community mental health setting

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

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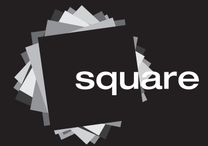
## An education resource for primary health care, specialist and community settings

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** **s**uicide **qu**estions **a**nswers **re**sources 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, **Community Mental Health Setting**, is aimed at nursing, medical and allied health workers in community mental health services, 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 8 other 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

**The role of Community Mental Health Services**

Responding to the wide range and complexity of mental health issues in South Australia requires a collaborative response across sectors and across the community. Community Mental Health Services have a specific role to play. Their broad and intensive responsibility creates a complex and demanding context within which individual workers and teams work. Community Mental Health Services workers necessarily have to respond to suicide and self harm prevention as a regular part of their work.

The general community member, family members and health workers who are not skilled in mental health work often feel challenged and unsure about responding to someone who is experiencing acute symptoms of mental distress or illness. In addition, social perceptions of mental illness and the stigma that surrounds it, can contribute to the notion that only experts are able to respond effectively. These issues add to a heavy demand on community mental health services.

These services respond to immediate situations and there is a need to be especially vigilant about assessment of suicide risk. This is an essential and high level skill because suicide may not be an obvious or presenting issue.

A key role is to triage mental health needs, setting in place the most relevant pathways of support according to current mental health policies – and in particular, to identify situations where there is a danger to the person or to others.

A key to systemic coherence lies in establishing a management plan that matches the person's changing needs at different times and recognising that a high degree of changeability is likely. Such a plan needs to involve the person, families/carers, and relevant hospital and primary health workers.

Documentation of management plans, including any relevant information (for example, particular fears or preferences of the client), needs to be completed and be available for others involved in the person's care. Where possible confidentiality must be respected. However, where there is a danger of risk to self or others appropriate information must be passed on.

Emergency demand management entails not only effective triage and appropriate referral to services, but also networks of good communication with services, with clients, primary health care workers, and significant people in the person's life. In this way an alliance of care can be established that demonstrates best practice in the care of people who are experiencing a mental health crisis.

## 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. Currently, males aged 30-34 years demonstrate the greatest risk of suicide.

- In the 1997 National Survey of Mental Health and Wellbeing, 3.5% of respondents aged 18 and over reported suicidal thoughts in the previous 12 months, and about 12% of that group also reported having made a suicide attempt (Pirkis et al., 2000).

- 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.

- The majority of suicide attempts are thought to go undetected, with only an estimated 5% to 30% of suicide attempts resulting in admission to hospital (Health Department WA, 2000)

- Most people who contact health services after a suicide attempt are seen by Emergency Departments. They may or may not be admitted as hospital in-patients, and the injury may or may not be recorded as intentional. Statistics therefore vary greatly between hospitals.

- ACIS often plays a central role in referral and management planning of these patients.

- 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.

- Domestic violence is a contributing factor in suicide, yet up to 70% of female domestic violence victims may not be detected by hospitals. (Sherrard et al., 1994). Childhood physical and sexual abuse are also contributing factors in suicidal ideation and behaviour.

- In a WA study, people discharged from hospital after deliberate self-harm were found to be over three times more likely to die, and over 20 times more likely to suicide, than the general population.
  (Health Department WA, 2000).

# the range of mental health services

**Community based services and teams**

- **Assessment and Crisis Intervention Service (ACIS)** provides a single point of first contact and is available 24 hours and 7 days a week. Referrals are accepted from any source.
- **Mobile Assertive Care Service** provides intensive and medium term support to people with a severe and chronically disabling mental health illness or disorder.
- **Community Treatment teams** provide a multidisciplinary case management consultancy service with an emphasis on assisting people to develop skills in self care and independent living in their own environment.
- **Mental health workers** include mental health nurses, psychologists, social workers, occupational therapists and psychiatrists.
- **Emergency Triage Liaison Service (ETLS)** provides (for people living in rural areas) a team of mental health nurses, a social worker and psychiatrists to offer telephone support and guidance to GPs and other health care workers, consumers and the community.

**Hospital in-patient services**

- **Consultation Liaison Psychiatry** provides assessment, consultation and referral for patients of the Emergency Department.
- **Acute in-patient units** provide care for people requiring hospitalisation. They operate 24 hours a day and care is provided by a multidisciplinary team.
- **Secure/extended care in-patient services** provide safe supportive care for people with a serious mental illness whose behaviours may put themselves or others at risk.

**Private practices**

- **General Practitioners** usually work in the private sector but also form a vital part of the public mental health system. They are often the first point of call for people with mental health concerns. Patients who have been treated and discharged from mental health services, are usually discharged into the care of a GP.
- The most common way of seeing a private psychiatrist is through a General Practitioner's referral. Some psychiatrists specialise in working with particular groups or with specific therapies.
- Private psychiatrists and GPs may work together as part of a community team in assisting skill development and independent living.

## Assessment and crisis intervention services (ACIS)

**A 'mental health crisis situation' refers to:**

A series of events and a combination of circumstances in which a person appears to be mentally disturbed, or impaired in judgment and/or exhibiting highly disordered behaviour. It is a situation that requires communication and coordination between relevant services and assessment at the earliest possible point to:

- ascertain the need for treatment
- prevent further deterioration in the mental condition and/or physical health of the person; and
- thereby **prevent or lessen harm to the safety and health of the person or any other person** or to the safety and health of the public in general.

By emphasising the need to identify and respond to the warning signs of an unfolding crisis, an approach consistent with the United Nations Principles for the Protection of People with Mental Illness and with the Australian National Standards for Mental Health Services is advocated. [National Mental Health Strategy, 2000].

ACIS is central to emergency demand management. Their services are available seven days a week and twenty four hours a day. ACIS comprises teams in the metropolitan area and the Rural and Remote Emergency Triage and Liaison Service (R&R ET&LS). ACIS has been established to provide a reliable, efficient and expert access point for all people requiring assistance for mental health issues.

ACIS is responsible for achieving good outcomes in emergency mental health management and crisis intervention. It has an assessment function for emergency and acute crisis management. In addition, it has a liaison and networking capacity within mental health services, and with other professionals and agencies who may be involved - as well as with care givers and families.

The core business of ACIS is emergency mental health care, regardless of any co-existing issues at initial presentation. ACIS is the interface between the community, private and public health and mental health systems. Primary aims of ACIS are to provide accurate and expert triage, clear identification of risk at the time of assessment for every person referred and optimum clinical intervention.

# assessment and management of suicide risk

While Community Mental Health staff will not be involved in all stages of this suicide prevention and management cycle, it is important that they are aware of the overall service delivery in which their involvement is located.

- **Engage with person's feelings and experiences**
- **Ask questions about suicidal thoughts or plans**
- **Be non-judgemental and respectful**

↓

**Assess risk** level and initiate a **management plan**

↓

If **LOW**, eg. **fleeting thoughts of self harm or suicide, but no past actions, current plan or immediate means**, low drug and alcohol use, little functional impairment and some positive options and relationships:

- Discuss support options and how to engage them
- Consider self management as an option
- Identify relevant community resources and provide contact details
- **Make review appointment.**

If **MODERATE**, eg. depression, grief or loss, feelings of hopelessness, **suicidal thoughts with past actions but no current clear intent, plans or immediate means,** moderate functional impairment, social isolation, drug and alcohol misuse (but not out of control):

- **Attend to immediate safety**
- Ask about significant others regarding support
- Decide on appropriate care
  - Management by GP?
  - Referral to or opinion from psychiatrist?
  - Involve mental health services? (eg. emergency or community team)
- Contact relevant people/services
- **Follow up.**

If **SIGNIFICANT/EXTREME**, eg. continual, specific suicidal thoughts, intent, plans and means, significant past actions, mental illness, despair, significant functional impairment and social isolation, drug and alcohol misuse:

- **Attend to immediate safety. Don't let the person leave until a safety strategy is in place.**
- Ask about significant others regarding support
- Decide on appropriate care and make immediate referral to
  - Emergency Mental Health Services, or
  - Specialist practitioner (e.g. psychiatrist)
- **Follow up.**

*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.*

## Guidelines for developing a management plan

A management plan is necessary to assist a person throughout a period of distress and/or recovery.
It should include:

- **The most appropriate options for the person's immediate needs and safety – also considering the safety of others.** This involves risk assessment, planning appropriate supervision, safety (including detaining), referral and treatment options.
- **The ongoing and changing needs of the person and the most effective options to address them.** This involves ensuring that the person's needs are clarified and planned for in an ongoing and negotiated way. The plan should reflect an appropriate range of options and these options should be relevant to needs as they arise.
- **The most meaningful way in which to monitor progress and adapt plans accordingly.** This involves regular evaluation of the relevance and efficacy of the care plan with the person for whom it was designed.

Roles and responsibilities of everyone involved in the management plan must be clear and agreed. This may involve communication between several agencies and/or individuals who are significant to the person.

## Guidlines for developing a management plan

☐ Ensure safety (supervision, removal of lethal means, backup assistance, security/police, if necessary)?

☐ 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
- ☐ be managed as an out-patient, by a GP, or in a shared care arrangement
- ☐ be managed in the short term in an Emergency Department or with specialist case management
- ☐ be admitted into specialist in-patient care – (including detention).

☐ Are antidepressants or other medications indicated?

☐ What other therapeutic interventions (such as counselling, psychotherapy) are appropriate and available?

☐ Is referral to a specialist mental health service/ward a desirable option?

☐ Contingency plan to address any potential escalations of risk

☐ What community support services can be utilised (alone or to supplement other interventions)?

☐ What longer term management arrangements can be set in place?

☐ Who will provide follow up and review the plan?

☐ Responsibility for ensuring that the relevant documentation is relayed in a timely manner to others involved.

**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

**The Mental Health Emergency Demand Management SA Policy includes the following best practice principles** (Adapted from Policy EDM P8-02)

**The Emergency Mental Health team will:**

- Be committed to person to person communication which may occur in a variety of settings (e.g. home, GP rooms, Emergency Department). Wherever possible assessments will be conducted face to face – but other technologies may be used where this is not possible.

- Ensure that every presentation receives a culturally appropriate comprehensive clinical assessment, by an appropriately qualified health worker within an agreed time frame (see **Risk Assessment Paper** on the **square** CD-ROM/Website **www.square.org.au**).

- Be focussed on client outcomes by ensuring that interventions are matched to needs. Each client will have an individual management plan within their record, which documents history, assessment, medical investigation, diagnosis, treatment, support required and follow up details.

- Have systems that ensure information is shared effectively with other care providers in a timely way to ensure continuity of care.

- Provide consumers and/or family and support workers with information about mental illness and services available within the community (this requires staff to be informed about issues and available options).

- Deliver reliable, consistent services, regardless of location or consumer characteristics (See the section on Stigma in the **Foundations booklet** and the **Management paper** on the **square** CD-ROM/Website **www.square.org.au**).

- Ensure evidence based assessment and treatment approaches.

- Ensure a safe environment.

- Ensure all staff have access to frequent and up to date training in assessment and management.

## Minimum standards

**The Mental Health Emergency Demand Management SA Policy includes the following minimum standards**
(Adapted from Policy EDM P8-02)

- Every telephone call will be answered promptly, will not be answered with a recorded message and will not ring out.
- Every health worker providing mental health assessments will have training in use of the relevant tools.
- Where further intervention is not clinically indicated, information and/or referral to the most appropriate agency to assist with the presenting problem will be provided.
- All clinical contacts will be recorded.
- Risk assessment will be linked to clinical prioritisation.
- An Action Plan will be documented that identifies individuals responsible for action/intervention (and individuals named have agreed to this).
- Every confirmed or likely mental health emergency will receive a comprehensive assessment (inclusive of cultural factors) and immediate Management Plan. Assessment tools should not replace clinical judgement and consultation (See **Risk Assessment Paper** on the **square** CD-ROM/Website **www.square.org.au**).
- In the event of competing clinical priorities the situation will immediately be referred to the Team Leader or delegate.
- The outcome of all emergency interventions will be identified by ACIS, through consumer tracking services and there will be targeted follow up.
- Every GP who refers for a comprehensive assessment will receive a summary of the assessment, Management Plan and decision about treatment and management by the day following the assessment.
- If a GP is not satisfied with an assessment, they will be provided with a second senior clinical opinion.
- The principles of customer service will be adopted by frontline clinical staff in all contacts.
- Each service is responsible for developing processes to ensure standards are achieved.
- Clinicians will have access to an up to date service directory.

It is important to ensure that the services delivered meet the standards that are set and to monitor and address any contraventions of these standards.

## Best practice in relation to suicidal ideation and behaviour

The standards previously outlined indicate the practices required to ensure that mental health services are operating effectively at all levels of its operation. In relation to suicide it is particularly important to emphasise the role of high quality engagement at point of contact (see **Engagement Paper** and the **Foundations booklet** on the **square** CD-ROM/Website **www.square.org.au**).

Engaging with a person empathically is a protective factor in itself. It can allow the person to process their thoughts and feelings in ways which may be helpful to them – as well as providing useful information upon which an initial assessment may be made. Engagement needs to be systematic. However, it should not become a mechanical process. Individuals usually know when the person speaking with them is open, concerned, respectful and genuine in their willingness to assist. In spite of the pressures of the role, it is important that clients experience a supportive interaction.

It is crucial that people do not become lost within systems. Mental health disorders notoriously separate people from support networks, and so it is especially important to protect and strengthen existing supports and to build on potential options for additional supports within the community.

Suicidal ideation and behaviour cannot be defined as a ‘clinical disorder’. It needs to be understood within a psychosocial context. It is often the result of multiple factors, which may include: alcohol and drug misuse, unemployment, sexual abuse or assault, family violence, chronic illness, or a significant loss or separation. It is important to maintain high awareness about the potential for suicide in relation to social circumstances – as well as clinical evidence.

It is important to be clear about your own options for seeking advice. Find out who to contact for a second opinion about your own assessments and who the appropriate people are to speak to about your own practice dilemmas. Be alert to the possibility of becoming desensitised by the intensity and demands of the work. Self protection strategies are vital, but ensure they are not counterproductive to the clients’ needs and circumstances.

Given the complexity of issues, it is vital to build confidence in your own practice and judgements. Protocols and assessment tools are valuable and necessary in conjunction with your professional judgement. Similarly, building knowledge of community initiatives and options and communicating with those who facilitate them, can develop a repertoire of support and referral possibilities.

## Challenges

- Sustaining high quality client interactions in spite of high demand on services.
- Fulfilling documentation requirements without compromising personal input, engagement or management.
- Being mindful of suicide risk at the same time as dealing with immediate issues.
- Establishing and sustaining holistic approaches in a diverse arena.
- Providing an individualised and authentic response to each client.
- Ensuring that management outcomes are the best possible available for each individual.
- Responding calmly and effectively in the face of challenging, unusual or confusing behaviour.
- Developing productive professional alliances and networks.
- Taking care of your own physical and mental health to sustain and enhance your professional work role.
- Keeping up to date with initiatives and relevant research about self harm and suicide risk.
- Demonstrating leadership in the community in best practice for suicide risk management.

All of the above issues relate to good individual practice and a strong workplace ethos. All of the issues are relevant to staff development strategies and planning.

## consumer issues

An acute episode is a bewildering and frightening time for people, and behaviours can be challenging. It is important to respond with calm and respect – especially, perhaps, when you feel overly tested by a particular client. In talking to consumers of services during the development of this resource, a recurring theme was about how individual health workers had interacted with them. Where this had been positive it was remembered as being extremely important. Often, what was remembered was one simple interaction. As Mick explained:

> I don't remember much [about hospital experience after suicide attempt]. Yeah I was off [medications] I was gone… way into the zone… but I do remember this bloke saying 'It's OK mate, it's going to be OK'. I do remember that. [Mick, interviewed for this resource, Adelaide 2005]

Sometimes, an episode of mental illness can produce a crisis for family and friends who are attempting to assist the person who is unwell. This can create a situation where crisis is being met with crisis and the client's needs may become overridden.

For health workers, the pressures will be different, but they may still experience a negative response or a particular client's needs as extremely stressful. Pressures on a worker can include: time pressures, frustration, or dealing with behaviours and demands that are tiring and perhaps even irritating. In spite of these realities, it is vital to keep in mind that the client is still in need and could be at risk of suicide. It is important to maintain compassion and best practice responses, especially those of empathic engagement. This in itself can be a potent positive intervention. And, it can also assist the health worker to develop a different perspective on the situation.

One of the most consistent messages from consumers of Community Mental Health Services was that even though they might be 'difficult' or behaving strangely when unwell, they were still very aware of whether they were being treated with respect and sensitivity – it made a difference and one that they remembered. Mick (above) put it this way:

> Some of them [workers] are the real deal and they do a bloody hard job, I know that. But there are some who need to know that crazies are still real human beings you know? It's not like we don't know how we're being treated or like we don't care!
> [Mick, interviewed for this resource, Adelaide 2005]

## support and self care

Self care is typically not given much emphasis in health worker training, and consequently health workers in the community mental health setting 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 community mental health setting are:

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

Mental Health workers are often dealing with clients in crisis and whose behaviour maybe 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.
- It’s OK to admit you don’t know. Seek assistance from others with specific knowledge and experience.
- Be aware of your agency’s procedures and protocols in relation to critical incident debriefing and staff support.
- Debrief with a skilled colleague after a critical incident or join a support group for trauma support.
- While maximising safety 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 client needs, and seek help if necessary.

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**for further information**
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