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OIA-2023-4751

5 July 2023

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Dear [redacted]

I refer to your email of 9 June 2023 requesting, under the Official Information Act 1982 (OIA), the following:

- *A copy of all research and advice in relation to personnel and veteran suicide within the New Zealand Defence Force/Ministry of Defence.*

  Dated between January 1, 2018 and today's date.

- *A copy of all drafts and completed studies in relation to personnel and veteran suicide within the New Zealand Defence Force/Ministry of Defence.*

  Dated between January 1, 2018 and today's date.

The New Zealand Defence Force (NZDF) and the Ministry of Defence are separate organisations. Rather than transferring your request, following consultation the Ministry has advised that it does not hold any information in scope of your request. Therefore, the aspects of your request related to the Ministry are declined in accordance with section 18(e) of the OIA.

Enclosed is a draft research paper, *Veterans suicide rate estimate 2005- 2014*, written by a member of the NZDF. The paper was not peer-reviewed and in the view of the researcher, it had limitations and was likely to be subject to data errors. For example, it is noted that the stated size of the overall veteran population had to be based on three different estimates because of uncertainty in available figures. Also, the data was based only on deaths confirmed as suicide at coronial review, and there was potential for missed or incomplete records. The name of the author is withheld in accordance with section 9(2)(g)(i) of the OIA. A copy of Defence Health Rules 38, Part 3, Suicide Prevention and Risk Management, being the current NZDF Health suicide assessment and management policy, is also enclosed.

For your information, the presentation for a 2017 NATO paper titled *Mental Health in the NZDF – Insights for Suicide* is publicly available online[1]. The paper was also provided to the Australian Royal Commission on Veteran Suicide.

[1] https://www.sto.nato.int/publications/STO%20Meeting%20Proceedings/STO-MP-HFM-275/MP-HFM-275-21P.pdf

You have the right, under section 28(3) of the OIA, to ask an Ombudsman to review this response to your request. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that responses to official information requests are proactively released where possible. This response to your request will be published shortly on the NZDF website, with your personal information removed.

Yours sincerely

AJ WOODS
Air Commodore
Chief of Staff HQNZDF

Enclosures:
1. Veterans suicide rate estimate 2005-2014
2. DHR 38, Part 3 - Suicide Prevention and Risk Management

s. 9(2)(g)(i)

5 December 2018

Veterans suicide rate estimation

Introduction

The suicide rate for New Zealand military veterans was estimated for the period 2005 to 2014, a 10 year period. This was undertaken as a data matching exercise between the Coroners Office and the New Zealand Defence Force, with the intent that this would be the first step in identifying the factors which may enable future intervention strategies.

Method

An agreement was reached with the Chief Coroner to examine the New Zealand suicide data in order to determine the veteran suicide rate. The Chief Coroner made available a consolidated record of suicides confirmed for the period 2005 to 2014. A ten year period was taken due to small numbers and relatively large fluctuations across years. The period also represents a period of high operational activity for the Military but relative stability in terms of factors which may impact the suicide rate.

Veterans Affairs New Zealand made available a consolidated list of those whom had ever served over the last 100 years. A manual data matching exercise was undertaken matching records by name, date of birth, sex, then a secondary identifier from both the service and coronial record, such as NHI number.

A veteran was defined as having attested into the New Zealand Defence force. The numbers therefore represent both in service and post service suicides.

A crude quality estimate was undertaken post the manual matching exercise by matching identified cases against known veteran suicides. In this there were no missing cases.

The rate was calculated using 3 different veteran populations due to uncertainty in the population numbers. The lowest likely population is estimated at 35,000, the highest at 50,000, with the most likely estimate being 40,000.

The New Zealand population data was taken from Statistics NZ published data and averaged across the period of interest.

The Defence population is not representative of the New Zealand population - there is an under representation of females and an increased proportion of Maori, particularly young male Maori. The data is therefore presented with an age, sex and Maori comparison.

The in service data is taken from the electronic health records over the same period. The NZDF population was estimated at 9500 for the period.

Results

62 records were matched.

Comparison with New Zealand general population statistics is shown in table 1 below.

Table 1	**Suicide rate per 100,000 per year**						
Likelihood	Population estimate	Veteran rate	NZ total population	NZ Age 25-44	NZ Male age 25-44	NZ Maori male age 25-44	NZDF
Lowest	35000	18					
Most likely	40000	15	11.6	16.2	25.2	42.1	15
Highest	50000	12					

Discussion

There are a number of sources of potential error in the data and this must be considered in interpreting the rate;

- The data is based upon those suicides that are confirmed at coronial review. There are potentially some cases that may be termed indeterminate, where the evidence for suicide is lacking but the suspicion exists.
- The manual matching exercise has the potential for missed records.
- A number of NZDF records are missing leading to under estimation in numbers, this may be up to 10% based upon experience with prior record requests.
- The population estimates for the maximum size of the veterans population may be lower than actually is the case.

The veteran suicide rate is, considering the potential errors, probably about the same as the in service rate, about the same as the New Zealand 25 to 44 age group and less than would be expected in a predominantly male population with a higher than the National average Maori component.

The NZDF in service rate is calculated based upon a 9500 population and reported as 14.8 per 100,000 per year in previous ministerial information requests. The potential error in historical calculations which have been averaged across a number of years is not taking the annual attrition into account. On average NZDF may recruit and release about 800 people per year. This can lead to a substantial over estimation of the suicide rate in service. Data on this should be re-examined as the in service rate may be over estimated by up to 100% depending upon the period examined. This point is important as it is a significant factor in risk estimation.

It can be argued that the 15 per 100,000 is in fact a lower rate than would be expected for the veteran population. The veteran population is a self selected population

in New Zealand as service is voluntary. It may be argued that the population may therefore represent an action oriented population with a higher risk tolerance, where a higher suicide rate may be expected.

The US reported rate for veterans over the same period was 37.2 per 100,000 per year. The UK in service reported rate is between 8 and 9 per 100,000 per year, however consolidated data beyond a study covering the period 1996 to 2005 could not be found. This study showed the same rate as that occurring in service.

The US and UK studies made a number of findings with respect to the age and sex skewing of the suicide data post service. It would be important to determine if, like the in service and post service rate similarity, the same pattern was true of New Zealand veterans. These same studies also identified factors which would potentially be useful in constructing intervention strategies for the New Zealand veteran population. Again, it is important to determine if this is in fact the case given the distinct population differences in the New Zealand serving population, particularly considering and increasing female and Maori component in the post 1995 service population, which may change the risk pattern.

The next phase is intended to examine coronial and service records looking for those factors which may enable risk factor identification and intervention strategies.

References

1. Suicide amount veterans and other Americans 2001 to 2014
https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf

2. Uk armed forces suicide statistics 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/694148/20180327-UK AF Suicide National Statistic 2018 O.pdf

PART 3 - SUICIDE PREVENTION AND RISK MANAGEMENT

Chapter 1 - Assessment and Initial Management of Suicide Risk within NZDF

Purpose of Rule

The purpose of this Rule is to describe the processes related to the delivery of evidence-based assessment and initial management of personnel at risk of suicide.

Application

a. This Rule applies for the assessment and initial management of tangata whaiora at risk of suicide in the New Zealand Defence Force (NZDF) by NZDF healthcare professionals.

b. Tangata whaiora includes—

(1) Members of the Armed Forces (Regular Force and Active Reserve personnel on active duty or employed within the Regular Force).

(2) Territorial Force personnel (not on active duty or employed within the Regular Force).

(3) NZDF civil staff.

(4) Family/whānau of NZDF members of the Armed Forces.

(5) Veterans.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this Rule is the Surgeon General.

b. The Approving Authority for this Rule is the Chief Mental Health Officer.

c. The Regulator for the Rule is Chief Medical Officer.

d. The Custodian for this Rule is the Director Defence Health Policy.

38.3.1.1 Personnel responsibilities

The following personnel are responsible for meeting this policy's requirements—

(1) Trained healthcare professionals. These must have sufficient skills to—

(a) identify possible suicidal risk;

(b) conduct an initial assessment of an individual; and

(c) be able to conduct initial risk management.

(2) **NZDF medical practitioners**. Manage the clinical care and case management of members of the Armed Forces assessed as being a moderate to high risk of suicide.

(3) **Senior Technical Advisors.** Monitor trade proficiencies in the management of healthcare professionals against this policy. Such monitoring includes—

(a) maintenance of training records (as part of the credentialing process); and

(b) quality assurance (auditing and review of clinical events).

(4) **Chief Mental Health Officer.** Coordinate the development of initial and ongoing training packages for healthcare professionals associated with suicide risk assessment.

38.3.1.2 General

NZDF risk assessment and initial management of suicide is guided by the following—

(1) The care of tangata whaiora at risk of suicide should never be managed in isolation. Professional support is important for the safety of the individual and the welfare of the provider. Clinical support or guidance should be obtained as soon as possible after identification of anyone at risk of suicide or self-harm.

(2) A multidisciplinary approach has been shown to improve outcomes in mental health conditions. The NZDF multidisciplinary team (MDT) approach (refer to Health Standard OM-CM-ORG-001: *Multidisciplinary Healthcare Provision in the NZDF*) must be used for serving members of the NZDF.

(3) All healthcare professionals are to receive a level of training and supervision appropriate to their role in responding to individuals at risk of suicide. This is to be determined by the Senior Technical Advisor, in consultation with Chief Mental Health Officer.

(4) Healthcare professionals will liaise and share information with appropriate internal and external professionals in a timely and open manner. Refer to DHR 30 *Applied Healthcare: Health and Disibility Services*, Part 1 Chapter 3 *Consent to Share Health Information*.

38.3.1.3 Tools

a. The MD1676: *NZDF Suicide Risk Assessment Tool* has been developed as a standardised NZDF suicide risk assessment tool. The processes associated with the use of the MD1676 are detailed in DHR 38 Rule 38.3.1.4 *Suicide Risk Assessment Process* and DHR 38 Rule 38.3.1.5 *Risk Assessment*. Healthcare professionals who are credentialed to use other validated tools may do so, however the assessment should reflect similar content and principles.

b. The MD1678: *NZDF Mental Health Safety Plan* has been developed as a standardised NZDF tool, should, as part of the risk assessment, a safety plan be required to be developed for an individual. The processes associated with the use of the MD1678 are detailed in DHR 38 Rule 38.3.1.6 *Safety planning*.

c. It is recommended that all healthcare professionals complete training on the use of the MD1676. Those likely to be in sole charge roles are encouraged to complete training on the MD1678.

38.3.1.4 Suicide risk assessment process

a. Provision and referral

(1) The MD1676 has been developed as a standardised NZDF tool and is based on best practice tools, most notably the Columbia Suicide Severity Rating Scale – Screen (CSSRS-S).

(2) Healthcare professionals (who are not medical practitioners) must refer an individual to a medical practitioner (or other appropriate higher level of care, if a medical practitioner is not available), if, by question 4 of the MD1676, a clinical concern is identified a full suicide risk assessment needs to be completed. Where referral is not readily available, the healthcare professional may proceed with the assessment in the interim, in order to inform immediate management until referral is possible.

(3) Members of the Armed Forces (Regular Force and Active Reserve personnel on active duty or employed within the Regular Force) are to be referred to NZDF medical practitioners.

(4) Territorial Force not on active duty, NZDF civil staff, family/whānau of members of the Armed Forces and veterans must be referred to their own medical practitioner or appropriate higher level of care if their own medical practitioner is not available.

(5) In the interim, it is important that the individual is supported and kept safe. Healthcare professionals may continue with the MD1676 and MD1678 whilst the individual is being referred. Any documentation completed as part of this process is to be made available as part of the referral.

b. **Triggers**

(1) An assessment must occur if an individual's presentation or circumstance elicits concern based on the healthcare professionals clinical judgement. Concerns include, but are not limited to—

(a) general appearance (eg agitation, distress, psychomotor retardation);

(b) form of thought (eg person's speech is illogical and not making sense);

(c) content of thought (eg hopelessness, ominous utterances, despair, anger, shame or guilt);

(d) mood and affect (eg depressed, low, flat or inappropriate);

(e) attitude (eg lacking insight, uncooperative); and/or

(f) sleep disturbance (eg possibly reflecting rumination and worry).

(2) Tangata whaiora must be assessed for suicide risk in situations such as, but not limited to—

(a) the evaluation and management of mental illness (eg depression, bipolar, schizophrenia, post-traumatic stress), or medical condition (eg traumatic brain injury, pain, sleep disturbance) known to be associated with increased risk for suicide;

(b) the individual reporting suicidal thoughts (including on deployment-related assessments, on routine screening tools, or other evaluation such as medical release review);

(c) the individual describes suicidal thoughts on a depression screening tool, scores above cut off on a mental health screening tool, or responds affirmatively on items within screens that are known markers of suicidality (eg those relating to suicidal ideation, hopelessness or worthlessness);

(d) if the individual is referred to a health or welfare practitioner by command, chaplains, social worker, or family/unit members who have expressed concerns about the person's behaviour;

(e) if the individual has a known history of suicide attempt(s) or a recent history of self-harm;

(f) if an individual's patterns of alcohol or other drug use indicates maladaptive coping strategies or a potential increase in impulsivity; and

(g) if an individual has experienced recent life events that may precipitate suicidality, including, but not limited to—

(i) relationship issues/problems;

(ii) death of a loved one (particularly if by suicide);

(iii) grief;

(iv) trauma;

(v) sexual or physical abuse;

(vi) domestic violence;

(vii) child custody issues;

(viii) financial setbacks;

(ix) legal or discipline problems; and/or

(x) career setbacks.

c. **Process**

(1) Determination of suicide risk covers four areas (reflected in MD1676)—

(a) information related to the individual's intent to engage in suicide-related behaviour;

(b) extent of the individual's suicidal plans and actions, including that of any previous attempts;

(c) identifying factors that elevate or reduce the risk of acting on that intent; and

(d) integrating all available information to determine the level of risk and appropriate intervention and management.

(2) The MD1676 provides a framework for the stratification and management of differing levels of risk (refer DHR 38 Rule 38.3.1.5 *Risk Assessment*).

(3) The healthcare professional assessing suicide risk is to remain both empathetic and objective throughout the course of the assessment. A direct non-judgmental approach allows the healthcare professional to gather the most reliable information in a collaborative way, and for the individual to accept help.

(4) As per the MD1676, tangata whaiora are to be directly asked if they have thoughts of suicide and to describe them. Asking directly does not increase an individual's ideation, but indicates a readiness to listen and help. Areas of inquiry include—

(a) onset (when did it begin);

(b) duration (acute, chronic, recurrent);

(c) intensity (fleeting, nagging, intense);

(d) frequency (rare, intermittent, daily, unabating);

(e) active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself');

(f) lethality and detail of the plan (no plan, overdose, hanging, firearm);

(g) triggering events or stressors (relationship, illness, loss);

(h) what intensifies and distracts from the thoughts;

(i) association with states of alcohol or drug use—

(i) are any episodes of ideation present or exacerbated only when individual is using alcohol or drugs?

(ii) this does not make them less serious; however may provide a specific target for treatment;

(j) reasons for living; and

(k) information on previous attempts, including triggering events and means.

(5) The MD1676 is relatively structured. However, healthcare professionals can modify the interview and their approach to suit the culture and context of both themselves and the tangata whaiora, with the proviso that they gather the relevant information and assess risk in a manner consistent with the tool.

AMC 7 - Suicide Risk Assessment Process Flowchart for non-medical practitioners

AMC 8 - MD1676: Suicide Risk Assessment Process Flowchart

38.3.1.5 Risk assessment

a. Where risk is assessed as moderate or high, the healthcare professional must directly refer to a medical practitioner or mental health specialist for both risk assessment and treatment planning. The healthcare professional should also consider doing this where risk is assessed as low. Rationale for the decision not to refer must be documented.

b. The following actions must be taken for tangata whaiora in relation to the level of risk that has been determined. All actions are to be completed as soon as is practical to do so—

(1) **High risk—**

(a) maintain direct observation and supervision of the individual;

(b) refer the individual to a medical practitioner or to Mental Health Services for a complete evaluation and treatment planning;

(c) develop an interim Safety Plan utilising MD1678;

(d) remove access to lethal means such as removal of medications or uplift of personal firearms, in order to protect themselves and others; and

(e) treat presenting problems.

AMC 9 - Risk Assessment Table- High Risk

(2) **Moderate risk—**

(a) refer the individual to a medical practitioner or to Mental Health Services for a complete evaluation and treatment planning;

(b) develop an interim Safety Plan utilising MD1678;

(c) limit access to lethal means such as removal of medications or uplift of personal firearms; and

(d) monitor daily until reviewed by a medical practitioner.

AMC 10 - Risk Assessment Table- Moderate Risk

(3) **Low risk—**

(a) consider referral of the individual to a medical practitioner for full assessment of risk;

(b) treat presenting problems;

(c) identify social support;

(d) identify workplace support;

(e) consider developing a Safety Plan (MD1678); and

(f) monitor risk regularly (eg weekly).

AMC 11 - Risk Assessment Table – Low risk

38.3.1.6 Safety planning

a. The process of developing a Safety Plan (MD1678) allows the tangata whaiora, healthcare professional and the NZDF to develop a clear shared understanding of how suicidal thoughts and urges will be managed.

b. The Safety Plan is best developed in a collaborative manner with the tangata whaiora, medical practitioner, other treatment team members, family/whānau, trusted unit members and command/management.

c. It is recommended healthcare professionals utilise MD1678 when the suicide risk assessment tool indicates the requirement to complete a safety plan (or when the healthcare professional makes a decision to do so based on professional judgement). If the professional opts not to use the MD1678 the safety plan is to reflect similar elements.

d. Healthcare professionals are to assess if the tangata whaiora—

(1) has the necessary resources to enact the safety plan;

(2) is able to access those resources;

(3) has the motivation and capacity to manage the components of the safety plan; and

(4) has restricted access to the means of suicide.

e. A Safety Plan is to be—

(1) collaborative between the provider team and the tangata whaiora;

(2) tiered to pre-empt possible triggers and address early warning signs, as well as respond to immediate suicidal crisis;

(3) proactive; by explicitly anticipating a future suicidal crisis;

(4) individually tailored;

(5) oriented towards a no-harm decision; and

(6) based on existing social support from family/whānau, friends and unit.

f. Safety plans are to include the following (reflected in MD1678)—

(1) early identification of warning signs or stressors;

(2) enhancing coping strategies (eg to distract and support);

(3) utilising social support contacts;

(4) professionals to call;

(5) restriction of access to lethal means; and

(6) reasons for living.

38.3.1.7 Referral procedure: Members of the Armed Forces (Regular Force and Active Reserve personnel on active duty or employed within the Regular Force)

a. Non-emergency referrals to external specialist providers are to be completed using the processes described in Health Instruction 012/15: *Authority for Private Healthcare at Public (NZDF) Expense*.

b. The process for maintaining high levels of communication with mental health services following an individual's transfer is to be clearly established, in order to facilitate management of referred individuals.

38.3.1.8 Follow-up and monitoring of individuals at risk: Members of the Armed Forces (Regular Force and Active Reserve personnel on active duty or employed within the Regular Force)

a. The nature of suicide risk is dynamic and changes over time. It requires an emphasis on pro-active follow up after acute interventions.

b. Tangata whaiora leaving the Emergency Department or community inpatient unit after a suicide attempt, or otherwise at a high risk for suicide, require frequent and pro-active follow up. This is to be completed in accordance with the individual's discharge plan and using the actions described for an individual assessed as being a 'moderate' risk of suicide (DHR 38 Rule 38.3.1.5 *Risk assessment*).

c. The management of individuals identified as moderate or high risk should be multifaceted and is to be discussed by the MDT once every three months whilst the individual is considered Level Three or Four.

38.3.1.9 Clinical documentation

a. All information pertaining to the care/service provided to an individual must be entered into the electronic health management system (Profile), including scanning any MD1676 or MD1678 forms.

b. For healthcare professionals who do not have access to Profile, information must be entered as per the processes described in Standard Operating Procedure: Profile Data Entry for Non-Users.

c. Documentation is required to be factual, accurate, complete, organised, current and timely (refer DHR 31 *Applied Clinical Practice - Medical*, Part 6 Chapter 3 *Clinical/Client Documentation*).

38.3.1.10 Training and support

a. Training in the use of the MD1676, MD1678 and associated processes are to be given to all relevant healthcare professionals.

b. The Chief Mental Health Officer is responsible for coordinating the development of initial and ongoing training packages for healthcare professionals associated with suicide risk assessment.

c. Ongoing competency training must be completed every two years.

d. Relevant healthcare professionals and Senior Technical Advisors are to ensure both existing and new personnel complete the relevant training packages and record completion as part of the annual credentialling process (refer Health Standard: CGS-PRG-002: *Credentialling of Healthcare Providers*).

e. Senior Technical Advisors are to maintain registers of those relevant healthcare professionals who have completed initial mandatory training and two yearly update training.

38.3.1.11 Audit

The Chief Mental Health Officer, in conjunction with the relevant Senior Technical Advisors, are to develop audit processes related to the use of the suicide risk assessment and safety plan tools.

Chapter 2 - Management of Personnel at Risk of Suicide

Purpose of Rule

a. The purpose of this Rule is to provide guidelines for the management of members of the Armed Forces (Regular Force and Active Reserve personnel employed within the Regular Force) identified as being at risk of suicide.

b. The effective management of suicide risk is fundamental to the effective health support to members of the Armed Forces, therefore this Rule guides the actions of all New Zealand Defence Force (NZDF) elements with a role in the management of such cases.

Application

a. This Rule applies to all NZDF healthcare professionals involved in the management of members of the Armed Forces identified as being at moderate to high risk of suicide (refer DHR 38 Part 3 Chapter 1 *Assessment and Initial Management of Suicide Risk within NZDF*) who are to refer to the management guidelines within this policy.

b. Defence Health is the primary health provider for service personnel employed within the Regular Force. It does not provide primary health care to Territorial Force personnel, civil staff, family/whānau or veterans at risk of suicide, beyond that covered in DHR 38 Part 3 Chapter 1. As such, these individuals are out of the scope of this Rule.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this Rule is the Surgeon General.

b. The Approving Authority for this Rule is the Chief Mental Health Officer.

c. The Regulator for the Rule is Chief Medical Officer.

d. The Custodian for this Rule is the Director Defence Health Policy.

38.3.2.1 Personnel responsibilities

a. All healthcare professionals are responsible for ensuring members of the Armed Forces at risk of suicide (as per the suicide risk assessment process, (refer DHR 38 Rule 38.3.1.4. *Suicide risk assessment process*)) receive appropriate assessment and treatment.

b. Members of the Armed Forces at risk of suicide are best managed by a lead clinician and a support team that may involve a range of healthcare professionals, working in liaison with command/management.

c. The lead clinician (with support) is responsible for—

(1) oversight and management of at-risk members of the Armed Forces;

(2) the development and maintenance of case management plans; and

(3) the implementation and review of case management plans.

d. Defence Health Centre, Health Centre Managers are responsible for—

(1) ensuring staff are aware of this policy; and

(2) establishing relationships and contracts with local mental health and other specialist services.

38.3.2.2 General

a. Risk of suicide necessitates active management. The desired end state is that an at-risk member of the Armed Forces has a well-organised support structure in place. Robust support structures have the following features—

(1) they encompass the significant spheres of the serviceperson's life and ensure there is co-ordination across these spheres. This includes the serviceperson, their family/whānau, other support people and the NZDF;

(2) all elements involved communicate with one another, including any mental health specialists;

(3) support people are well prepared for their role and have ready access to appropriate oversight and guidance;

(4) all elements collaborate to develop a pathway to recovery that promotes the serviceperson's hope for the future; and

(5) this support structure is described in a safety or case management plan.

b. All healthcare professionals are to recognise the limits of their individual roles and competence, and actively seek specialist advice and supervision when necessary. Suicide risk is not to be managed by one healthcare professional in isolation.

38.3.2.3 Oversight and coordination

a. The case lead holds overall responsibility for—

(1) the management of the serviceperson's safety and management plan;

(2) making sure care is co-ordinated; and

(3) all pertinent information is recorded on the NZDF Patient Management System (Profile).

b. It is recommended the case lead involve a multidisciplinary team (MDT).

c. Tangata whaiora at risk of suicide are to be an active partner in planning and decision-making around their care. This includes the generation of their Safety Plan and treatment. Similarly, efforts should be made to keep them aware of, and potentially involved in, discussions.

d. Where the tangata whaiora is resistant or unwilling to engage in safety planning, advice should be sought from a mental health professional.

38.3.2.4 Suicide risk management process

a. Members of the Armed Forces with an evolving/high risk of suicide must be referred to a mental health specialist for a comprehensive assessment. This should occur as soon as practicably possible after the risk is recognised.

b. Public Mental Health services should be consulted with, in most acute high-risk presentations.

c. If the risk of suicide is moderate or lower, non-emergency referral to appropriate care may also be required.

d. Healthcare professionals should refer to Health Instruction 012/15: *Authority for Private Healthcare at Public (NZDF) Expense*, when considering referral to external mental health practitioners for non-emergency referral.

e. The tangata whaiora are to be actively monitored until any assessment is completed. The case lead is to ensure a continuity of care plan is considered as part of the initial Safety Plan.

f. The case lead is to communicate with unit command/management regarding associated risk and the tangata whaiora current status. All healthcare professionals should be conscious of the requirements for protection of the serviceperson's health information in communication to command/management. Where possible the tangata whaiora is to be consulted on the involvement of command/management.

38.3.2.5 Safety planning

a. All members of the Armed Forces who are at moderate to high risk of suicide are to have a collaboratively developed Safety Plan (refer DHR 38 Rule 38.3.1.6. *Safety planning*). The Safety Plan provides the foundation for co-ordinated management and should include the following—

(1) social support including, but not limited to (includes support from and for) the following)—

(a) family/whānau;

(b) friends; and

(c) trusted unit members.

(2) professional support including NZDF health, public health and welfare practitioners and 24 hour support services;

(3) the identification and mitigation of triggers, such as events, people or situations that increase risk;

(4) identifying warning signs, including thoughts, feelings, urges, behaviours or symptoms that might indicate increased risk;

(5) developing coping strategies that reduce distress and might include places, people and activities that are calming and healthy;

(6) establishing the roles of friends and family/whānau, medical, unit and welfare staff in providing support; and

(7) restriction of means; consideration of actions taken to limit access to identified means, as well as any other means of high or immediate lethality.

b. A template Safety Plan (MD1678) is available for healthcare professionals to use. However, a more detailed and tailored safety plan may be necessary in some cases. In such instances, specialist mental health providers in either the public or private sectors should be consulted.

38.3.2.6 Case management plan

a. All members of the Armed Forces with a moderate to high risk of suicide are to be managed by a lead clinician.

b. A case management plan is to be developed and implemented by the lead clinician (in conjunction with the support team. The case management plan is to describe—

(1) the relevant roles and responsibilities;

(2) the key points of contact and means of contact, including after hours;

(3) a safety plan;

(4) a treatment and recovery plan; and

(5) review dates.

38.3.2.7 Communication outside the clinical team

a. Support people and organisations outside health, such as family/whānau, should be incorporated into the safety and case management plans.

b. Ideally command/management is an active participant in the support and management of the tangata whaiora. At times, however the possible involvement of command/ management may impede a serviceperson's willingness to engage with health processes. In these instances, the clinical rationale for not informing command/ management is to be documented.

c. When NZDF healthcare professionals communicate outside of the clinical team, they must be conscious of protecting the health information privacy of the patient (refer Health Instruction: 021/17: *Health Information Management*).

d. If a member of the Armed Forces declines consent for their health information to be shared, healthcare professionals can only provide specific health information related to the risk of harm, if there is a 'serious and imminent' risk of harm to the patient or others.

e. Command/management is to be provided information relevant to minimising any risk to the safety of the tangata whaiora, or others. In making this determination, the lead clinician is to consider the nature of the tangata whaiora's role and any associated risk, such as access to weapons and safety critical roles.

f. Decisions relating to disclosure of information are to be documented, and healthcare professionals are encouraged to discuss these with other healthcare professionals or NZDF legal advisors.

38.3.2.8 Discharge from specialist assessment

a. The case lead must be aware of discharge and follow-up arrangements following specialist assessment or discharge from inpatient care.

b. The case lead should ensure the following—

(1) thorough notes are received from the external provider detailing the reasons for discharge/non-admission, and details of arrangements for safety and ongoing care;

(2) a schedule of follow-up appointments with appropriate services is made;

(3) that notes are made of the involvement and roles of any people or groups contacted/aware of the situation, this includes (but may not be limited to)—

(a) Defence medical personnel;

(b) the individual's command/management; and

(c) family/whānau; and

(4) the transfer of notes to NZDF Health is entered into Profile.

c. The case lead is to communicate the plan (to the extent that is appropriate), with relevant people (command/management etc) and groups.

d. The serviceperson should be contacted and assessed by a NZDF medical practitioner responsible for their care (ideally the lead clinician) within 24 hours of discharge from in-patient care.

38.3.2.9 Monitoring and follow up

a. The member of the Armed Forces must have regular contact with medical and mental health specialists if at a moderate to high risk of suicide. This could include NZDF healthcare professionals and external services.

b. This contact is to be co-ordinated and monitored by the lead clinician.

c. The lead clinician must be notified of any information that might affect the risk profile or treatment plan.

38.3.2.10 Medical gradings and employment limitations

a. Members of the Armed Forces at moderate to high risk of suicide should be given an operational fitness grading of 445 R6.

b. Specific employment limitations (eg access to weapons/service driving) should balance the risk to the individual and the benefit of continued involvement in work. Employment limitations are to be discussed with the individual and, where appropriate, their command/management.

38.3.2.11 Clinical documentation

a. All information pertaining to the assessment and care provided to an individual is to be entered into Profile. (Refer DHR 31 *Applied Clinical Practice - Medical*, Part 6 Chapter 3 *Clinical/Client Documentation*).

b. Where a template or tool is used, this is to be scanned into Profile and the location of the document noted in a Profile Encounter with a summary of any observations and/or plan.

c. For healthcare professionals who do not have access to Profile, information must be entered as per the processes described in Standard Operating Procedure: Profile Data Entry for Non-Users.

38.3.2.12 Appropriate training and supervision

All healthcare professionals involved in the support of a serviceperson at risk of suicide are to be provided with appropriate training and supervision (refer Part 4 *NZDF Mental Health Care Pathway – Training*, on issue). This includes—

(1) Friends and family/whānau supporting the serviceperson are to be briefed on relevant components of the safety and management plan. This would typically include risk indicators, restriction of access to means and how the lead clinician or support services might be contacted.

(2) Unit personnel tasked with monitoring the serviceperson are to be briefed on—

(a) the risk;

(b) any known triggers or warning signs;

(c) restriction of access to means; and

(d) procedures for seeking immediate further guidance.

38.3.2.13 Case lead supervision

Case leads are to have professional supervision process relationships in place as per their professional regulations.