

29th November, 2002

Ms Bernadette Dagg
Suicide Prevention Coordinator
Centre for Mental Health
NSW Health Department

Dear Ms Dagg

Thank you for providing the Mental Health Co-ordinating Council (MHCC) with the opportunity to review the Comprehensive Risk Assessment Guidelines Documents. MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW. MHCC represents the views and interests of over 100 NGOs in the formation of policy and acts as a liaison between the government and non-government sectors. A number of our member organisations specialise in the provision of suicide risk assessment and management services while all our members are concerned about, and involved in, this vital area.

MHCC strongly supports the benefits and value of increased education, awareness and skill development in suicide risk assessment and management for all staff and welcomes the development of comprehensive and detailed guidelines in this area.

General comments

- The guidelines refer frequently to carers and support persons. It is highly desirable and appropriate for these people to be involved. However, it needs to be acknowledged, and guidelines included for, those persons who do not have carers or support persons.
- There needs to be a mechanism whereby staff can provide feedback if they are unable to implement the guidelines, for example due to inadequate staffing or other resources.

Specific comments

The Principles Supporting the Assessment of Suicide Risk

It is helpful to summarise the principles at the beginning and everything included is useful, however, it would be improved by including engagement, close observation and safety.

Suicide Risk Assessment Framework

This is comprehensive and useful. The emphasis on engagement is important as this is often overlooked, especially by inexperienced staff.

Components of a Comprehensive Suicide Risk Assessment

The detailed information and explanation contained here is very helpful. The information is sensible and relevant. The explanations relating to how to carry out the various stages, what to look for, what to check, how to ask questions to obtain information and assess the person are very useful. The various categories of risk factors are well done, however it would be helpful to include impulsivity in "at risk

mental status” in “current personal risk factors” No3, Pg12. I can see that it has been included further down but feel that it should also be in the section referred to as it is such an important factor and one which is often overlooked. It is helpful that the concept of the convergence of multiple predisposing and concurrent risk factors has been included as this broader, more layered scenario of risk is often not recognised. In the section on self-mutilating behaviour, it would be helpful to include that the person who is acting out inner distress in this manner often feels that he or she is not able to communicate distress in a less harmful way. It is useful that the concept that the person’s internal distress may not be evident in their external demeanour has been included as this is often not understood. It is also useful that the possibility of harm to others has been included as this is also often overlooked. It is helpful that the concepts of “apparent improvement” and “changeability of risk” status have been included as these are often poorly identified.

In the section on Discharge, it would be helpful to include the importance of staff providing information about, and linking the person with, appropriate community supports eg Schizophrenia Fellowship, Mental Health Association or Carers’ association etc.

Mental Health Inpatient Units

This section is comprehensive and useful. The comments made in relation to “components of a comprehensive suicide risk assessment” also apply in this section.

Community Mental Health Services

This section is comprehensive and helpful. The comments made in relation to “components of a comprehensive suicide risk assessment” also apply in this section. Additionally, it would be advisable that someone assessed as being at high risk should be assessed more frequently than “within 24 hours.” It would be helpful to state that support and encouragement should also be provided.

General Hospital Wards

The comments made in relation to “components of a comprehensive suicide risk assessment” also apply to these guidelines for the General Hospital. Additionally, in the section “Factors that need to be considered prior to the suicide risk assessment,” there needs to be a statement highlighting the combination of stressors that frequently occur when a person is a patient in a General Hospital:

- Worry and distress about symptoms, investigations, diagnosis, prognosis;
- Stressful environment – noise; lack of privacy; exposure to the suffering, distress and bad outcomes of other patients; foreign environment; continual activity in the ward; close proximity to other patients and visitors that the person may find irritating, stressful or obnoxious.
- Difficulty sleeping due to noise; worry; pain or other symptoms; treatments such as intravenous therapy, drains, catheters, naso-gastric tubes.
- Anxiety, depression and agitation due to a) unwanted side effects of medications such as steroids and chemotherapy; b) biochemical abnormalities due to the illness or injury eg burns; vomiting; haemorrhage; intravenous therapy or medications.
- Anxiety, distress and confusion from delirium due to infections, metabolic disturbances, medications or neurological conditions.

As can be seen, the mental health assessment of a person with a medical illness or condition is complex. Mental health staff assessing such a person need to be aware of the above factors. They also need to realize that difficulty in sleeping and not wanting to eat are frequently present in this population for reasons other than the person being depressed. They also need to realize that a person may feel very low and may see the future as being very bleak and that this may be an appropriate and understandable reaction to the situation and prognosis that the person is facing. In a situation like this the person needs care, support and empathy and needs to be reassured that he or she will be cared for and supported and will not have to cope with worsening health and death alone. The person can be gently helped to identify what they would like to do at this stage. For example, they may want to write letters for their children to keep, or they may want to speak to a sister, brother or friend about caring for their dependents. The way in which the patient responds to such support, empathy and assistance will often give a clearer indication as to whether the person is depressed and needs treatment for depression and monitoring for suicide risk or whether the person is understandably distressed due to what they are going through and needs support and assistance through a major and distressing adjustment. For example, if the person responds to, and feels comforted and supported by such assistance, this is a better indicator of the person not being depressed than whether they can or cannot eat and sleep. Conversely, if this type of support does not appear to comfort or assist the person at all, then this is likely to be a more reliable indicator of depression than difficulty with eating and sleeping in a person who has medical reasons for experiencing these difficulties.

The above comments which apply to General Hospital Wards, also apply to General Community Health and to patients brought in to Emergency Department who have a major medical illness.

The comments made previously in relation to “components of a comprehensive suicide risk assessment” also apply to the General Community Health and Emergency Department Guidelines.

If you would like to clarify any points in this submission, please do not hesitate to contact me on (02) 9555 8388. MHCC would be pleased to review any further drafts.

Thank you for considering this feedback.

Yours sincerely,

Jenna Bateman
Executive Officer
Mental Health Co-ordinating Council