultural supports and networks – these support a person to thrive and have a life they want to live. Promote activities that strengthen recovery and consolidate protective

factors. This includes considering factors such as employment, housing, spirituality, cultural connections and social networks.[15]

How to implement

Identify key issues in discussion with the person. The selection of treatments or therapies should be guided by evidence. A range of psychological treatments and psychosocial supports have been shown to reduce suicidal thinking and attempts.

Treatment for suicidality and address drivers of suicidality

Psychosocial and behavioural interventions that directly target suicidal thinking and behaviours are more effective in reducing suicidality than interventions that target associated conditions, such as depression.[63, 65]

The therapies with the strongest evidence for effectiveness in reducing suicidal thinking and behaviours include:

- cognitive behaviour therapy for suicide prevention (CBT-SP)
- collaborative assessment and management of suicidality (CAMS)
- dialectical behaviour therapy (DBT).[66-77]

Address modifiable suicide risk factors

The management of modifiable risk factors should involve evidence-based treatments delivered by members of a multidisciplinary care team. The team needs to have appropriate training and scopes of practice, with progress ideally monitored within multidisciplinary reviews. Engage multidisciplinary supports via referral and collaborative case management to address the modifiable factors as appropriate.

It is important to note that modifiable risk factors may naturally resolve or may change during the course of treatment. This is why it is important to review these regularly.

Consider and incorporate social and cultural supports and networks

Strengthening protective factors is a key component in treating a person with suicidality. These are factors that enable a person to thrive while protecting against relapse. Protective factors may also reduce suicide risk.

It is important to identify ways to support and enhance protective factors and incorporate these in to care plans. This may include providing support with employment, housing, social networks, physical health, problem solving and coping skills.[78]

Treatment activities may be delivered by the mental health service or by community or other service providers. Clear referral pathways and contacts should be provided to the person, including appointment and contact details.

Transition of care

Why this is important

Many people who die by suicide and have been in contact with mental health services take their lives soon after the last contact or discharge.[14, 79-82] Follow-up after a suicidal presentation and effective transition between services is a key element in providing good clinical care.

Continued review and support are essential during transition of care and after contact with a mental health service due to a suicidal crisis. Ensuring a person remains connected and engaged with supports will help limit the likelihood that a person will 'fall through service system gaps'.[51] This is particularly critical during the period of discharge from acute care and transition to community services. It provides an opportunity to interrupt cycles of crisis and prevent subsequent suicide attempts.[45]

Follow-up interventions that encourage people to engage with treatments and supports that address their needs have been effective in preventing repeat suicide attempts within six months for people admitted to an emergency department.[60]

Key components

Facilitate a warm handover – is important and refers to combining written referrals with a person-to-person discussion with other service providers. This enables you to highlight key points and introduce the service to the person.[83]

Assertive follow up during transition – proactive contact with a person should be maintained during transitions of care to ensure the person connects with the new services or supports. Contacts during transition of care can also provide reminders and encouragement about recovery and the supports available. During follow-up contacts, suicide risk formulations need to be reviewed and supports amended accordingly; increasing or decreasing as needed.[14] Contingency plans and escalation processes for acute deterioration should be reviewed at each follow-up opportunity.

Ensure holistic supports are engaged – to help the person live well. These may include employment, housing issues or connecting people with peer-led or social networks. Ensuring these supports are activated provides the necessary environment to assist recovery.

How to implement

An effective support system often relies on a range of services and people working together. Good transitions of care require clear, collaborative and proactive communication about roles, responsibilities and the scope of available support.[84]

Where possible it's important to involve family members and identified support people in these discussions.[84-86]

Facilitate a warm handover

Using a consistent format such as ISBAR (introduction, situation, background, assessment, recommendation) for warm handover discussions and to document transition plans is recommended to ensure consistency and comprehensiveness.[37, 85]

Developing and providing the person with their discharge plan is recommended. Also include a copy for their family or carer, as appropriate. The discharge plan should contain details of ongoing clinical interventions, such as medications and psychological therapy, and non-clinical interventions. It also needs to include contact details for relevant services and a summary of who will provide what support and when.[18, 85] As well as discharge plans, it is helpful to add wellness or relapse prevention plans, including specific details about when a person should recontact.[61]

Assertive follow-up during transition

Following up with the person and their family or carer is a key component in the transition of care and should be included in the plans for next actions during the discharge process.[86, 87] The following points guide the process of transition and how to best implement follow-up care.

- The timing of follow-up contact should be based on clinical need.[85]
- Discharge planning should be a collaborative process involving the person and their family or carers.[84]
- Follow-up may occur by phone or face-to-face appointment.[84]
- If the person is not reachable, the family or carer needs to be contacted.[85] This arrangement should be discussed at discharge with the person and their carer.
- Planning should occur to identify potential early warning signs of deterioration in a person's mental health and wellbeing and actions identified to address this. Once discharged, a process for rapid re-entry back to mental health services should be available if required.
- Information should be provided on suicide crisis supports and resources available to the person and family on discharge. For example, *Mental Health Line*, *Lifeline*, *Suicide Call Back* and *Beyond Blue*.[14]

Assertive follow-up services such as *The Way Back Support Service* and similar models should form part of transition plans wherever possible.[88] They can provide rapid follow-up post-discharge, a focus on therapeutic alliance, continuity of care and integration of clinical and non-clinical support.

The use of brief caring contacts, for example, postcards, text messages, emails, and short phone calls, may be combined with more assertive modes of follow-up. The caring contacts highlight that support options remain available and help to promote re-engagement, if required. Caring contacts are associated with reduced repetition of self-harm and suicide.[78, 82, 89, 90]

Ensure holistic supports are engaged

During the transition of care period, there is an opportunity to ensure that supports that were put in place during the treatment phase are being engaged with, and are available for the person during their transfer of care.[18] It is important that clinicians follow-up referrals to ensure they are effective and meeting the needs of the person. The follow-ups should be incorporated into the warm handover process.

Tailored approaches for priority populations

Evidence suggests specific populations are at higher risk of suicide and suicidal behaviour. Suicide rates among Aboriginal and Torres Strait Islander peoples are twice that of non-indigenous people. As well, LGBTQI+ communities have the highest rate of suicide of any population in Australia.[64] Examples of people who have been shown to be over-represented in current suicide rates can be seen in Table 1.

Populations	
• Children in out-of-home care • Care leavers (people who spent time in care as a child) • Children and young people in the youth justice system • People who have experienced bullying and victimisation • Survivors of abuse or violence, including sexual abuse and domestic violence • People who use or experience domestic violence • People living with long-term physical health conditions • People with untreated depression • People who are socioeconomically disadvantaged • People who misuse drugs or alcohol • People bereaved or affected by suicide • People who do not have strong connections to their culture or identity	• Aboriginal and Torres Strait Islander people • Lesbian, gay, bi-sexual, transgender, and intersex people • Young people • People with severe mental health conditions • Certain occupational groups with increased knowledge of, and ready access to the means to attempt suicide, such as, doctors, nurses, farmers, and other agricultural workers • Some male-dominated industries, such as construction and mining • Some culturally and linguistically diverse (CALD) communities • Asylum seekers and refugees • Prisoners and others in contact with the criminal justice system • Rough sleepers, the homeless and those at risk of homelessness • Older people, especially men • Residents of aged care facilities

Table 1: Populations at higher risk of suicide and suicidal behaviour[64] Adapted

In addition to the general advice provided in this guide, there is clear evidence for the need to tailor approaches to the needs of certain population groups that are over-represented in current suicide rates. Consideration of a person's cultural context and identity, and how this may influence suicidality and pathways to recovery, should be routine for any interaction regarding interventions and care planning. Consideration should also be given to matching the recommended interventions with the person's needs and circumstances.

Specific resources for Aboriginal and Torres Strait Islander peoples

When working with Aboriginal and Torres Strait Islander peoples consider the impact of:

- racism
- a history of colonisation
- intergenerational trauma
- dispossession
- polices of exclusion and child removal
- social and economic disadvantage.

In addition to the general guidance provided for the engagement of any priority populations, these resources provide specific information about the contextual factors impacting suicidality among Aboriginal and Torres Strait Islander peoples. The resources also provide practical implications and guidance for clinical practice:

- *Guidelines for Best Practice Psychosocial Assessment of Aboriginal and Torres Strait Islander People Presenting to Hospital with Self-Harm and Suicidal Thoughts*[91]
- *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice 2nd Ed*[92]
- *Wellbeing and Healing Through Connection and Culture*[93]
- *Solutions That Work: What the Evidence and our People Tell Us – Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*[94]

The NSW Health suicide care pathway is suitable for all population groups within the state. It provides the framework for LHDs and SHNs to embed the essential components of suicide care into any locally developed suicide care pathway within their districts.

Along with this document, which is aimed at clinicians, there is another publication for LHDs and SHNs. Entitled *A guide for developing a suicide care pathway for local health districts and specialty health networks,* it provides a step-by-step process to assist districts and networks to develop their locally specific suicide care pathway.

Acknowledgements

The ACI would like to acknowledge and thank the following groups and organisations for their significant contributions to this document:

- ACI Suicide Care Pathway Working Group
- Clinical Excellence Commission
- Gold Coast Health and Hospital Service, Queensland
- Health Education and Training Institute
- Mental Health Branch, NSW Ministry of Health
- NSW local health district Towards Zero Suicide and Zero Suicides in Care leads, clinicians and peer workers
- Zero Suicide Institute of Australasia.

Glossary

Carer: Any person who provides paid or unpaid care and support to a relative or friend who has a disability, a mental illness, a chronic health condition, a terminal illness, drug or alcohol issue or who is elderly and frail.

Collaborative: We work with each other to achieve the best possible outcomes for our patients who are at the centre of everything we do. In working collaboratively, we acknowledge that every person working in the health system plays a valuable role that contributes to achieving the best possible outcomes.[1]

Culturally safe: Cultural safety in healthcare means designing and providing services that meet the needs of patients through a process of self-reflection, awareness of cultural biases and processes to actively respond in a way that will benefit the person's health and wellbeing.[6]

Inclusive: Aiming to provide equal access to opportunities, resources, and care for all people.

Mental health: A positive concept relating to resilience, enjoyment of life and social connection. This state of wellbeing increases the person's ability to realise their own abilities, cope with the normal stresses of life, work productively and contribute to their community.

Non-judgmental: Not judged or judging based on one's personal standards, experiences, or opinions.

Person: A person with lived experience of a mental health condition who is accessing or has previously accessed a mental health service.

Person-centred: The person is placed at the centre of the service and they are treated as a person first. The focus is on what the person can do rather than their condition or disability. Support focuses on achieving the person's aspirations and is tailored to their needs and circumstances.

Recovery: The person is able to create and live a meaningful life, contribute to the community that they choose with, or without, mental health issues.

Recovery-oriented: The principles of this approach include understanding that each person is different and should be supported to make their own choices. They should be listened to and treated with dignity and respect. They are the expert in their own life and support should assist them to achieve their hopes, goals and aspirations. Recovery will mean different things to different people.[7]

Recovery-oriented practice: The application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Respectful: Respecting the abilities, knowledge, skills and achievements of all people who work in the health system. It is coupled with a commitment to provide health services that acknowledge and respect the feelings, wishes and rights of the person and their carers.[3]

Self-harm: Any behaviour that involves the deliberate causing of pain or injury to oneself. Self-harm is usually a response to distress – often the distress associated with mental illness or trauma. In the short term, some people find that it provides temporary relief from the psychological distress they are experiencing. While people who self-harm do not necessarily mean to kill themselves, it often becomes a compulsive and dangerous activity, and requires careful professional help.

Suicide: An act of intentionally terminating one's life.

Suicidal attempt: Self-initiated, potentially injurious behaviour with the intent to die but does not result in a fatal outcome.

Suicidal behaviours: Thinking or talking about suicide, planning a suicide, or taking actions related to ending one's own life.[95]

Suicidal ideation: Thoughts about wanting to be dead or killing oneself.

Trauma-informed care: Involves the re-conceptualisation of traditional approaches to healthcare that means all aspects of services acknowledge the high incidence of trauma within the community.[4] Trauma-informed services are aware of, and sensitive to, the dynamics of trauma as distinct from directly treating trauma.[5]

Treatment: Specific physical, psychological and social interventions provided by health professionals aimed at reducing impairment and disability and/or the maintenance of current levels of functioning.

Wellbeing: The state of complete physical, mental, and social satisfaction and not merely the absence or presence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic and social condition.

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