forensic setting

suicide **qu**estions **a**nswers **re**sources

square **s**uicide **qu**estions **a**nswers **re**sources

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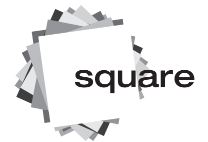
An education resource for primary health care, specialist and community settings



Most people who die by suicide have sought help in the weeks before death. Therefore the nature and quality of response offered by workers in primary health care is crucial.

Even a simple interaction like listening can be significant.

Everyone can make a difference.

note

This Booklet is designed to be used with the rest of the **square** resources, not alone or as a substitute for an informed professional response. Its main focus is on adults although much of it is also relevant to young people. Those seeking specific guidance about working with young people should source relevant Australian, state government and local information.

You will find information in the service setting books that will be helpful in your own practice. This will be particularly relevant where referrals are made or received from these services or there is a shared care arrangement in place.

Your service will also have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this Booklet.

In addition it may be useful to consult the South Australian Emergency Demand Management policies, which cover best practice and specific procedures on matters such as admission, care and discharge, contingency planning, restraint and seclusion, emergency transport, assessment and crisis intervention service.

The experience of consumers and carers has been incorporated into these training materials.
This reflects the priority placed on consumer and carer participation in decision and policy making.
The contribution of these consumers and carers is gratefully acknowledged.

Note: All names used in quotes from consumers are pseudonyms to ensure anonymity and protect confidentiality.

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how to use this resource

This booklet is part of an integrated resource – **square suicide questions answers resources** developed for South Australia as part of the National Suicide Prevention Strategy (NSPS). **square** consists of 3 layers, each progressively providing more detailed information about suicide prevention.

A The first layer is the **Desk Guide**, a quick reference providing key information, tools, guidelines and questions.

B The second layer is a series of **9 booklets**

1. **Foundations for effective practice**
2. **Community setting**
3. **Primary health care setting**
4. **In-patient setting**
5. **Emergency department setting**
6. **Community mental health setting**
7. **Forensic setting**
8. **Mental health in-patient setting**
9. **Suicide postvention counselling.**

This booklet, **Forensic setting**, is aimed at nursing, medical and allied health workers in forensic mental health hospital settings who may, in their professional roles, encounter people at risk of suicide. It is designed to be used in conjunction with the **Foundations booklet** which has been written for a broad audience and provides the foundations which underpin the following 8 booklets addressing specific settings and audiences.

C The third layer is the **square** CD-ROM/Website **www.square.org.au**. It is intended for those readers who want a more in-depth discussion and application of the key topics covered in the Desk Guide and the booklets. It contains discussion papers, video clips, resource lists, some downloadable forms and plans, and pdf files of all the **square** print materials – the 9 booklets and the Desk Guide.

introduction

This Booklet is designed to be used by staff in forensic hospital services, whose work may involve working with offenders who are at high risk of self harm or suicide. This includes nurses, allied health workers, and medical practitioners, including psychiatric consultants and other specialists.

There are approximately 40 beds allocated for forensic in-patients in South Australia. James Nash House is South Australia's secure facility for offenders who are acutely psychotic or who have severe depression and are at high suicidal risk. Approximately half of the in-patients at James Nash House are 'forensic' patients – alleged offenders who have been dealt with in the courts and who have been found not fit to stand trial or not guilty on the grounds of mental impairment. Some of these patients may stay at James Nash for an extended period of time. The remaining 50% have been convicted and are serving prison sentences and have been transferred from prison for acute care. They are generally returned to prison once the illness is stabilised.

Staff at James Nash House work closely with prison medical staff and the psychiatric clinics in prisons and remand centres. They also work closely with ACIS (Assessment & Crisis Intervention Services) when 'forensic' patients are discharged back to the community. James Nash House also caters for some out-patients, for example, people on bail or parole.

James Nash House is a mental health facility based soundly on a multidisciplinary team approach and mental health nursing principles. Its brief is to provide psychiatric assessment and treatment with clinical standards that are comparable to other psychiatric in-patient services. There are no correctional officers and there is an emphasis on control rather than punishment.

In working with these patients staff are inevitably faced with balancing the need to control the person within a safe and containing environment and the need to provide a therapeutic relationship in a supportive environment which can promote some degree of autonomy.

Key facts

- Despite a decline of 18% in suicide rates since a peak in 1997, suicide is still a major public health problem in South Australia and nationally. Approximately 2100 Australians were reported as taking their own lives in 2005 (ABS, 2007).
- People of all ages and from all walks of life may be suicidal, but there are some population groups which are particularly vulnerable.
- Attempted suicide may be 30-50 times more common than death by suicide (Martin et al. 1997). Admissions to hospital for intentional self injury are about 10 times as common as deaths due to suicide.
- Female hospitalisation rates for suicide attempts are consistently higher than for males. However, the death rates from suicide are about three to four times greater for males than females.
- Suicide is the leading cause of death in Australian prisons, and is estimated to be between 2.5 times and 15 times that of the general population (depending on calculation methods).
- In the period 1980-1998, a total of 787 people died in Australian prisons and 46.6% of these deaths were as a result of suicide. While the national average prison population almost doubled during this period, the number of deaths and those resulting from suicide, increased at the alarming rate of 240% (Dalton, 1999; McArthur et al., 1999).
- Some demographic findings from Dalton's study of this group of inmates who suicided in this 8 year period are:
  - 96.5% were male
  - 14.4% were Indigenous
  - The mean age was 29 years at the time of suicide
  - 20% had been sentenced for homicide and almost 15% for assault (Dalton, 1999, p.6).
- The incidence and rate of self harm in prisons is also higher than in the general population and there are also higher levels of suicidal ideation among self harmers in prison.
  - 'It has been estimated that for every suicide there are 60 incidents of self-harming behaviour …. It is evident that inmate self-harm has become endemic in many correctional institutions' [McArthur et al., 1999, p.1].

> Inmates with mental illness are clearly some of the most vulnerable members of the prison population, frequently made more so by issues of intellectual disability, dual diagnosis, their youth or racial demographics such as being members of the Aboriginal and Torres Strait Islands or culturally and linguistically diverse communities. These inmates frequently become victims of violence in custody. [MHCC]

suicide and self harm in the forensic hospital setting

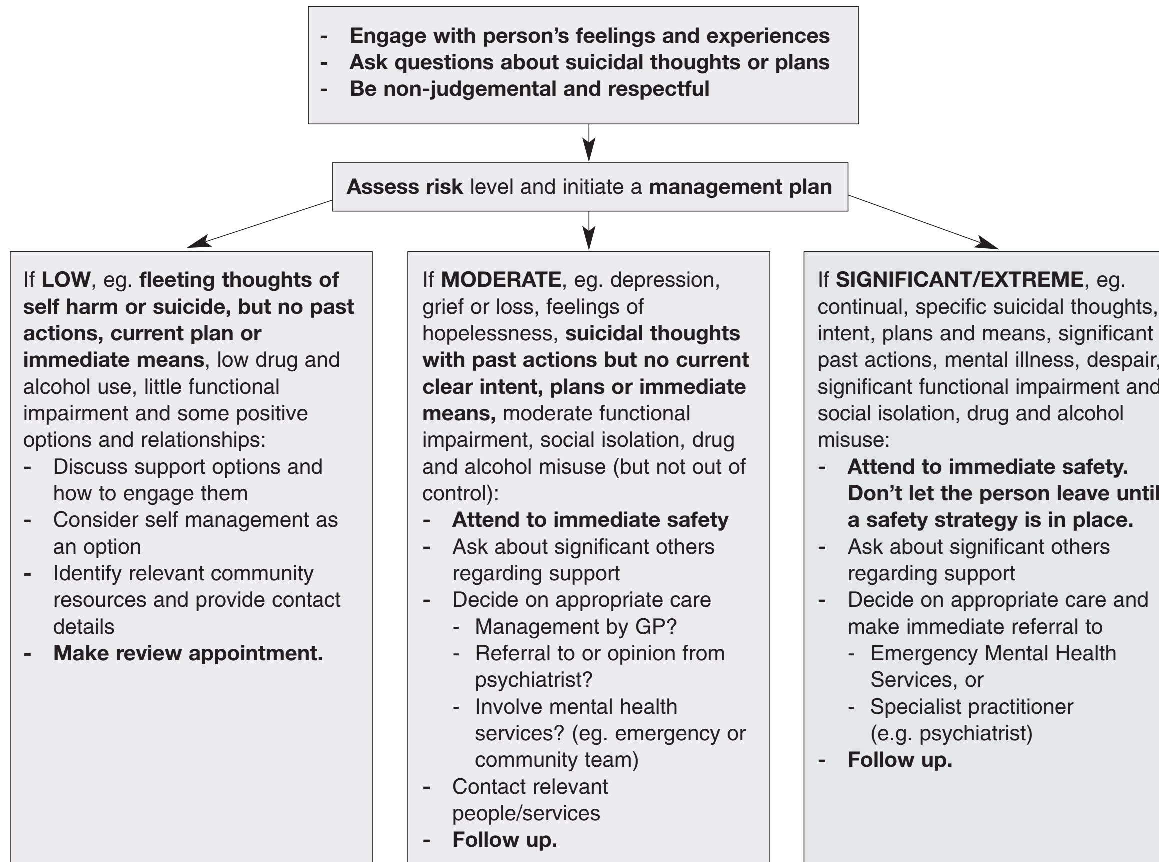
This Suicide Prevention resource highlights the following issues for staff in the Forensic setting:

- Staff in forensic mental health services are very likely to encounter patients who have deliberately harmed themselves or attempted suicide, at some stage.
- People in the criminal justice system are significantly more likely to have a mental disorder. Henderson (2003) cites figures from a 2001 study by the Schizophrenia Fellowship of NSW which identified 60% of people admitted to prison as having an active mental illness. The NSW Corrections Health Service Inmate Survey (1997) found that 50% of women and 33% of men reported that they had undergone some form of psychiatric treatment or assessment for an emotional or mental problem, at some stage.
- There is a higher incidence of schizophrenia, depression and borderline personality disorder among offenders, than in the general population.
- People suffering mental illness are at high risk of offending due to factors such as homelessness, unemployment and poverty (Mental Health Coordinating Council – MHCC)
- 25-40% of urban males with mental illness are arrested before they turn 18 (MHCC)
- Many in-patients in forensic hospital settings have co-morbidities, including mental and physical illness, and may also have intellectual disabilities or acquired brain injury.
- There is a high incidence of histories of drug and alcohol misuse and of drug induced psychosis. One 'study of people with a mental illness in prison showed that 86% had a history of substance abuse and 76% had an active substance abuse problem on arrest, with 66% of their crimes related to their substance use, usually non-violent'. (MHCC)
- The custodial culture of prisons and criminal justice systems and the constraints of resources, make the delivery of adequate psychiatric services in prison, very difficult, and inmates may have been in prison environments which have exacerbated their mental illness.
- Some individuals may be at particular risk of suicide while in-patients in a forensic mental health ward. Factors which may exacerbate an existing suicide risk include:
  - Stressors such as an impending court appearance
  - The effects of having been recently sentenced and imprisoned
  - The effects of violence, aggression and difficult interpersonal dynamics in the prison environment
  - The fear of being sent back to prison
  - The impact of detention on sustaining relationships and retaining custody of children
  - Shame resulting from both the stigma of mental illness and criminal offence
  - Treatment of mental illness and drug misuse is very difficult in the prison environment.
- Being in a secure hospital facility does not necessarily protect a patient against suicidal behaviour.

> Separated from usual support systems in an intimidating environment, prisoners and forensic patients may rapidly deteriorate and experience increased depression and suicidality. [MHCC]

Assessment and management of suicide risk

The following diagram represents some general principles and options for assessing and managing suicide risk. Some of the care and referral pathways will need to be adapted for the forensic setting.



Active, connected referral and follow up are essential for ongoing care.
Ensure a seamless, supported transition to the next stage in the person's care. Do not leave gaps in follow up.

The role of forensic health staff in suicide prevention

Suicide prevention is a whole of community responsibility and the best interventions will be collaborative ones. Health workers in forensic settings have crucial roles and responsibilities in this collaborative enterprise and are in the frontline of balancing difficult issues of safety and containment, supervision and therapeutic support, often with patients who are at high risk and may exhibit challenging behaviours.

As with health workers in other contexts there are some key requirements for managing potentially suicidal in-patients. These include:

- the importance of engaging effectively with patients
- the priority of ensuring safety for all in the hospital context
- knowledge of the risk factors for suicide
- familiarity with the processes involved in assessing risk
- appropriate interventions to minimise risk and maximise safety
- awareness of the circumstances in which specialist services need to be involved
- familiarity with discharge and follow up arrangements to ensure continuity of care
- awareness of available community support options and therapeutic interventions.

In addition to these generic requirements, patients detained under the Mental Health Act 1993 (or amendments) or patients subject to section 269 of the Criminal Law Consolidation Act 1935 (or amendments) have special risk assessment, observation and monitoring, and discharge/transfer of service requirements.

Engaging effectively with forensic patients

- Many people do not disclose suicidal thoughts or desires because of the **stigma** that is attached to 'not being able to cope' or to being diagnosed as having a mental illness. In addition, forensic patients/prisoners may be experiencing the dual stigma of mental illness and their alleged or proven offence. The prison environment is likely to be particularly stigmatising of mental illness.

- In a forensic hospital setting it is possible that a patient has thoughts or plans of suicide even though this may be masked by other symptoms of their mental illness. Hospital staff therefore need a **high index of awareness about suicide.**

- Many in-patients in forensic hospital settings may have dual diagnosis (co-morbidity of mental illness, drug and alcohol abuse and/or intellectual disability). These people have often been unable to access appropriate psychiatric treatment and may also be difficult to engage and treat in view of their higher levels of physical, social and psychological impairment (MHCC). Staff in the forensic setting will often be **challenged by the difficulty of engaging effectively with these vulnerable in-patients.**

- Responding appropriately to someone who may be at risk of suicidal behaviour is vital in determining whether or not that person receives appropriate support – or even whether they disclose their thoughts and feelings at all. Listening attentively and non-judgementally, as well as opening possibilities for the person to describe their feelings and experiences in their own ways, is the first step of appropriate engagement.

- Engagement is essential for establishing a therapeutic alliance with the patient. (See **Engagement Paper** on the **square** CD-ROM/Website **www.square.org.au**). Regardless of whether the therapeutic relationship is short or longer term, it is important that health workers in forensic settings engage with respect and empathy.

- **Do not panic or be afraid** of the issue of suicide. Raising it in an appropriate way will not escalate its likelihood. If you think that someone may be at risk, do not avoid the issue or assume that someone else must be dealing with it. Ask a question like: *Do you wish you didn't have to go on living?* (For further appropriate questions see the Risk Assessment section of the **Foundation booklet** and the **Risk Assessment paper** on the **square** CD-ROM/Website **www.square.org.au**).

- Remember that support is available to you (e.g. from your supervisor) as well as to the person in question. Reporting your concerns might, in some contexts, be the end of your involvement.

Patient multidisciplinary action plan

The Forensic setting involves a multi-disciplinary team working together with the patient to create an individual plan of coordinated actions, which will assist with the patient's recovery and enable their transition to the next phase on the continuum of care. The plan must be regularly reviewed with the patient and their carers (according to unit policy) and be available to them.

The plan is commenced on admission following assessment and consultation with the patient, their carers and other support services. The plan is action driven. It is reviewed, modified and evaluated in consultation with the patient and carer(s) and according to the nature and structure of the service and the patient's needs. It involves the following domains. [A checklist for this Action Plan will be available at your hospital].

Domains	Refers to
1 Risk identification	Risk areas of concern e.g. aggression toward others; harm to self; damage to property; non-compliance; vulnerability; substance misuse; absconding.
2. Psychiatric health issues	Management of mental state, symptoms; illness behaviour (includes psycho-education); medication efficacy and side effects.
3. Physical health issues	Physical conditions requiring attention e.g. diabetes; asthma; epilepsy; drug withdrawal; blood monitoring; diagnostic tests.
4. Personal functioning issues	Activities of Daily Living (ADLs); financial; legal; vocational.
5. Psychological issues	Trauma; loss; stress; motivation; social skills.
6. Family inclusion	Issues which may influence care and treatment outcome include: children; support systems.
7. Cultural issues	Issues which may influence care and treatment outcome (include ethnicity but not exclusively).
8. Continuum of care issues	Factors that may influence ongoing care following transfer from one service to the next e.g. accommodation; support services; community integration.

Risk assessment

Your hospital will have comprehensive standards and Risk Assessment Guidelines and stringent requirements for review and update of documentation.

The following minimum standards apply in South Australian Mental Health Services:

The Risk Assessment form is to be **completed for all patients on admission and at regular intervals**. Assessments are done every 24 hours in the admission ward – or more frequently if indicated by a patient's deteriorating clinical presentation. The following expectations will be met:

1. A comprehensive Risk Assessment will have input from mental health nurses, psychiatric medical officers and other professional disciplines.
2. The Risk Assessment is an essential part of the management plan.
3. The Risk Assessment form is used to measure the observed risk over the previous interval between assessments. Risk should be assessed in the context of the patient being discharged.
4. The history of risk to self and others will be documented on the Alert Form placed at the front of the current volume of the client record. This Alert Form is to be updated by the primary nurse, and any changes written in the patient's clinical notes, which will be discussed as part of the daily handover.
5. Where risk is identified, the management plan will address the immediate risks and the development of a specific management plan and a relapse prevention plan. Such plans will be individualised for each patient and take account of the context, opportunity, means, motivation and foreseeable consequences.
6. The Risk Assessment is linked to the level of nursing observation (see Nursing Observations section).
7. Where the nursing observation level and management plan are inconsistent with the level of risk, a clear rationale in the client record is to be provided.
8. Where possible, mental health workers undertaking the Risk Assessment will ensure patient input and where appropriate and agreed, carer participation. This is particularly important when drafting the relapse prevention plan.

In addition, Risk Assessment will be done in the following circumstances:

1. On admission, discharge and transfer between units or health facilities
2. On return from absconding
3. Significant change in clinical condition
4. Major treatment reviews, including changes to medication regime
5. Commencing and concluding seclusion episodes
6. Formal patient review meetings
7. When any discipline of the multidisciplinary team feels that a formal review of risk is required, and
8. Following collection of information from patient or carer which impacts on the level of assessed risk.

Risk assessment

A Mental Health Risk Assessment Form is used in South Australian Mental Health Services. This form will be readily available at your hospital.

The form documents:
- Risk of self harm or suicidal behaviour
- Risk of Harm to others
- Risk of Absconding
- Individual risk (including sexual disinhibition, impulsivity, intrusiveness, poor judgement, substance misuse, falls).
- Problems with functioning
- Levels of support
- Response to treatment
- Attitude and Engagement to Treatment.

Risk is classified as **None, Low, Moderate**, or **Significant/Extreme**. While these classifications are not universally agreed upon, they are useful in that they alert practitioners to a range of factors and differences.

Risk assessment guide

This risk assessment is from the Mental Health in South Australia Emergency Demand Management Policy and Procedure Series (2002) that is used by staff in mental health services. It forms part of the risk assessment, referral and follow up form developed for private practitioners. The form and the accompanying guidelines can be downloaded from the **square** CD-ROM/Website **www.square.org.au**.

Please note form continues over the following pages.

risk of harm to: ☐ **self** ☐ **others** ☐ **both**

☐ **none**	☐ **low**	☐ **moderate**	☐ **significant**	☐ **extreme**
No thoughts or action of harm.	Fleeting thoughts of harming themselves or harming others but no plans, current low alcohol or drug use.	Current thoughts/distress, past actions without intent or plans, moderate alcohol or drug use.	Current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed. Increased alcohol or drug use.	Current thoughts with expressed intentions/past history/plans. Unstable mental illness. High alcohol or drug use, intoxicated, violent to self/others, means at hand for harm to self/others.

level of problem with functioning

☐ **none/mild**	☐ **moderate**	☐ **significant impairment in one area**	☐ **serious impairment in several areas**	☐ **extreme impairment**
No more than everyday problems/slight impairment when distressed.	Moderate difficulty in social, occupational or school functioning. Reduced ability to cope unassisted.	Significant impairment in either social, occupational or school functioning.	Serious impairment in several areas such as social, occupational or school functioning	Inability to function in almost all areas.

Risk assessment guide

level of support available

☐ no problems/ highly supportive	☐ moderately supportive	☐ limited support	☐ minimal	☐ no support in all areas
Most aspects are highly supportive. Effective involvement of self, family or professional.	Variety of support available and able to help in times of need.	Few sources of help, support system has incomplete ability to participate in treatment.	Few sources of support and not motivated.	No support available.

history of response to treatment

☐ no problem/ minimal difficulties	☐ moderate response	☐ poor response	☐ minimal response	☐ no response
Most forms of treatment have been successful, or new client.	Some responses in the medium term to highly structured interventions.	Responds only in the short term with highly structured interventions.	Minimal response even in highly structured interventions.	No response to any treatment in the past.

Risk assessment guide

attitude and engagement to treatment

☐ no problem/ very constructive	☐ moderate response	☐ poor engagement	☐ minimal response	☐ no response
Accepts illness and agrees with treatment, or new client.	Variable/ ambivalent response to treatment.	Rarely accepts diagnosis.	Client never cooperates willingly.	Client has only been able to be treated in an involuntary capacity.

Is the person's risk level changeable?	**Highly Changeable**	☐ yes	☐ no
Are there factors that indicate a level of uncertainty in this risk assessment? (e.g: poor engagement, gaps or conflicting information)	**Low Assessment Confidence**	☐ yes	☐ no

overall assessment of risk

☐ none	☐ low	☐ medium	☐ high	☐ extreme

Note Risk assessment is not a precise 'science'. A form such as the one above is a valuable guide, but your professional judgement and experience are also crucial. Remember too, that a person's risk of suicide may be highly changeable, fluctuating at different times and in response to certain events.

In the **Desk Guide** and **Foundation Booklet** you will find a series of questions you can ask to ascertain where a patient is located on a spectrum of suicidal thinking and behaviour. These questions were designed by Dr Randall Long from the Flinders Medical Centre as part of a risk assessment process to assist medical practitioners.

You will find an explanation and discussion of these questions in Dr Long's **Risk Assessment** paper on the **square** CD-ROM/Website **www.square.org.au.**

Nursing observation

It is important that nursing staff implement the appropriate nursing observation categories for patients' management and safety in accordance with a risk assessment plan. More detail can be found in the document *Nursing Observation*, which will be available in your hospital.

There are four nursing observation categories that can be assigned to a patient. These categories identify presenting behaviours and provide a guide to assigning the appropriate nursing category. A patient is assigned to one of these categories on the basis of risk to self and to others. The four categories are:

Observation Category	Behaviour examples	Notes
Specialling (continuous) observation **(S)**	Intent to self harm. Suicide plans. Mental state that puts self/others at risk. Poor impulse control. Sexually inappropriate - risk to self and others high.	Most restrictive category. Continual observation.
Close observation **(C)**	Detained with evidence of risk. Anger at hospitalisation. Absconding attempts. Confusion and/or wandering.	Regular sighting recorded in client record. In open ward risk assessment 24 hourly. Observations at least every 15 minutes.
Regular observation **(R)**	Some evidence of risk. Moderate risk of absconding. Ambiguous about assurance of personal safety. Conversation/behaviour indicates some risk of harm to self/others.	At least hourly observations.
General observation **(G)**	Voluntary status, minimal risk to self/others. Able to give assurance of personal safety. Impairment related to dementia.	At least 2 hourly sightings by assigned nurse.

Guidelines for developing a management plan

- ☐ Have you ensured safety (i.e. considered supervision, removal of lethal means, backup assistance, security/police, if necessary)?
- ☐ Has the appropriate nursing observation protocol been set in place?
- ☐ Is the person able and willing to engage with treatment and support options?
- ☐ What protective factors are evident (e.g. support networks)?
- ☐ When reviewing risk assessment, consider if it is appropriate for the person to:
  - ☐ be self managed in the community on discharge
  - ☐ be managed as an out-patient, or by a GP, or in a shared care arrangement
  - ☐ be discharged back to prison and managed there and if so, in which division/prison
  - ☐ be managed in a less restrictive hospital environment
  - ☐ continue to be managed in the acute forensic facility.
- ☐ Are antidepressant, antipsychotic or other medications indicated?
- ☐ What other therapeutic interventions (such as psychotherapy) are appropriate and available?
- ☐ Is there a contingency plan to address any potential escalations of risk, and does it clearly identify appropriate and feasible roles and responsibilities?
- ☐ Is there a contingency plan to cover events such as adequate care following release on bail?
- ☐ What community support services can be utilised (alone or to supplement other interventions)?
- ☐ Has a comprehensive discharge/transfer plan been devised and thoroughly documented?
- ☐ What aftercare/longer term care arrangements can be set in place?
- ☐ Who will provide follow up and review the plan?
- ☐ Who will be responsible for ensuring that the relevant documentation is relayed to others involved in a timely manner?

A Collaborative Management Plan has been developed for private practitioners as part of this suicide prevention initiative. It is useful as a guide, referral document and record. The management plan can be downloaded from the management section of the square CD-ROM/Website www.square.org.au.

best practice for the forensic context

Hospital protocols

Hospital protocols should specify lines of responsibility and information about accessing senior clinicians for second opinion, assessment, treatment and planning. Management issues include:

- Assessing the competence of the patient in providing informed consent to treatment.
- Facilitating informed consent to treatment.
- Ensuring clinician knowledge about relevant mental health legislation.
- Ensuring 'duty of care' for patient safety during episodes of care and during transfer to other settings.
- Attending to confidentiality. (Risks to safety may mean that confidentiality cannot be preserved – but patients should be consulted about what may be told and to whom).
- Ensuring that discharge/transfer of service planning is appropriate and documented clearly.

Key practice recommendations

1. Ensure prompt access to medical care using appropriate triage procedures.
2. Ensure prompt risk assessment and maintenance of safety.
3. Ensure prompt access to psychiatric assessment.
4. Treat underlying mental disorders optimally.
5. Encourage engagement with treatment and follow-up attendance.
6. Avoid treatments that might increase the risk of self-harm.
7. Facilitate a unified team approach to discharge/transfer of care, to ensure continuity of care.

NB. The above management information has been adapted from the Summary of Australian and New Zealand Clinical Practice Guidelines for the management of adult deliberate self harm, RANZCP, 2003.

Discharge/transfer of service

Effective discharge/transfer of service planning is an essential component of providing quality patient care. Collaboration between health care workers, patients, prison medical staff and psychiatric clinics (where relevant), carers, and others in the community, ensures continuity of patient care either into the community (if nearing release) or back to prison.

Discharge/transfer of service planning should occur as a continuous and integrated process. In order to ensure continuity of care and ease of transition for the patient, a unified team approach to discharge/transfer of service planning is to be adopted, based upon each patient's individual needs, the safety of others in the prison or community, and the requirements of the criminal justice system. The patient's right to privacy, confidentiality, civil liberty and freedom of opinion is of paramount importance, and patients and significant others should always be consulted in the development of the treatment plans and out-patient treatment options.

Planning for discharge or transfer to a less restrictive environment, or alternatively back to prison, should occur frequently, every 24 hours for some patients.

A discharge/transfer of service plan should be devised and should include:

- Responsibilities and actions related to care and treatment decided by the multidisciplinary team.
- A recent Risk Assessment and a Risk Management Strategy which is understood by the patient, carers and, if relevant, prison staff.
- A documented plan for care and treatment identifying who is responsible for specified actions, and the time frame for formal review.
- A summary of the goals of admission and what has been achieved.
- A description of possible signs of relapse and the completion of a Relapse Prevention Plan.
- Evidence of any communication between the in-patient team and prison health or community service providers (e.g. prison medical staff or a GP) and the role they will play in the next stage of treatment.
- Documentation of illness symptoms or behavioural issues present at the time of discharge/transfer and recommended strategies to manage these.
- Documentation of potential barriers to a successful reintegration within the prison or community and strategies for addressing these.
- A discharge summary is to be completed and forwarded within 24 hours of discharge or transfer to: the patient's GP (if they have one) or other relevant service providers or significant others; community mental health service (some patients have an identified community mental health team); or if relevant, to prison medical staff.

[The above has been summarised from the SA Discharge/Transfer of Service Policy, MHCLPR2100].

More detailed patient discharge procedures, checklists and specific forms are provided in your forensic mental health setting.

support and self care

Self care is typically not given much emphasis in health worker training and consequently health workers in forensic mental health settings may not take sufficient time out to deal with their own stress or grief. Yet there are proactive ways in which practitioners may engage in self care to prevent burnout or other long term negative effects. Common stressors within the forensic mental health setting are:

- Understaffing/high client load/inadequate mental health resources
- Constantly having to make critical decisions
- High levels of emotional interaction with clients
- The litigious context within which health care operates (Gundersen, 2001).

Forensic mental health staff are working constantly with clients in crisis, and often with patients whose behaviour is challenging. This can contribute to feelings of negativity and cynicism, and sometimes to high levels of drug and alcohol use, relationship problems and mental health problems.

> People who self-harm may reject help from health professionals and many do not keep appointments. Others may be rejected by health professionals and may not find health services helpful. Dysfunctional coping styles and chaotic ways of seeking help can induce negative attitudes in clinicians. Those who regularly work with [self harming] patients need appropriate strategies for their own support, including supervision, peer discussion and specific training to manage patients. Inexperienced clinicians need to discuss and understand their own reactions… Health services should consider training their staff in the management of [self harming] patients (RANZCP, 2004, p.873).

Some reminders

- Remember that while you can assess the risk of suicide, you cannot always prevent it. Don't blame yourself if you have taken every reasonable precaution.
- It's OK to admit you don't know. Seek assistance from others with specific knowledge and experience.
- De-brief with a skilled colleague after a critical incident or seek trauma support.
- While maximising safety in the hospital must always be a short term priority, in the longer term supporting patients to develop their own skills may be the best strategy.
- Reflective thinking is integral to self care.
- Review your own needs with the same seriousness as you review patient needs, and seek help if necessary.

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