

mental health in-patient setting



square

suicide **qu**estions **an**swers **re**sources

ERISUPPS

square suicide questions answers resources

mental health in-patient setting

ISBN 0 9752419 6 6

© Commonwealth of Australia 2007

Jointly funded by the Australian Government and the Government of South Australia

The opinions expressed in this document do not necessarily reflect those of the Commonwealth or indicate a commitment to a particular course of action.

Health professionals should note that the information contained in this document is not a substitute for, and is not intended to replace, formal education and training in the subject area or to be used as a clinical tool. All users should note that the information in this document is not intended to be used to diagnose, treat, cure or prevent any disease, nor should it be used as a substitute for a health professional's advice.

The Commonwealth does not accept any liability for any injury, loss or damage incurred by use of or reliance on the information in this document.

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.

contents

how to use this resource	4
1 introduction	5
2 suicide risk assessment and management	11
3 best practice for the mental health in-patient setting	20
4 consumer issues	22
5 support and self care for the mental health worker	23
6 references	24



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, **Mental Health In-patient Setting**, is aimed at nursing, medical and allied health staff working in specialist 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 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 working in specialist mental health hospital settings. These people include nurses, allied health workers and medical practitioners, including psychiatric consultants and other specialists, whose responsibilities include working with in-patients at high risk of self harm or suicide.

Specialist mental health hospital settings, also known as psychiatric in-patient facilities, may include wards or units within generalist hospitals or those within psychiatric hospitals themselves. Individuals treated in such specialist settings are frequently admitted in acute or crisis states and the risk of suicide or other form of self harming behaviour may be particularly high or, indeed, the principal reason for admission.

Like their community based counterparts, the staff of mental health in-patient settings draw upon a multidisciplinary team approach and best practice mental health nursing principles and practice. They employ a variety of psychotherapeutic and pharmacological interventions for the range of mental health problems that may be presented.

Therapeutic and other psychosocial goals are determined in collaboration with the in-patients and their families or carers, wherever possible. The aim is to discharge to the community, individuals who are no longer demonstrating acute symptoms of mental illness, who have gained some confidence and skills in managing their condition and in general problem solving, and who have commenced the recovery and rehabilitation process.

Prior to and following discharge the staff work closely with specialist community based mental health teams and, frequently, with other relevant government and non-government agencies in mental health and related areas such as accommodation, family support and work rehabilitation services, in accordance with the principles of shared care.

The development of these partnerships across the continuum of care is essential for integrated and effective long term care and a seamless transition between services and agencies. Ongoing, shared care serves to consolidate the therapeutic and other gains attained during the in-patient stay, further contributing to the prevention of relapse and, in particular, self harm and suicide.

Key facts

- Depression was the leading cause of disability and the 4th leading contributor to the global burden of disease in 2000. It is projected to reach 2nd place by the year 2020.
- Self harm and suicidal behaviour are observed across all age groups and in people from all walks of life.
- Currently, males aged 30-34 years demonstrate the greatest risk of suicide.
- Admissions to hospital for intentional self harm are about 10 times the rate of deaths due to suicide.
- The hospitalisation rate of females who attempt suicide is consistently higher than that for males.
- Most people who die by suicide have a mental disorder at the time of their death and up to a third have had recent contact with mental health services (Foster, Gillespie, & McLelland (1997)

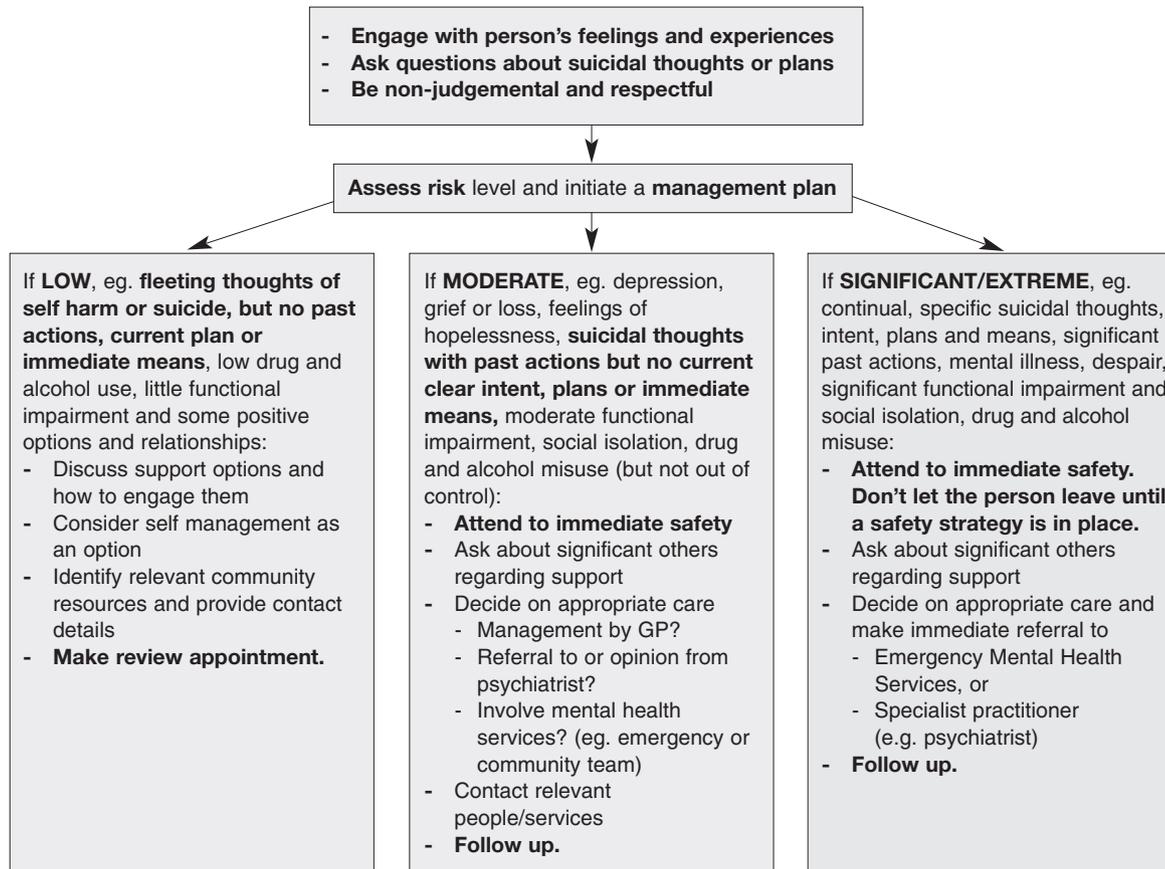
Suicide and the mental health in-patient setting

Staff in mental health in-patient settings should familiarise themselves with the issues listed below, some of which are discussed in greater detail in this and other parts of the **square resource:**

- A high rate of substance abuse co-morbidity is often seen among those admitted to specialist mental health in-patient settings which may greatly exacerbate the likelihood of self harm or suicide through ongoing disinhibition or problems with withdrawal.
- Being in a secure hospital facility does not necessarily protect a patient against suicidal behaviour.
- The clinical research literature demonstrates that the week following admission to a specialist in-patient mental health setting constitutes a critical period, the first of two peaks over the continuum of care, for increased risk of suicide and self harm.
- The commonality of suicidal and self harming behaviour in the in-patient mental health setting demands that staff are fully trained and competent in the assessment of risk, local policies and procedures and in implementing timely and effective responses.
- Management plans governing intervention for underlying disorders while in an in-patient mental health setting must take into account the ongoing risk of self harm and suicidal behaviour.
- A comprehensive management plan will have collaboration with the patient as its central focus in setting and monitoring therapeutic goals.
- Comprehensive management will also draw upon a multidisciplinary approach and shared care principles, ensuring partnership and collaboration with potential internal and external sources of support.
- Management plans must take into account the needs of the in-patient's transition to other forms of support.
- Prevalence of relapse in this population and the demonstrated second peak of elevated suicide risk in the week following discharge necessitates careful post-discharge planning, with well established and agreed goals, support processes and seamless transition along the continuum of care.
- Research literature suggests risk of suicide and self harm following discharge may be ameliorated greatly if an empathic and supportive connection has been established during the in-patient period.
- The risk of attempted suicide in acute psychiatric units has been estimated at over 50 times the risk in the general population.
- There is an inevitable tension between non-coercive, open (non-locked) community interactive treatment settings and the need for supervision of those at risk

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 mental health in-patient 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 suicide prevention role of mental health in-patient staff

Suicide prevention is a whole of community responsibility and the best interventions will be collaborative ones. Health workers in specialist in-patient mental health settings have crucial roles and responsibilities in this collaborative enterprise and are on the frontline of reconciling the complex issues of safety (staff and consumers), supervision and therapeutic support, often with patients who are at very high risk of harming themselves or others and who may exhibit extremely challenging behaviours.

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

- the importance of engaging effectively with patients
- maximising safety and implementing appropriate interventions to minimise risk
- knowledge of the risk factors for suicide and self harm
- knowledge of the factors that confer protection against risk and promote overall resilience
- familiarity with the processes involved in assessing risk in a timely manner
- knowledge of and ability to implement appropriate interventions to minimise risk and maximise safety
- awareness of the circumstances in which specialist or other services need to be involved
- familiarity with discharge procedures and follow up arrangements to ensure continuity of care
- awareness of available community support options and post-discharge therapeutic interventions.

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

Engaging effectively with 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 a specialist in-patient mental health 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. Staff therefore need **a high awareness of suicidal ideation and behaviour**.
- Many of those admitted to specialist in-patient mental health settings have a dual diagnosis (e.g. co-morbidity of mental illness, drug and alcohol misuse, gambling problems and/or intellectual disability). These people have often been unable to access appropriate treatment for their mental health or other psychosocial problems and may be difficult to engage and treat because of their higher levels of physical, social, psychological and cognitive impairment.
- Responding appropriately to someone who may be at risk of suicidal behaviour is the fundamental first step 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 way, 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 specialist in-patient mental settings engage with the in-patient 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 **Foundations booklet** and the **Risk Assessment** paper on the CD-ROM/Website).
- Remember that support is available to you (e.g. from your supervisor) as well as to the person in question. In some contexts, reporting your concerns might be the end of your involvement. In others you may be involved in a shared care partnership with other clinical and non-clinical professionals.

suicide risk assessment and management



The following sections contain information and tools that may assist in the assessment and management of individuals in the specialist in-patient mental health setting.

Risk assessment

The specialist in-patient mental health setting 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 involved in-patient care.
- 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 always 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** and 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 conducting 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 Significant change in clinical condition
- 3 Major treatment reviews including changes to medication regime
- 4 Formal patient review meetings
- 5 When any discipline of the multidisciplinary team feels that a formal review of risk is required, and
- 6 Following collection of information from patient or carer which affects the level of assessed risk.

Risk assessment forms

A Suicide Risk Assessment form, that complements the one in use in mental health services settings, is provided on the **square** CD-ROM/Website www.square.org.au for private practitioners. Copies could be downloaded and made available in the specialist in-patient mental health setting. A form may already have been generated where individuals have been referred by General Practitioners or Community Mental health teams through Emergency Departments.

Further, a **Mental Health Risk Assessment Form is used in South Australian Mental Health Services**. This form should be readily available and used by staff in the specialist in-patient mental health setting.

The **Mental Health Risk Assessment Form** should document:

- 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
- Engagement with 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

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> moderate	<input type="checkbox"/> significant	<input type="checkbox"/> 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

<input type="checkbox"/> none/mild	<input type="checkbox"/> moderate	<input type="checkbox"/> significant impairment in one area	<input type="checkbox"/> serious impairment in several areas	<input type="checkbox"/> 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

<input type="checkbox"/> no problems/ highly supportive	<input type="checkbox"/> moderately supportive	<input type="checkbox"/> limited support	<input type="checkbox"/> minimal	<input type="checkbox"/> 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

<input type="checkbox"/> no problem/ minimal difficulties	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor response	<input type="checkbox"/> minimal response	<input type="checkbox"/> 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

<input type="checkbox"/> no problem/ very constructive	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor engagement	<input type="checkbox"/> minimal response	<input type="checkbox"/> 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

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> medium	<input type="checkbox"/> high	<input type="checkbox"/> extreme
-------------------------------	------------------------------	---------------------------------	-------------------------------	----------------------------------

In the **Desk Guide** and **Foundations 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.

For more information about each of the categories in this form and specific questions which can be asked of patients, see the **Foundations booklet** and the **Risk Assessment paper** on the CD-ROM/Website.

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.

Patient Multidisciplinary Action Plan

The specialist in-patient mental health setting involves a multidisciplinary team approach in which members of the team work together with the patient to create an individual plan of coordinated actions which aims to facilitate patient recovery and a smooth transition to the next phase on the continuum of care. The plan must be regularly reviewed with both patients and carers (according to unit policy) and be available to them.

The multidisciplinary 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.

The Multidisciplinary Action Plan should include the components described in the following table. It may be useful to develop a checklist for use in the in-patient mental health setting to guide the development of individual Action Plans.

Domains	Refers to
1. Risk identification	Priority areas of concern re risky behaviours e.g. aggression toward others; harm to self; damage to property; non-compliance; vulnerability; substance misuse; absconding.
2. Psychopathology and symptoms	Management of mental state, symptoms; illness behaviour (includes psycho-education); current and previous response to therapeutic intervention; 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. Psychosocial issues	Relevant current and historical psychosocial issues. e.g. trauma; loss; stress; motivation; problem solving; social skills.
6. Family inclusion	Issues which may influence care and treatment outcome. These include: relationship with family members; children; support systems.
7. Cultural issues	Issues which may influence care and treatment outcome (includes 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.

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. 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.

* Please note that the categories presented here are not the only ones possible (for example, local unit policy may indicate R30 and R60 observations – regular 30 or 60 minute observations, to provide an intermediate step from 15 min observations to regular 60 min observations). These are **the minimum standards** – not the only standards.

Guidelines for 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, and if so, where
 - be managed in a less restrictive environment
 - continue to be managed in the acute 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 discharge?
- 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 mental health in-patient setting

In-patient mental health setting protocols

Specialist in-patient mental health setting 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. Treat underlying mental disorders optimally.
4. Encourage engagement with treatment.
5. Encourage 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 management information provided above 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

A comprehensive planning process for discharge/transfer of service is integral to providing high quality patient care. The effectiveness of the transition process is greatly enhanced through a holistic approach to the psychosocial needs of the individual being discharged, and/or transferred, and by the development of effective working partnerships between clinicians and others who will be involved in short and long term care. Collaboration between health care workers, patients, mental or community health units, carers, GPs and others in the community, makes more likely seamless continuity of care throughout the recovery process.

Discharge/transfer of service planning should be continuous and integrated, reflected in a cohesive team approach based upon therapeutic and broader psychosocial need, and the safety of the individual and of others in the in-patient mental health setting and in the community. However, the right to privacy, confidentiality, civil liberty and freedom of opinion of individuals is also of paramount importance, and they and their significant others should always be consulted in the development of management plans, including discharge plans.

Planning for discharge or transfer to a less restrictive environment 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 the management strategy developed by the multidisciplinary team.
- A recent **Risk Assessment and Risk Management Strategy** which is understood by both patients and carers.
- A documented plan for management of mental health problems, including risk, which identifies 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**.
- 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 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).
- Evidence of any communication between the in-patient mental health team and community service providers (e.g. GP) and the agreed roles and responsibilities for the next stage of treatment, including contingencies for any problems that may arise.

The material above was summarised from the SA Mental Health Service Discharge/Transfer of Service Policy, MHCLPR2100.

More detailed or additional patient discharge procedures, checklists, forms or other requirements may be provided in your specialist in-patient mental health setting.



Just being in hospital...you felt powerless and you didn't have a sense of control over what you were doing. And I think when you take that away from people, you actually demean them and you actually make them act in ways which are powerless...I sometimes felt that [it] was a gross inconvenience on the medical system that they had to look after me.....I think ... we want people to behave in certain ways in hospitals and that's to sit quietly and be compliant.

[Diane, Adelaide 2005]

The comment above reflects the experience and feelings of a consumer in an in-patient setting, following a suicide attempt. It highlights the vulnerability of individuals in such circumstances and their heightened awareness of, and sensitivity to, the demands of a standard hospital environment and its routines. It illustrates the need for in-patient staff in generalist and specialist settings to be aware of the profound effect of what may be regarded as standard procedures and communications within such environments during such a critical time.

Although the quote above specifically refers to a consumer's experience in a generalist hospital setting, it is important to recognise that those admitted to specialist in-patient mental health settings may encounter similar routines and feel confused, ashamed, guilty, or disoriented, despite the best intentions of staff. This may particularly be the case for the individual who has never experienced such processes or facilities before, especially young people in a first episode of psychosis.

There is a wealth of information to suggest that the responses of all such individuals admitted to specialist in-patient settings may vary from shock and bewilderment to fear and trauma, necessitating empathic and sensitive management of the admission process to avoid long term adverse consequences.

An individual worker's response to each admission will be influenced by many factors, including personal issues, level of comfort with particular diagnoses and (risky) behaviours and work-related pressures, such as demands upon their time and fatigue. Despite these realities, it is important to recognise one's own vulnerabilities and responses under such circumstances. Feedback from consumers suggests that negative responses may be communicated, albeit subconsciously. However, the patient could be at risk of further acts of self harm, suicide or other risky behaviour and very much in need of effective assessment and compassionate and empathic engagement. It is therefore useful to reflect upon such responses and to address them in clinical supervision or peer support settings, wherever possible.



support and self care for the mental health worker

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

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

Mental health staff are working constantly with individuals in crisis and often with patients whose behaviour is extremely challenging. This can contribute to feelings of negativity and cynicism, and sometimes to high levels of their own risky behaviours, such as drug and alcohol misuse, 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.
- De-brief with a skilled colleague after a critical incident or join a support group for 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.



references

- Appelby, L., Dennehy, J.A., Thomas, C.S. (1999) 'Aftercare and clinical characteristics of people with mental illness who commit suicide: a case control study'. *Lancet*, 353, 1397-1400.
- Australian Bureau of Statistics (2004) *Suicides: Recent Trends Australia*, <http://www.abs.gov.au/Ausstats/abs@.nsf/0/a61b65ae88ebf976ca256def00724cde?OpenDocument>
- Dalton, V. (1999) 'Suicide in Prison 1980 to 1998: National Overview', Australian Institute of Criminology, *Trends & Issues in Crime and Criminal Justice*, August 1999.
- Dirk, M., Dhossche DM, Ulusarac A & Syed W. (2001) 'A retrospective study of general hospital patients who commit suicide shortly after being discharged from the hospital'. *Arch Intern Med*. Apr 9;161(7):991-4.
- Fernando, S. & Storm, V. (1984) Suicide among psychiatric patients of a district general hospital. *Psychological Medicine*, 14, 661-72
- Foster, T., Gillespie, K. & McLelland, R. (1997) Mental Disorders and Suicide in Northern Ireland. *British Journal of Psychiatry*, 170, 447-452
- Gundersen, L. (2001) 'Physician burnout', *Annals of Internal Medicine*, 1135: 145-148.
- Health Department of Western Australia (2000) 'Hospitalisation as a Consequence of Deliberate Self-harm in Western Australia, 1981-1998', *Epidemiology Occasional Paper 11*, March 2000, Health Information Centre.
- Henderson, S. (2003) 'Mental Illness and the Criminal Justice System', Mental Health Co-ordinating Council, May 2003. http://www.mhcc.org.au/projects/Criminal_Justice/PosPaper%20CrimJustice%20May03.pdf
- Lawrence D, Holman CD, Jablensky AV, Fuller SA, Stoney AJ. (2001) 'Increasing rates of suicide in Western Australian psychiatric patients: a record linkage study'. *Acta Psychiatrica Scandinavica*. Dec;104(6):443-51.
- Martin, G., Clark, S., Beckinsdale, P., Stacy, K. & Skene, C. (1997) *Keep yourself alive*. Adelaide: Foundation Studios.
- McArthur M., Camilleri, P. & Webb, H. (1999) 'Strategies for Managing Suicide & Self Harm in Prisons', Australian Institute of Criminology, *Trends & Issues in Crime and Criminal Justice*, August 1999.
- MHCC (no date) Mental Health Coordinating Council, Fact Sheet 1: *Criminal Justice and Mental Health* http://www.mhcc.org.au/factsheets/factsheet1_Criminal_justice.htm
- Pirkis, J., Burgess, P., & Dunt, D. (2000) 'Suicidal ideation and suicide attempts among Australian adults'. *Crisis* 2000; 21:16-25.
- Qin P. & Nordentoft M. (2005) 'Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers'. *Arch Gen Psychiatry*. Apr;62(4):427-32.
- RANZCP (2003) 'Summary of Australian and New Zealand Clinical Practice Guidelines for the management of adult deliberate self harm', *Australasian Psychiatry*, 11, 2 June 2003.
- RANZCP (2004) Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Deliberate Self-harm, *Australian and New Zealand Journal of Psychiatry*, 38:868-884 <http://www.ranzcp.org/pdf/files/cpgs/Clinician%20version%20full%20DSH.pdf>
- Sherrard, J., Ozanne-Smith, J., Brumen, I., V. Routley, V. & Williams, F. (1994) 'Domestic Violence: Patterns and Indicators', *Monash University Accident Research Centre - Report #63*.
- World Health Organization (2006) http://www.who.int/mental_health/management/depression/definition/en/

for further information
www.square.org.au

ERISUPPS