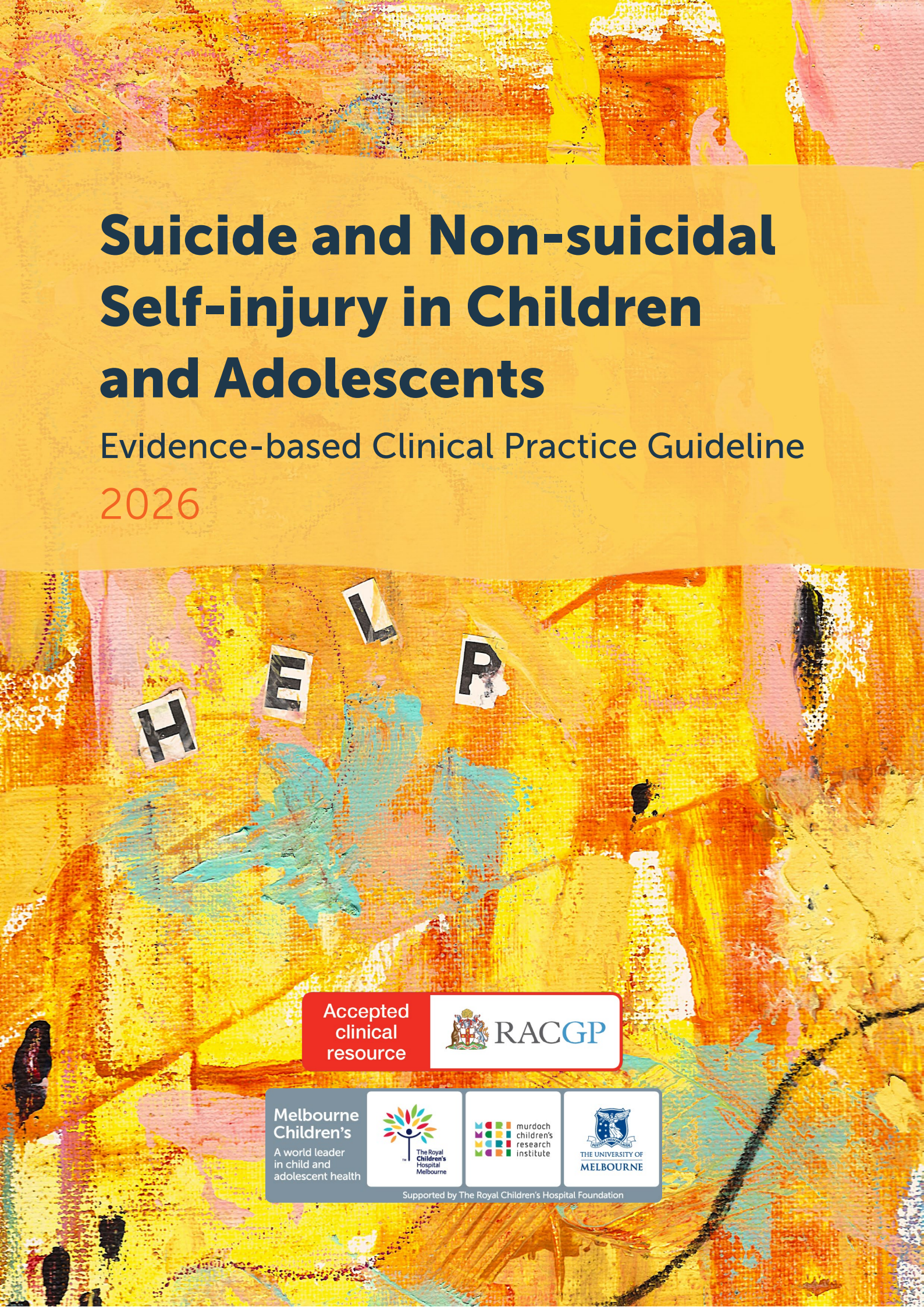
# Suicide and Non-suicidal Self-injury in Children and Adolescents

## Evidence-based Clinical Practice Guideline

2026

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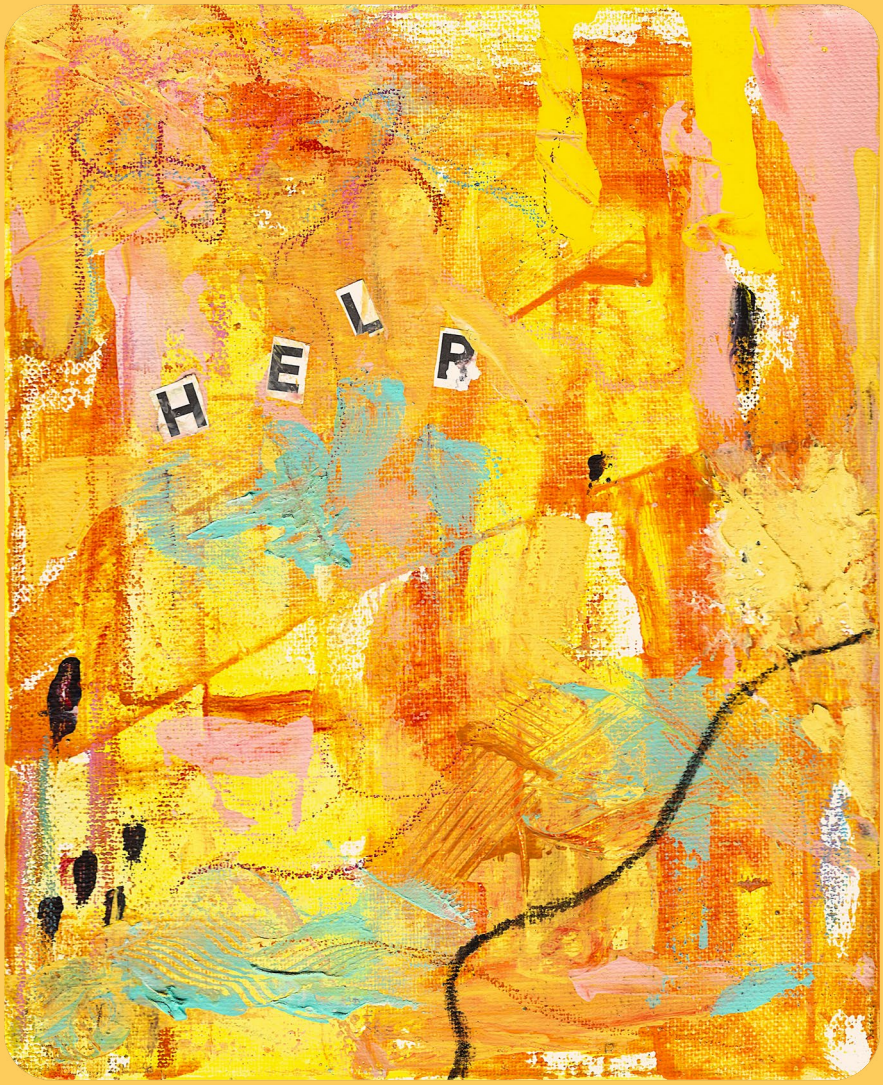
# Cover artwork

**“You There?” by Jeanette Chan (she/they), Lived Experience Advisor.**

The artist reflected, “I sat teetering on the edge between life and death for a really long time. I didn’t know it wasn’t commonplace. One day, I realised I wanted to live. And that’s when I realised I didn’t before – or rather I was quite ambivalent about it all. I’m grateful for the teeter that helped me survive. And the grace I gave myself to imperfectly ask for help – which at the time felt wholly excruciating, embarrassing, and unnatural.

The artwork appears to have the word ‘HELP’ collaged on it, but it actually says ‘HELR’. This small but significant detail symbolises the difficulty folks face in seeking help. Yet, what I’ve perceived to be my most incomprehensible innermost thoughts have somehow always found a home in others. May you be one of the many outstretched hands ready and waiting to walk alongside folks as they reach out for support on their journey”.



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See page 77 for full authorship, Guideline Development Group membership, and governance.

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**Acknowledgements**

This guideline was developed on the lands of the Wurundjeri Woi-wurrung and Boon Wurrung peoples of the Kulin Nation in Naarm, Melbourne. Melbourne Children's recognises all First Nations Australians, their cultural heritage, beliefs, and relationships to Country and acknowledges the significant impact of colonisation, intergenerational trauma, and systemic disadvantage that affects mental health outcomes for Aboriginal and Torres Strait Islander communities across Australia. As healthcare professionals, we recognise our responsibility to seek improvement for these communities.

This guideline was developed in partnership with people with lived and living experiences of mental health challenges and recovery, whose contributions were integral in driving this content. Melbourne Children's acknowledges that lived experience is critical to the meaningful improvement of mental health care and outcomes, and we recognise there is more to accomplish in ensuring the voices and broader life experiences of children, young people, and their support systems are at the heart of our work.

Thank you to everyone who has shared their story so that we can learn and improve.

# A note from the Chair

After 18 months of evidence reviews, discussions, and editing, it is my privilege to introduce the Australian-first, *Suicide and Non-suicidal Self-injury in Children and Adolescents: Evidence-based Clinical Practice Guideline*. We embarked on this project because the need for clinical practice guidance was clear: suicide and non-suicidal self-injury (NSSI) is a growing concern for young people,[1] evidence-based guidance for clinicians is insufficient,[2] and the healthcare system is ill-equipped to help them.[3]

The complexity of this topic was a challenge at every stage. Suicide and NSSI are experiences that intersect with developmental, societal, cultural, and systemic factors, making assessment and support for children and adolescents far from straightforward. In addition, policy and legal frameworks across Australia provide conflicting advice for organisations and individuals. So, how do we compile the best practice advice for such a complex, multifaceted condition? Using available evidence and experience from clinicians, researchers, and people with lived and living experience, we compiled this extensive resource to guide professionals caring for any young person who experiences suicide and NSSI.

It is difficult to discuss suicide and NSSI without acknowledging the deep stigma that exists within our society. Stigma and misunderstanding continue to be a major barrier to early identification and help-seeking, limiting open conversations and consistent care. While this guideline provides practical evidence-informed recommendations, it represents only a small step in an effort to strengthen and improve systems that care for young people who experience suicide and NSSI. Meaningful progress requires coordinated action from every level, across services, communities, schools, and policy settings.

I want to acknowledge the extraordinary commitment and expertise of the Guideline Development Group (GDG). Clinicians and researchers brought thoughtful insights and genuine passion for improving outcomes for young people and their families who experience suicide and NSSI. In addition, we are very lucky to have five Lived Experience Advisors as members of the GDG, to share their stories and insights. Their willingness to speak openly, challenge assumptions, and reflect on what truly supports recovery and safety strengthened this guideline in ways that evidence alone cannot. Through their contributions, I hope this guideline not only supports clinicians but also respects the real experiences of children, adolescents, and their wider networks.

Finally, I want to thank Dr Marie Misso, guideline methodologist, who's advice and knowledge of guideline development kept us on track through the weeds. And Melissa McKinlay, evidence review consultant, who was often knee deep in articles to screen and extract. Both Marie and Melissa have made this rigorous guideline possible with their involvement and dedication.

So much work has gone into the creation of this resource, with input from people across Australia. My thanks go out to everyone that has supported us.

**Sydney Stevens, Guideline Development Group Chair**

# Contents

# Summary of recommendations

| 1. Principles of care | | |
|---|---|---|
| **No. #** | **Type** | **Recommendation** |
| **1.1** | CBR | Steps should be taken to ensure pathways are available within communities, schools, and clinical settings for children, adolescents, and their support systems to recognise, raise concerns about, and seek help for experiences of suicidal ideation, attempts, and NSSI. |
| **1.2** | CBR | Organisations that provide services to children and adolescents should have clearly defined policies and procedures appropriate to their setting.<br><br>Such organisations should provide supports to staff who care for children and adolescents experiencing suicidal ideation, attempts, and NSSI.<br><br>Examples of these staff supports may include:<br>• social workers/counsellors<br>• specialists (eg child and adolescent psychiatrists)<br>• legal advisors<br>• translators<br>• peer workers, lived experience professionals |
| **1.3** | CBR | Care should be person-centred and culturally safe, with respect to the child/adolescent and their support system. Decisions should involve the child/adolescent and their support system wherever possible while ensuring their safety and wellbeing. Note, there are situations where the involvement of some support people is not appropriate, for example, in circumstances of family violence. |
| **1.4** | CBR | Questions and conversations about suicidal ideation, attempts, or NSSI should be specific and unambiguous. |
| **1.5** | CBR | Professionals caring for and supporting children and adolescents who experience suicidal ideation, attempts, and NSSI should:<br>• be aware of policies and procedures for identifying and accessing supports, including organisational and legal frameworks relevant to their field<br>• know how to implement the policies and procedures within their role and responsibilities<br>• know who to go to for support and supervision |
| **1.6** | CBR | Healthcare professionals caring for children and adolescents who experience suicidal ideation, attempts, and NSSI should be:<br>• appropriately trained in child and adolescent mental health, including in developmentally nuanced, trauma-informed, intersectionality sensitive approaches and undergo supervision with a healthcare professional experienced in this field<br>• appropriately qualified, with current registration with the standard registration body for their profession (such as the Australian Health Practitioner Regulation Agency), if applicable<br>• appropriately credentialed and supervised in the therapy they are offering, if applicable<br>• aware of relevant legal frameworks or regulations |

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| **1.7** | EBR | Information and support for **children and adolescents** who experience suicidal ideation, attempts, or NSSI should be provided.<br><br>Topics to discuss may include:<br>• what suicidal ideation, suicidal attempts, or NSSI encompasses<br>• why people might experience suicidal ideation, attempts, or NSSI and, where possible, the specific circumstances of the child/adolescent<br>• available treatment options<br>• available supports, including lived experience workers, community supports, and peer groups<br>• self-care<br>• how to manage wounds and care for their injuries<br>• how to manage scars<br>• safety plans, and what they involve, including protective measures<br>• stigma and common misunderstandings around suicide and NSSI, and how they might react to this<br>• what to do if they have any concerns<br>• what to do in an emergency, including when to seek help<br><br>See page 75 for helpful resources to share with children and adolescents. |
| **1.8** | CBR | Information and support for the **support system** of children and adolescents who experience suicidal ideation, attempts, or NSSI should be provided.<br><br>Topics to discuss may include:<br>• the emotional impact on the child/adolescent and their support system<br>• what to do if the child/adolescent engages in NSSI or a suicide attempt again<br>• what to do if the child/adolescent discloses an experience of suicidal ideation<br>• how to seek help for the physical harm that may occur<br>• how to assist and support the child/adolescent to prevent perpetuation of stigma or blame<br>• how to recognise signs that the child/adolescent might be at risk for further harm<br>• steps to reduce the likelihood of suicidal ideation, attempts, or NSSI in the future<br>• advice on how to cope when supporting a child/adolescent who experiences suicidal ideation, attempts, or NSSI, including self-care and peer support for the support person(s)<br>• what to do in an emergency, including when to seek help<br><br>See page 75 for helpful resources to share with support person(s). |
| **1.9** | CBR | Information and resources for children, adolescents, and their support systems should be tailored to the child/adolescent's needs and circumstances, considering:<br>• the child/adolescent and their support system's preferred method of receiving support or information (eg digital, written, visual, audio etc)<br>• the child/adolescent's existing community and social supports, including involvement from their support system<br>• whether this is a first known presentation or a repeat event<br>• the nature and type of self-harm (suicidal ideation, attempts, or NSSI)<br>• if the child/adolescent has any co-occurring health, mental health, or neurodevelopmental conditions<br>• environmental, cultural, and intersectional factors that may contribute to symptoms and their impact |

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| **1.10** | CBR | Recognise that support and information may need to be adapted for people who are physically disabled, neurodivergent, have a learning or intellectual disability, Aboriginal and/or Torres Strait Islander peoples, culturally and linguistically diverse people, racially marginalised people, refugees, and LGBTQIA+ people to avoid discrimination and ensure equity in access and care. |
| **1.11** | CBR | If the child/adolescent who experiences suicidal ideation, attempts, or NSSI finds it difficult to vocalise their distress when they require care, professionals should:<br>• recognise the reasons why the child/adolescent may have difficulty communicating their distress and take steps to mitigate these (such as building trust and rapport, and engaging in calming activities)<br>• support the child/adolescent and their support system in trying alternative methods of communication (eg non-verbal language, letters, emotional wellbeing passports, and using agreed safe words, phrases, or emojis)<br>• work collaboratively to establish and document preferred methods of communication throughout care<br>• provide appropriate access to translations |
| **1.12** | CBR | Healthcare professionals caring for children and adolescents who experience suicidal ideation, attempts, or NSSI should, as early as possible, engage in clear, age-appropriate discussions with the child/adolescent and their support system about:<br>• **Confidentiality:** what information will be kept private, what might be shared, with whom, and under what circumstances.<br>• **Mandatory reporting obligations:** a clinician's legal duty to report concerns about abuse, neglect, or serious risk of harm in the interest of safety for the child/adolescent and others.<br>• **Consent:** what the adolescent or legal guardian is being asked to consent to (eg treatment), and that their preferences will be respected. |
| **1.13** | CBR | Aversive treatment, punitive approaches, or criminal justice approaches, such as community protection laws or prosecution for high service use, should not be used as an intervention for frequent suicidal ideation, attempts, or NSSI. |
| **1.14** | CBR | The use of restrictive interventions should be prevented wherever possible and used only in accordance with federal and state legislation (eg mental health and wellbeing acts), including relevant authorisation, observation, and reporting obligations. |

## 2. Identification and risk assessment

| No. # | Type | Recommendation |
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| **2.1** | CBR | Healthcare professionals concerned about the risk of suicidal ideation, attempt, or NSSI can engage in clear, unambiguous clinical discussion with the child/adolescent and their support system to identify risk and inform next steps in assessment or care planning.<br><br>This should include:<br>• consideration of individual context, needs, and risks<br>• discussion in a quiet, private space<br>• establishing connection/rapport with the child/adolescent<br>• supporting the child/adolescent through a non-judgemental, active supporting role |

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| **2.2** | CBR | Mental health professionals should undertake a risk formulation as part of every biopsychosocial assessment to assess current risk and inform interventions and support for the child/adolescent. |
| **2.3** | CBR | A risk formulation should:<br>• be in collaboration with the child/adolescent and their support system<br>• be focused on the child/adolescent's needs and wants<br>• consider how to support immediate and long-term psychological and physical safety<br>• consider risk and protective factors (see recommendations 2.4-2.5)<br>• consider potential triggers for risk escalation<br>• consider risk caused or exacerbated by any co-occurring conditions (see recommendation 2.6) |
| **2.4** | EBR | Healthcare professionals caring for children and adolescents should consider the potential increased risk of suicidal ideation, attempt or NSSI in those who have experienced any of the following factors:<br>• previous suicide attempt<br>• personal history of mental illness<br>• neurodivergence<br>• taking medications with known adverse effects of suicidal ideation or self-harm<br>• family history of mental illness, or death by suicide<br>• peer suicide attempt or death by suicide<br>• maltreatment or abuse<br>• parental incarceration<br>• contact with Child Protection Services or out-of-home care<br>• bullying or cyber-bullying |
| **2.5** | CBR | Healthcare professionals caring for children and adolescents could consider the potential increased risk of suicidal ideation, attempt or NSSI in those who have experienced any of the following factors:<br>• increased social media use (including bullying and harmful online experiences)<br>• social isolation<br>• adverse childhood experiences<br>• sexual abuse or unwanted sexual experiences<br>• financial stress<br>• family history of legal difficulties<br>• chronic illness within the support system<br>• death of a loved one<br>• community or family violence<br>• discrimination<br>• racism<br>• common co-occurring conditions (see recommendation 2.6)<br><br>Note: Some groups in the community (eg Aboriginal and Torres Strait Islander people, LGBTQIA+ people, gender diverse people, and people with disabilities) may be disproportionately exposed to these determinants due to structural and systemic inequities and stigma. Healthcare professionals should consider that these identities may hold an increased risk. However, the identity itself is not a risk factor. |

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| **2.6** | CBR | Suicidal ideation, attempt, or NSSI commonly co-occurs with (or is experienced in the context of) a range of medical, mental health, and neurodevelopmental conditions that should be considered during assessment, care planning, treatment, and management. This includes, but is not limited to, the following diagnoses and presenting problems, which may first emerge in childhood or adolescence, including:<br>• ADHD, autism spectrum disorder, and specific learning disorders<br>• anxiety disorders<br>• asthma<br>• attachment-based disorders<br>• bipolar and related disorders<br>• borderline personality disorder<br>• depressive disorders or depressive factors, such as feeling hopeless or worthless<br>• dissociative disorders<br>• epilepsy<br>• feeding and eating disorders<br>• intellectual disabilities<br>• obsessive-compulsive disorder and body dysmorphic disorder<br>• oppositional defiant disorder and conduct disorder<br>• physical disabilities and chronic conditions (eg chronic pain)<br>• post-traumatic stress disorder (PTSD) and complex PTSD<br>• schizophrenia spectrum disorders (including psychosis)<br>• substance-related and addictive disorders |
| **2.7** | CBR | To ensure appropriate holistic care, healthcare professionals caring for or supporting children and adolescents who experience suicidal ideation, attempts, or NSSI, and a co-occurring condition should:<br>• recognise how co-occurring conditions may present in children and adolescents of different ages, genders, and cultural backgrounds<br>• understand early warning signs, symptoms, prognosis, and best practice treatment, and support options associated with these co-occurring conditions<br>• understand precipitating factors and functions associated with suicidal ideation, attempt, or NSSI that may co-occur with other conditions<br>• consider subclinical psychological symptoms and traits that may be associated with suicidal ideation, attempt, or NSSI (eg impulsivity, lower self-esteem, emotional dysregulation) and a co-occurring condition, even if a person does not meet the criteria for a diagnosis<br>• enable appropriate, affordable, accessible, and timely assessment and referral pathways for children and adolescents who may be experiencing these co-occurring conditions<br>• respect individual preferences regarding the use of diagnostic labels, including person-first, gender affirming, and neuro-affirming language |
| **2.8** | CBR | Population-level screening for suicidal ideation, attempt, or NSSI should not be routinely implemented when working with children and adolescents. |
| **2.9** | CBR | Risk assessment tools and scales can be helpful to aid in assessment, but should not be used solely to:<br>• predict future suicide or repetition of suicidal ideation, attempt or NSSI<br>• determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI |

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| **2.10** | CBR | Global risk stratification (eg low, medium or high risk) should not be used to:<br>• categorise risk of future suicide or repetition of suicidal ideation, attempts, or NSSI<br>• determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI |

## 3. Care in non-mental health settings

| No. # | Type | Recommendation |
|---|---|---|
| **3.1** | CBR | If suicidal ideation, attempt, or NSSI is identified or suspected during care or other points of contact by a non-health professional, they should establish the following as soon as possible:<br>• the severity of any physical injury, and if urgent medical treatment is needed<br>• the child/adolescent's emotional and mental state, and level of distress<br>• whether there is immediate concern about the child/adolescent's safety<br>• whether the child/adolescent has a safety plan and/or an established relationship with a mental health service or GPs |
| **3.2** | CBR | The child/adolescent should be referred to healthcare professionals for physical injury and mental healthcare as soon as possible after a suicide attempt, or NSSI is identified. |
| **3.3** | CBR | When supporting a child/adolescent who experiences suicidal ideation, attempts, or NSSI, non-health professionals should:<br>• discuss with the child/adolescent and their support system the best way to help in their role/capacity<br>• follow the child/adolescent's safety plan, if available<br>• seek advice from healthcare professionals<br>• communicate with relevant people involved in ongoing care, including support person(s) or healthcare professionals, with consent from the child/adolescent if safe to do so<br>• empower the child/adolescent to support themselves independently, where developmentally appropriate |
| **3.4** | CBR | GPs caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI in primary care should consider referring to mental health services for a biopsychosocial assessment or informing their existing mental health team, with consent from the child/adolescent and their support system.<br><br>Make referral to mental health professionals a priority when:<br>• the child/adolescent or their support system asks for further support from mental health services<br>• the child/adolescent's levels of concern or distress are increasing, they are a risk to self and others, or are not otherwise manageable in the community<br>• the frequency or degree of suicidal ideation, attempt, or NSSI is increasing<br>• levels of distress in their support system are increasing or not improving, despite attempts to help |
| **3.5** | CBR | When communicating with relevant healthcare professionals or referring to specialised mental health services, collect and document relevant information about the child/adolescent's:<br>• home environment<br>• social and family support network |

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| | | • community involvement (eg school, sport, religion)<br>• history of NSSI or suicide attempts<br>• current emotional and mental state, and level of distress<br>• access to means of self-harm, including medications |
| **3.6** | CBR | GPs supporting children and adolescents who experience suicidal ideation, attempts, or NSSI in primary care should ensure that the child/adolescent has:<br>• regular appointments for review of symptoms and their impact<br>• a medicines review (see recommendations 9.1-9.4 for considerations about prescribing medications)<br>• information about available supports, including lived experience workers, community supports, or peer groups, and how to utilise these<br>• care for any co-occurring conditions<br>• information about safety planning, including harm minimisation or appropriate coping strategies |
| **3.7** | CBR | Healthcare professionals caring for a child/adolescent after an episode of NSSI or suicide attempt should:<br>• establish the means of self-harm and, if accessible to the child/adolescent, discuss removing with therapeutic collaboration or negotiation to keep them safe<br>• gather information to understand the full context and function of the behaviour<br>• seek consent to liaise with the support person(s)<br>• discuss with the child/adolescent and their support system, about safety plan(s) or appropriate coping strategies |

## 4. Care in emergency or urgent care settings

| No. # | Type | Recommendation |
|---|---|---|
| **4.1** | CBR | Healthcare professionals in an ED or urgent care clinic caring for a child/adolescent after an episode of suicidal ideation, attempt, or NSSI, should establish the following as soon as possible:<br>• information included in CBR 3.7<br>• the child/adolescent's willingness to accept medical treatment and mental healthcare |
| **4.2** | CBR | When a child/adolescent attends the ED or urgent care clinic with risk of suicidal ideation, attempts, or NSSI, a referral should be offered to a specialist mental health service as soon as possible after arrival, for a biopsychosocial assessment, support, and assistance concurrent with physical healthcare. |
| **4.3** | CBR | A mental health professional should consult with the child/adolescent and their support system during an ED attendance, after an episode of suicidal ideation, attempt, or NSSI.<br><br>If a mental health professional is not available to consult with the child/adolescent directly, the treating team should liaise with a mental health professional for advice in the interim. |

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| **4.4** | CBR | EDs or urgent care clinics should have:<br>• a quiet, designated area for biopsychosocial assessments to take place, where it is possible to speak in confidence with the child/adolescent and their support system without being overheard<br>• waiting area(s) close and visible to staff who can provide care, support, and observation |
| **4.5** | CBR | EDs or urgent care clinics should ensure that physical and mental health care can be delivered concurrently.<br><br>This can include:<br>• access to electronic document systems for both mental health services and medical treatment at the point of care<br>• agreed referral pathways for concurrent physical and mental healthcare<br>• jointly agreed approaches to initial assessment and triage<br>• shared understanding of relevant organisation and legal frameworks<br>• jointly agreed observation policies<br>• referral pathways to appropriate community services |
| **4.6** | CBR | The use of restrictive interventions in EDs or urgent care clinics should be prevented wherever possible and used only in accordance with federal and state legislation (eg mental health and wellbeing acts), including relevant authorisation, observation, and reporting obligations. |
| **4.7** | CBR | Short-term extended stay in an ED should be avoided where possible. Short-term extended stay could be considered when:<br>• there are concerns about the safety of the child/adolescent (eg risk of violence, abuse, homelessness, or exploitation)<br>• the child/adolescent requires further care or surgery and cannot yet be admitted<br>• the child/adolescent requires support while being referred to specialist mental health supports or transferred to a mental health inpatient unit |

## 5. Care in specialist mental health settings

| No. # | Type | Recommendation |
|---|---|---|
| **5.1** | CBR | Mental health professionals caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI should carry out a biopsychosocial assessment as soon as possible to:<br>• build rapport and develop a collaborative therapeutic relationship with the child/adolescent<br>• begin to develop a shared understanding of why the child/adolescent is at risk of, or experiencing suicidal ideation, attempts, or NSSI<br>• ensure that the child/adolescent receives the mental and physical healthcare they need |
| **5.2** | CBR | Biopsychosocial assessment should not be delayed due to physical injury or until treatment for physical injury is complete. |

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| **5.3** | CBR | Mental health professionals should focus the assessment on the child/adolescent's needs and how to support their immediate and long-term psychological and physical safety. |
| **5.4** | EBR | Biopsychosocial assessments should be carried out in a quiet area where the child/adolescent feels comfortable and can speak in confidence without being overheard. |
| **5.5** | CBR | Mental health professionals conducting a biopsychosocial assessment should ask about the child/adolescent's:<br>• social, peer group, education, and home situation<br>• caring responsibilities, if any<br>• use of social media and the internet to connect with others, and the effects of these on their mental health and wellbeing<br>• issues or concerns regarding their safety<br>• historic factors or past experiences<br>• changeable and current factors, including current symptoms or substance use<br>• future factors, including specific upcoming events or circumstances<br>• protective or mitigating factors |
| **5.6** | CBR | Mental health professionals conducting the biopsychosocial assessment should explore the function, motivation, or purpose of the child/adolescent's suicide attempt(s) or NSSI.<br><br>Consider:<br>• their values, wishes, what matters to them and their support system<br>• the need for psychological interventions, social care and support, or occupational rehabilitation<br>• any learning disability, neurodevelopmental condition, or mental health concerns<br>• their treatment preferences<br>• that each episode should be treated in its own right, and the reasons for self-harm may vary from episode to episode, individual to individual<br>• involvement of their support system and who their trusted persons are<br>• existing safety plans or plans for treatment and management |
| **5.7** | CBR | Mental health professionals conducting biopsychosocial assessments should consider the needs and preferences of the child/adolescent and their support system as much as possible, including:<br>• making appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition they may have<br>• the child/adolescent's preferences regarding the demographics of the treating clinician (eg gender) and accommodate this where possible<br>• involvement of other appropriately trained professional(s) with whom the child/adolescent trusts or has an existing relationship with |
| **5.8** | CBR | If the child/adolescent is not able to or does not want to participate in a biopsychosocial assessment, mental health professionals should:<br>• assess their physical and psychological safety using available sources of information (eg level of distress)<br>• continue to build rapport and develop a collaborative therapeutic relationship with the child/adolescent<br>• ensure that they have regular reviews<br>• complete the assessment when possible |

## 6. Aftercare and safety planning

| No. # | Type | Recommendation |
|---|---|---|
| **6.1** | CBR | After an episode of suicidal ideation, attempts, or NSSI, healthcare professionals should discuss and agree with the child/adolescent and their support system the purpose, format, and frequency of initial aftercare and which professionals/services will be involved in their care.<br><br>These decisions should be documented in the child/adolescent's medical record. Ensure that the child/adolescent and their support system have contact details for the care team providing the aftercare. |
| **6.2** | CBR | If there are ongoing safety concerns for the child/adolescent after an episode of suicidal ideation, attempts, or NSSI, the team that carried out the initial biopsychosocial assessment or the team responsible for care should provide initial aftercare as soon as practically possible, ideally within 24 hours of the biopsychosocial assessment. |
| **6.3** | EBR | Healthcare professionals caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI could consider developing a safety plan in partnership with the child/adolescent and their support system.<br><br>Safety plans should be used to document ways to keep the child/adolescent safe in times of distress or crisis, including:<br>• identified triggers and warning signs of increased distress, or further episodes of suicidal ideation, attempts, or NSSI<br>• identified appropriate coping strategies, including problem-solving and any factors that may act as a barrier to these<br>• identified people in the support system who can provide support and/or help resolve a crisis<br>• contact details for healthcare services, including existing links to mental health professionals and emergency contact details<br>• established intended means of self-harm<br>• making their environment psychologically and physically safe, including managing access to means of self-harm |
| **6.4** | EBR | The safety plan should be:<br>• developed in collaboration with the child/adolescent and their support system<br>• in a format that is accessible and understandable to the child/adolescent (eg digital or visual)<br>• developed using a problem-solving approach<br>• held by the child/adolescent or their support system, where appropriate<br>• shared with relevant professionals involved in their care, with consent from the child/adolescent<br>• accessible to the child/adolescent, their support system, and professionals involved in their care at times of crisis or distress |
| **6.5** | CBR | The use of digital safety plans or phone safety apps could be used to increase access for the child/adolescent and their support system. |

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| 6.6 | CBR | Together with the child/adolescent and their support system, the mental health professional should develop or update a plan for ongoing treatment and management (sometimes called a care plan) using the key areas of need and safety considerations identified in the biopsychosocial assessment and follow as closely as possible.<br><br>The child/adolescent and their support system should understand and have access to written information about the plan for treatment and management. Document this in the child/adolescent's medical record (including MyHealthRecord, if available) and, as soon as possible, share necessary information with all professionals involved in their care, with consent from the child/adolescent or their support system. |

## 7. Treatment

| No. # | Type | Recommendation |
|---|---|---|
| 7.1 | CBR | Mental health professionals should offer psychological interventions without delay to children and adolescents who present with suicidal ideation, attempts, or NSSI, regardless of age, diagnosis, substance use, or co-occurring conditions. |
| 7.2 | CBR | When offering any intervention to children and adolescents, their age, culture, neurodiversity, gender diversity, support system or structure, available resources, rurality, and any planned transition between services should be taken into consideration. |
| 7.3 | EBR | If a psychological intervention is considered, dialectical behavioural therapy (DBT) tailored for children and adolescents should be offered first-line. |
| 7.4 | CBR | Alternative psychological interventions, such as cognitive behavioural therapy (CBT) based approaches, could be considered to engage children and adolescents where developmentally appropriate. |
| 7.5 | EBR | Pharmacological treatment should not be offered as a first-line intervention specifically to reduce suicidal ideation, attempts, or NSSI. |
| 7.6 | CBR | Therapeutic risk-taking, which includes independent decision-making around taking risks, and sometimes called dignity of risk, can be considered after a biopsychosocial assessment and should be:<br>• discussed in collaboration with the child/adolescent, their support system, and other relevant professionals involved in their care<br>• draw on the child/adolescent's strengths, appropriate coping strategies, and what matters to them<br>• focus on positive outcomes<br>• part of ongoing care and management<br>• reviewed as part of regular ongoing care |

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| **7.7** | CBR | If a child/adolescent is engaged in ongoing care and treatment for a suicide attempt(s) or NSSI but is not yet in a position to resist the urge to harm themselves, harm minimisation strategies could be considered:<br>• in the spirit of hope and optimism, and to reduce the severity and/or recurrence of injury<br>• as part of an overall approach to the child/adolescent's ongoing recovery-focused care and support, and not as a standalone intervention<br>• after being discussed and agreed upon collaboratively with the child/adolescent, their support system, and the wider multidisciplinary care team |
| **7.8** | CBR | Mental health professionals should discuss with the child/adolescent and their support system harm minimisation strategies that could help to avoid, delay, or reduce suicide attempts or NSSI.<br><br>For example:<br>• alternate distraction techniques or coping strategies<br>• approaches to self-care<br>• wound hygiene and aftercare<br>• providing factual information about the potential complications of injury<br>• discussing the impact alcohol and recreational drugs have on the urge to harm oneself<br>• information about available supports, including lived experience workers, community supports, or peer groups |
| **7.9** | CBR | If a child/adolescent presents with frequent episodes of suicidal ideation, attempts, or NSSI, because treatment has not been effective, the care team should conduct a multidisciplinary review with the child/adolescent, their support system, professionals involved in their care, and others who need to be involved, to agree upon a joint plan and approach.<br><br>This involves:<br>• identifying an appropriately trained professional whom the child/adolescent trusts to coordinate their care and act as a point of contact<br>• reviewing existing care and support, and arranging referral to any necessary services<br>• developing or updating the plan for treatment and management<br>• developing or updating the safety plan, which should be written with and agreed upon by the child/adolescent and their support system |
| **7.10** | CBR | Co-occurring conditions that may be related to or contributing to symptoms of suicidal ideation, attempts, or NSSI should be investigated and managed according to condition-specific evidence-based guidelines.<br><br>See CBR 2.6 for common co-occurring conditions.<br><br>See CBRs 9.1-9.4 for considerations on prescribing medication for co-occurring conditions. |

## 8. Admission to hospital

| No. # | Type | Recommendation |
|---|---|---|
| 8.1 | CBR | Admission to a non-mental health hospital ward after an episode of suicidal ideation, attempt, or NSSI should only be considered if there is clear clinical justification, including treatment for physical injury. |
| 8.2 | CBR | The child/adolescent and their support system should be involved in making decisions about hospital admission, considering:<br>• specific goals for the child/adolescent at that point in time<br>• the home and social environment that will be supporting the child/adolescent<br>• existing links to mental health and community outpatient supports<br>• existing safety plans, and plans for treatment and management |
| 8.3 | CBR | Children and adolescents who have been admitted to hospital and who are at risk of suicidal ideation, attempts, or NSSI should have:<br>• access to specialist mental health services 24 hours a day<br>• a joint daily review by both the paediatric team and the mental health team<br>• daily access to a support person(s), ideally 24 hours a day<br>• regular multidisciplinary meetings between the paediatric team and mental health team |
| 8.4 | CBR | If a 16 to 19-year-old is admitted to an adult hospital ward, ensure that the ward can meet the needs of adolescents. |
| 8.5 | CBR | Before discharging a child/adolescent who experiences or is at risk of suicidal ideation, attempts, or NSSI from hospital, ensure that:<br>• a biopsychosocial assessment has taken place<br>• a plan for further management has been decided and agreed upon by the child/adolescent and their support system, including a safety plan<br>• a discharge planning meeting with the care team has taken place, including physical healthcare professionals if necessary<br>• arrangements for aftercare have been specified, including clear documentation and written communication with the relevant care or primary care team |

## 9. Safer prescribing

| No. # | Type | Recommendation |
|---|---|---|
| 9.1 | CBR | When prescribing medication for co-occurring conditions to a child/adolescent who experiences suicidal ideation, attempts, or NSSI, healthcare professionals should consider:<br>• potential adverse effects and risk of increased suicidal ideation, attempts, and NSSI<br>• the potential toxicity of the prescribed medications if not taken as prescribed, particularly where there is a risk of serious harm or death, including higher doses (eg opiate-containing painkillers, tricyclic antidepressants, and propranolol)<br>• recreational drug and alcohol consumption, the risk of misuse, adverse events, and possible interaction with prescribed medicines<br>• the need for effective communication where multiple prescribers are involved<br>• the preferences of the child/adolescent and their support system |

| | | |
|---|---|---|
| **9.2** | CBR | Discuss with the child/adolescent and their support system elements of safe prescribing, including:<br>• a symptom diary to track adverse effects<br>• education on how to manage medications, including medication adherence, and warning signs/symptoms of stockpiling medications<br>• safe medication storage, including who is responsible for and has access to medications<br>• limiting the quantity of medicines supplied (eg staged supply arrangements or weekly prescriptions)<br>• safe disposal of unwanted medications<br>• the child/adolescent's wider access to medicines prescribed for themselves or others |
| **9.3** | CBR | Healthcare professionals prescribing medication should carry out a medicines review after an episode of suicidal ideation, attempt, or NSSI.<br><br>This medicines review should consider:<br>• medications where suicidal ideation/attempts have known adverse effects (eg isotretinoin)<br>• the pharmacokinetic properties of medicines (eg half-life)<br>• the risk of toxicity<br>• the concurrent use of medicines such as benzodiazepines and opiates |
| **9.4** | CBR | Healthcare professionals, including GPs and community pharmacy staff, could use consultations and medicines reviews as an opportunity to identify risk of suicidal ideation, attempts, or NSSI, if appropriate.<br><br>For example:<br>• asking about thoughts of self-harm or suicidal ideation<br>• identifying access to substances that might be taken in overdose (including prescribed, over-the-counter medicines, herbal remedies, and recreational drugs) |

# Introduction

## Purpose of this guideline

The purpose of this guideline is to provide evidence-based guidance about the identification, assessment, and management of suicide and NSSI in children and adolescents (0-19 years) to ensure optimal and consistent care. The recommendations are informed by discussion of the research evidence among multidisciplinary health professionals, researchers, young people, and their caregivers with lived and living experience.

This guideline does not include specific guidance about the treatment of repetitive stereotypical self-injurious behaviour without deliberate intent to harm oneself (eg head-banging).

## Intended users of this guideline

This evidence-based clinical practice guideline is intended for use by a broad range of professionals who support or care for children and adolescents, including both health and non-health professionals. Professionals with appropriate training and credentials can use this guideline to inform identification, assessment, management, and support for children, adolescents, and their support systems experiencing suicidal ideation, suicide attempts, and NSSI within their scope of practice. Some recommendations are intended for professionals with specialised training, and these are indicated within the recommendation(s) or section.

The term "**professional**" is used to encompass all these roles.

**Figure one: Professional roles referenced within this guideline**

**Figure two: List of recommendations specific to each role**

| | |
|---|---|
| Recommendations specific to **non-health professionals** | 1.5, 3.1-3.3 |
| Recommendations specific to **healthcare professionals** | 1.6, 1.12, 2.1, 2.4, 2.5, 2.7, 3.7, 6.1, 6.3, 9.1-9.4 |
| Recommendations specific to **GPs** | 3.4-3.6, 9.1-9.4 |
| Recommendations specific to **mental health professionals** | 2.2-2.7, 5.1-5.8, 6.2, 6.6, 7.1-7.10 |

# Considerations for using this guideline

Recommendations in this guideline were developed using a recognised framework for evidence-based clinical guidelines that integrates the available evidence, clinical expertise, and lived experience perspectives.[4,5] See page 79 for a summary of **how the recommendations were developed**.

Each section contains recommendations in a table, evidence summary, discussion, and implementation considerations. Specific recommendations are referenced in brackets (eg [CBR x.x]).

**Figure three: Types of recommendations used in this guideline**

| **Evidence-based recommendations (EBR):** | **Consensus-based recommendations (CBR):** |
|---|---|
| Recommendations formulated from the Guideline Development Group (GDG) discussion of the research evidence, where a systematic search and evidence review were conducted, and evidence was identified and analysed. | Recommendations formulated by the GDG in the absence of research evidence, where a systematic search was conducted, and evidence was not identified or was of insufficient quality/quantity; or where there is known to be little high-quality evidence, in which case evidence was not sought, and the GDG formulated recommendations based on clinical expertise and experience. |

Despite the significant impact of suicide and NSSI on children, adolescents, and their families, there remains a notable lack of high-quality evidence to guide practice in many areas. During the development of this guideline, four comprehensive evidence reviews were conducted to identify available evidence for use in paediatric clinical practice. Unfortunately, very little high-quality evidence was identified (see the Technical Evidence Report for details of these reviews). As a result, the GDG was frequently required to draft recommendations where the evidence base is limited, inconsistent, or emerging. 7 of the 71 recommendations in this guideline can be considered EBRs. Whilst the remaining 64 recommendations are CBRs based on the experience of clinicians, researchers, and consumers, due to a known lack of evidence. This guideline aims to bring clarity by synthesising the best available evidence while also being transparent about gaps in knowledge and the need for ongoing research to strengthen future practice.

The terms "should", "could", and "should not" are used to reflect the GDG's interpretation of the balance of benefits and harms. The broad range of contextual factors that may contribute to the experience of suicide or NSSI for a child/adolescent (eg social determinants of health like living situation, environment, family mental health, as well as underlying motivations and coping mechanisms) and also the crucial role of the support system for a child/adolescent's health and wellbeing were considered.

# Language used in this guideline

The authors of this guideline aim to use respectful and inclusive language that avoids reinforcing stigma, prejudice, or discrimination. In some instances, terms aligned with international diagnostic classification standards are used for consistency and clarity. However, these may not always be appropriate when communicating with children, adolescents, or their support systems. It is important to recognise that different communities may have their own preferred terms, and professionals are encouraged to use language that is culturally safe, person-centred, and aligns with the preferences of those they are supporting.

See page 72 for a glossary of terms used in this guideline.

**Figure four: Abbreviations used in this guideline**

| | |
|---|---|
| **NSSI** | Non-suicidal self-Injury |
| **GDG** | Guideline Development Group |
| **EBR** | Evidence-based recommendation |
| **CBR** | Consensus-based Recommendation |
| **PTSD** | Post-traumatic stress disorder |
| **NICE** | National Institute for Health and Care Excellence (UK) |
| **ED** | Emergency department |
| **DBT** | Dialectical behavioural therapy |
| **CBT** | Cognitive behavioural therapy |
| **CMHS** | Campus Mental Health Strategy |
| **PICO** | P: population, I: intervention, C: comparison, O: outcomes |

There are many terms and definitions used to describe the experience of self-harm and suicide. In this guideline, the GDG has chosen to use the terms suicide, including suicidal ideation and attempts, and non-suicidal self-injury (NSSI) to encompass these experiences.

# What is suicide?

Suicide is an action or behaviour that an individual takes to cause harm to themselves and deliberately end their own life, resulting in death. This can include actions in the form of injury or poisoning and involves an intent to die.

When these actions or behaviours do not result in death, this is called a "suicide attempt". Like suicide, suicide attempts involve an intent to die but are distinguished by the outcome.

"Suicidal ideation" is the experience of thoughts of suicide or ending one's life, especially when these thoughts are persistent in nature. This can also include non-specific thoughts of death and can vary from a general sense of life being meaningless to a preoccupation with ending one's own life. Suicidal ideation can occur with or without suicidal behaviours. Suicidal ideation is a clinical term that can be confusing or confronting for young people and their families. In plain language, suicidal ideation refers to "thoughts of suicide or death".

# What is non-suicidal self-injury?

NSSI is the intentional harm to a person's own body without the intent to cause death. Common behaviours associated with NSSI are cutting, scratching, burning or hitting. NSSI can be chronic or acute in nature. Some people who engage in NSSI will also experience periods of suicidal ideation or intent.

There is international debate about the terms "NSSI", "suicide attempt", and "self-harm", noting that separating the terms based on intent creates rigid diagnostic criteria that are difficult to discern in clinical practice.[6] Others state that differentiation is important because each is distinct but can and do co-occur and deserve to be treated separately.[7] Reflecting on this, the GDG decided to adopt the terms "NSSI" and "suicide" as distinct but interrelated concerns that exist on a continuum. While suicidality and NSSI can be conceptually different, they are not fixed states. People may move between these experiences over time, and professionals should acknowledge this fluidity.

# The role of support people

Support people play a pivotal role in caring for and supporting children and adolescents experiencing suicidal ideation, attempts, and/or NSSI. Many children and adolescents remain safe due to the actions of those around them and the support they provide. This often includes essential emotional, practical, and relational support, and can help reinforce recovery and continuity of care across settings.

Families can come in many forms. This guideline uses the term "support system" and "support person(s)" to encompass all people who may care for or support a young person, including those with direct caring responsibility, like carers and guardians, and those who do not directly care for a child/adolescent, like siblings.

> *"Carers and support people are the lifeblood of those struggling. Too often we're dismissed by clinicians, instead of being seen as assets that can inform their decision-making process."*
>
> – support person

It is important to note that not all support people will be appropriate or safe to involve in care. Decisions about their inclusion should be guided by the child/adolescent's preferences, developmental stage, and safety considerations, recognising that some people, such as those involved in family violence, abuse, or coercion, may increase risk rather than reduce it.

This guideline does not provide advice or guidance to support those bereaved or impacted by loss of life to suicide. See page 75 for helpful resources to share with the support system.

# Caring for First Nations children and adolescents

Suicide and NSSI continue to occur at disproportionately high rates among First Nations children and adolescents, reflecting the ongoing impacts of colonisation, intergenerational trauma, systemic disadvantage, and inequitable access to culturally safe care in Australia. Between 2020 and 2024, 21 per cent of deaths among Aboriginal and Torres Strait Islander children (5-17 years) were due to suicide, compared to 16 per cent in their non-Indigenous counterparts.[8] While this guideline offers general clinical recommendations, it acknowledges the importance of culturally grounded, community-driven solutions and the need to work collectively toward better, safer, and more accessible care for First Nations children, adolescents, and communities.

See page 75 for resources about caring for Aboriginal and Torres Strait Islander children and adolescents.

# Section one
# Principles of care

## 1. Principles of care

| No. # | Type | Recommendation |
|---|---|---|
| 1.1 | CBR | Steps should be taken to ensure pathways are available within communities, schools, and clinical settings for children, adolescents, and their support systems to recognise, raise concerns about, and seek help for experiences of suicidal ideation, attempts, and NSSI. |
| 1.2 | CBR | Organisations that provide services to children and adolescents should have clearly defined policies and procedures appropriate to their setting.<br><br>Such organisations should provide supports to staff who care for children and adolescents experiencing suicidal ideation, attempts, and NSSI.<br><br>Examples of these staff supports may include:<br>• social workers/counsellors<br>• specialists (eg child and adolescent psychiatrists)<br>• legal advisors<br>• translators<br>• peer workers, lived experience professionals |
| 1.3 | CBR | Care should be person-centred and culturally safe, with respect to the child/adolescent and their support system. Decisions should involve the child/adolescent and their support system wherever possible while ensuring their safety and wellbeing. Note, there are situations where the involvement of some support people is not appropriate, for example, in circumstances of family violence. |
| 1.4 | CBR | Questions and conversations about suicidal ideation, attempts, or NSSI should be specific and unambiguous. |
| 1.5 | CBR | Professionals caring for and supporting children and adolescents who experience suicidal ideation, attempts, and NSSI should:<br>• be aware of policies and procedures for identifying and accessing supports, including organisational and legal frameworks relevant to their field<br>• know how to implement the policies and procedures within their role and responsibilities<br>• know who to go to for support and supervision |
| 1.6 | CBR | Healthcare professionals caring for children and adolescents who experience suicidal ideation, attempts, and NSSI should be:<br>• appropriately trained in child and adolescent mental health, including in developmentally nuanced, trauma-informed, intersectionality sensitive approaches and undergo supervision with a healthcare professional experienced in this field<br>• appropriately qualified, with current registration with the standard registration body for their profession (such as the Australian Health Practitioner Regulation Agency), if applicable<br>• appropriately credentialed and supervised in the therapy they are offering, if applicable<br>• aware of relevant legal frameworks or regulations |

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|---|---|---|
| **1.7** | EBR | Information and support for **children and adolescents** who experience suicidal ideation, attempts, or NSSI should be provided.<br><br>Topics to discuss may include:<br>• what suicidal ideation, suicidal attempts, or NSSI encompasses<br>• why people might experience suicidal ideation, attempts, or NSSI and, where possible, the specific circumstances of the child/adolescent<br>• available treatment options<br>• available supports, including lived experience workers, community supports, and peer groups<br>• self-care<br>• how to manage wounds and care for their injuries<br>• how to manage scars<br>• safety plans, and what they involve, including protective measures<br>• stigma and common misunderstandings around suicide and NSSI, and how they might react to this<br>• what to do if they have any concerns<br>• what to do in an emergency, including when to seek help<br><br>See page 75 for helpful resources to share with children and adolescents. |
| **1.8** | CBR | Information and support for the **support system** of children and adolescents who experience suicidal ideation, attempts, or NSSI should be provided.<br><br>Topics to discuss may include:<br>• the emotional impact on the child/adolescent and their support system<br>• what to do if the child/adolescent engages in NSSI or a suicide attempt again<br>• what to do if the child/adolescent discloses an experience of suicidal ideation<br>• how to seek help for the physical harm that may occur<br>• how to assist and support the child/adolescent to prevent perpetuation of stigma or blame<br>• how to recognise signs that the child/adolescent might be at risk for further harm<br>• steps to reduce the likelihood of suicidal ideation, attempts, or NSSI in the future<br>• advice on how to cope when supporting a child/adolescent who experiences suicidal ideation, attempts, or NSSI, including self-care and peer support for the support person(s)<br>• what to do in an emergency, including when to seek help<br><br>See page 75 for helpful resources to share with support person(s). |
| **1.9** | CBR | Information and resources for children, adolescents, and their support systems should be tailored to the child/adolescent's needs and circumstances, considering:<br>• the child/adolescent and their support system's preferred method of receiving support or information (eg digital, written, visual, audio etc)<br>• the child/adolescent's existing community and social supports, including involvement from their support system<br>• whether this is a first known presentation or a repeat event |

| | | |
|---|---|---|
| | | • the nature and type of self-harm (suicidal ideation, attempts, or NSSI)<br>• if the child/adolescent has any co-occurring health, mental health, or neurodevelopmental conditions<br>• environmental, cultural, and intersectional factors that may contribute to symptoms and their impact |
| **1.10** | CBR | Recognise that support and information may need to be adapted for people who are physically disabled, neurodivergent, have a learning or intellectual disability, Aboriginal and/or Torres Strait Islander peoples, culturally and linguistically diverse people, racially marginalised people, refugees, and LGBTQIA+ people to avoid discrimination and ensure equity in access and care. |
| **1.11** | CBR | If the child/adolescent who experiences suicidal ideation, attempts, or NSSI finds it difficult to vocalise their distress when they require care, professionals should:<br>• recognise the reasons why the child/adolescent may have difficulty communicating their distress and take steps to mitigate these (such as building trust and rapport, and engaging in calming activities)<br>• support the child/adolescent and their support system in trying alternative methods of communication (eg non-verbal language, letters, emotional wellbeing passports, and using agreed safe words, phrases, or emojis)<br>• work collaboratively to establish and document preferred methods of communication throughout care<br>• provide appropriate access to translations |
| **1.12** | CBR | Healthcare professionals caring for children and adolescents who experience suicidal ideation, attempts, or NSSI should, as early as possible, engage in clear, age-appropriate discussions with the child/adolescent and their support system about:<br>• **Confidentiality:** what information will be kept private, what might be shared, with whom, and under what circumstances.<br>• **Mandatory reporting obligations:** a clinician's legal duty to report concerns about abuse, neglect, or serious risk of harm in the interest of safety for the child/adolescent and others.<br>• **Consent:** what the adolescent or legal guardian is being asked to consent to (eg treatment), and that their preferences will be respected. |
| **1.13** | CBR | Aversive treatment, punitive approaches, or criminal justice approaches, such as community protection laws or prosecution for high service use, should not be used as an intervention for frequent suicidal ideation, attempts, or NSSI. |
| **1.14** | CBR | The use of restrictive interventions should be prevented wherever possible and used only in accordance with federal and state legislation (eg mental health and wellbeing acts), including relevant authorisation, observation, and reporting obligations. |

# Evidence review summary

The GDG formulated the principles of care recommendations [EBR 1.7, CBRs 1.1-1.6, 1.8-1.14] informed by comprehensive review, discussion, and adaptation of the National Institute for Health and Care Excellence UK (NICE) guideline evidence review and recommendations.[9] The evidence review conducted by NICE was not updated, and instead, the GDG sought to narratively discuss the work of NICE in the context of the experiences and needs of those in the GDG with lived and living experience in the Australian health care setting, led by the discussion questions below.

# Discussion and context

**Discussion was centred around the following questions:**

- What are the information and support needs of children and young people who have engaged in suicide or NSSI?
- What are the information and support needs of the families and carers of children and young people who have engaged in suicide or NSSI?
- What is best practice in the clinical management of suicide risk, suicidal ideation and NSSI in children and young people from special populations, including First Nations, culturally and linguistically diverse communities, LGBTQIA+ people, neurodivergent people, and those with co-occurring conditions?
- What is the most effective approach to obtain consent, ensure confidentiality, and promote safeguarding when children and young people have engaged in suicide and NSSI?

Evidence synthesised by NICE suggests that children, adolescents, and their support systems assess the quality of support they receive largely through the clarity, compassion, and consistency of communication. They also value support from a range of sources, including community services, and peer and lived-experience workers, which can reduce isolation and help counteract feelings of shame or guilt.[10,11] The GDG agreed that information and support must be tailored to each child/adolescent's circumstances, acknowledging that support people frequently struggle to access the guidance they need and may require specific supports or information tailored to them [EBR 1.7, CBR 1.8-1.10].

Conversations about support and information can be used to build trust with the child/adolescent and their support system, validate experiences, and address stigma. The GDG noted that trust is a crucial aspect of care and treatment, as people often will not disclose or discuss information with those they do not trust or know. Further, building trust and rapport early on is especially important with children and adolescents who may not be able to communicate their distress or emotions, which is common in neurodiverse children and adolescents or those with communication disorders. The use of non-verbal forms of communication can reduce the need for the person to explain how they are feeling and help to build the initial therapeutic rapport and understanding of the child/adolescents needs [CBR 1.11].

The GDG recognised the importance of individualised and culturally safe support as each child/adolescent will vary widely in their developmental stage, socioeconomic and cultural background, neurodiversity, and co-occurring conditions. Clear, direct communication is essential, particularly because some children may misinterpret vague or euphemistic language about suicide and NSSI. In addition, recognition of specific needs and how they can affect the child/adolescent and their support system is essential as these can be causal factors for suicidal ideation, attempts, and NSSI [CBR 1.4,1.10].

The GDG had many conversations about the complexity of confidentiality and consent, including the significant legal and ethical variability across jurisdictions and the need to consider a child/adolescent's age, developmental stage, and decision-making capacity. Given the variation in government and organisational policies, the GDG agreed that only high-level guidance should be provided around consent, confidentiality, and mandatory reporting [CBR 1.12]. The GDG agreed that conversations about these topics should be engaged early in the care journey, ensuring the child/adolescent and their support system understand and agree on what will be shared, with whom, and under what circumstances. Safety and wellbeing of the child/adolescent should always be prioritised, considering circumstances where a support person may increase risk (eg family violence, abuse, coercion), or when an environment is unsafe (eg homelessness). Throughout the recommendations, there are references to consent and confidentiality. Professionals should be aware of and follow the regulations of their jurisdiction and organisation.

In addition to the above questions, the GDG discussed a public health approach to the prevention of suicide and NSSI, acknowledging the role social determinants play in health and wellbeing, and the role organisations play in addressing these determinants. The GDG stressed that the responsibility to provide appropriate structures, supports, and pathways rests with organisations, not individual professionals or families. Organisations must ensure that professionals have access to timely guidance, supervision, and escalation pathways appropriate to their context. This includes both health and non-health organisations that routinely engage with children and adolescents [CBR 1.1,1.2].

> *"After losing my friend to suicide, I felt incredibly supported across two community groups where we ran sharing circles. I had space to offload about my struggles, but I also got to hear the challenges of others, giving me perspective, purpose and connection."*
>
> – support person

# Implementation considerations

The GDG discussed several implementation considerations that may affect uptake of these recommendations across different settings. Access to organisational policies, specialist advice, and supporting resources varies substantially based on the setting, with some environments, such as schools, community services, and youth programs, having limited organisational supports or policies. Whereas established healthcare providers like hospitals may have greater access to support or already developed systems. In addition, the GDG noted that costs associated with implementing recommended supports may limit feasibility in some services, considering the size and remoteness of organisations. Even within established health systems, the GDG identified delays in accessing specialist or medico-legal consultation as a key challenge, with the potential to compromise timely and safe care and put strain on therapeutic relationships.

# Section two
# Identification and risk assessment

## 2. Identification and risk assessment

| No. # | Type | Recommendation |
|---|---|---|
| 2.1 | CBR | Healthcare professionals concerned about the risk of suicidal ideation, attempt, or NSSI can engage in clear, unambiguous clinical discussion with the child/adolescent and their support system to identify risk and inform next steps in assessment or care planning.<br><br>This should include:<br>• consideration of individual context, needs, and risks<br>• discussion in a quiet, private space<br>• establishing connection/rapport with the child/adolescent<br>• supporting the child/adolescent through a non-judgemental, active supporting role |
| 2.2 | CBR | Mental health professionals should undertake a risk formulation as part of every biopsychosocial assessment to assess current risk and inform interventions and support for the child/adolescent. |
| 2.3 | CBR | A risk formulation should:<br>• be in collaboration with the child/adolescent and their support system<br>• be focused on the child/adolescent's needs and wants<br>• consider how to support immediate and long-term psychological and physical safety<br>• consider risk and protective factors (see recommendations 2.4-2.5)<br>• consider potential triggers for risk escalation<br>• consider risk caused or exacerbated by any co-occurring conditions (see recommendation 2.6) |
| 2.4 | EBR | Healthcare professionals caring for children and adolescents should consider the potential increased risk of suicidal ideation, attempt or NSSI in those who have experienced any of the following factors:<br>• previous suicide attempt<br>• personal history of mental illness<br>• neurodivergence<br>• taking medications with known adverse effects of suicidal ideation or self-harm<br>• family history of mental illness, or death by suicide<br>• peer suicide attempt or death by suicide<br>• maltreatment or abuse<br>• parental incarceration<br>• contact with Child Protection Services or out-of-home care<br>• bullying or cyber-bullying |
| 2.5 | CBR | Healthcare professionals caring for children and adolescents could consider the potential increased risk of suicidal ideation, attempt or NSSI in those who have experienced any of the following factors:<br>• increased social media use (including bullying and harmful online experiences)<br>• social isolation |

| | | |
|---|---|---|
| | | • adverse childhood experiences<br>• sexual abuse or unwanted sexual experiences<br>• financial stress<br>• family history of legal difficulties<br>• chronic illness within the support system<br>• death of a loved one<br>• community or family violence<br>• discrimination<br>• racism<br>• common co-occurring conditions (see recommendation 2.6)<br><br>Note: Some groups in the community (eg Aboriginal and Torres Strait Islander people, LGBTQIA+ people, gender diverse people, and people with disabilities) may be disproportionately exposed to these determinants due to structural and systemic inequities and stigma. Healthcare professionals should consider that these identities may hold an increased risk. However, the identity itself is not a risk factor. |
| **2.6** | CBR | Suicidal ideation, attempt, or NSSI commonly co-occurs with (or is experienced in the context of) a range of medical, mental health, and neurodevelopmental conditions that should be considered during assessment, care planning, treatment, and management. This includes, but is not limited to, the following diagnoses and presenting problems, which may first emerge in childhood or adolescence, including:<br>• ADHD, autism spectrum disorder, and specific learning disorders<br>• anxiety disorders<br>• asthma<br>• attachment-based disorders<br>• bipolar and related disorders<br>• borderline personality disorder<br>• depressive disorders or depressive factors, such as feeling hopeless or worthless<br>• dissociative disorders<br>• epilepsy<br>• feeding and eating disorders<br>• intellectual disabilities<br>• obsessive-compulsive disorder and body dysmorphic disorder<br>• oppositional defiant disorder and conduct disorder<br>• physical disabilities and chronic conditions (eg chronic pain)<br>• post-traumatic stress disorder (PTSD) and complex PTSD<br>• schizophrenia spectrum disorders (including psychosis)<br>• substance-related and addictive disorders |
| **2.7** | CBR | To ensure appropriate holistic care, healthcare professionals caring for or supporting children and adolescents who experience suicidal ideation, attempts, or NSSI, and a co-occurring condition should:<br>• recognise how co-occurring conditions may present in children and adolescents of different ages, genders, and cultural backgrounds<br>• understand early warning signs, symptoms, prognosis, and best practice treatment, and support options associated with these co-occurring conditions |

| | | |
|---|---|---|
| | | • understand precipitating factors and functions associated with suicidal ideation, attempt, or NSSI that may co-occur with other conditions<br>• consider subclinical psychological symptoms and traits that may be associated with suicidal ideation, attempt, or NSSI (eg impulsivity, lower self-esteem, emotional dysregulation) and a co-occurring condition, even if a person does not meet the criteria for a diagnosis<br>• enable appropriate, affordable, accessible, and timely assessment and referral pathways for children and adolescents who may be experiencing these co-occurring conditions<br>• respect individual preferences regarding the use of diagnostic labels, including person-first, gender affirming, and neuro-affirming language |
| **2.8** | CBR | Population-level screening for suicidal ideation, attempt, or NSSI should not be routinely implemented when working with children and adolescents. |
| **2.9** | CBR | Risk assessment tools and scales can be helpful to aid in assessment, but should not be used solely to:<br>• predict future suicide or repetition of suicidal ideation, attempt or NSSI<br>• determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI |
| **2.10** | CBR | Global risk stratification (eg low, medium or high risk) should not be used to:<br>• categorise risk of future suicide or repetition of suicidal ideation, attempts, or NSSI<br>• determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI |

# Evidence review summary

The GDG formulated the identification and risk assessment recommendations [EBR 2.4, CBRs 2.1-2.3, 2.5-2.10,] based on evidence review and clinical discussion, and informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations.[9]

**Evidence reviews were conducted for the following questions:**

- What are the risk factors for suicidal ideation in children and young people?
- What are the risk factors for suicide attempts in children and young people?
- What are the risk factors for NSSI in children and young people?
- What are the key protective factors for suicide attempts in children and young people?
- What are the key protective factors for suicidal ideation in children and young people?
- What are the key protective factors for NSSI in children and young people?
- What are the benefits and harms of a risk assessment and formulation, including those models or tools that combine elements of machine learning and artificial intelligence for children and young people who have engaged in NSSI?

## Risk factors

The GDG introduced a new question and search strategy to identify possible risk factors. The search conducted in April 2025 identified 3768 potentially relevant articles. After the review of titles and abstracts, 132 full-text articles were reviewed, and 18 articles were included. Of these articles, 16 were eligible primary studies and were extracted. The identified risk factors are reflected in EBR 2.4. The summary table and full evidence review can be found in the Technical Evidence Report: Evidence review 4.

### Risk assessment and formulation

The NICE group sought evidence for the question, "What are the benefits and harms of a risk assessment and formulation, including those models or tools that combine elements of machine learning and artificial intelligence for people who have self-harmed" in October 2020 and did not identify any evidence in children and adolescents. The search developed by NICE was adopted to update the evidence review in October 2024. Of the 5867 article titles and abstracts screened, 188 full articles were reviewed, and 2 primary studies were eligible for inclusion, summarised below.

Brent 2023 prospectively compared the validated Computerized Adaptive Screen for Suicidal Youth (CASSY) tool and the Ask Suicide-Screening Questions (ASQ) tool in 12 to 17-year-old children (n=2750) seen in paediatric emergency care centres in the United States. At the 3-month follow-up, risk of suicide attempt and suicide related events were predicted with similar accuracy using either tool when sensitivity and specificity were calculated.[12]

Mayes 2023 retrospectively assessed the predictive accuracy of the Concise Health Risk Tracking Self-Report (CHRT-SR) tool and the Columbia Suicide Severity Rating Scale (C-SSRS) in 12 to 18-year-old children and adolescents (n=539) with severe suicidal ideation and/or behaviours who were enrolled in an intensive outpatient program for youth at risk of suicide in a large not-for-profit children's hospital for 5 to 8 weeks. Statistical significance of comparisons was not reported, and a ROC analysis suggested that both tools performed similarly.[13]

Given the limited volume and certainty of the evidence, the GDG sought to narratively discuss the development of CBRs for risk assessment and formulation. The full evidence review methods and results can be found in the Technical Evidence Report: Evidence review 1.

### Assessment for suspected self-harm, suicidal ideation, behaviours or attempt

The NICE group identified limited evidence in October 2020 (1 study, n=35) for the assessment of suspected self-harm in children and young people. The search developed by NICE was adopted to update the evidence review in October 2024. Of the additional 5867 article titles and abstracts screened, 188 full articles were reviewed. None of these articles met the selection criteria, thus the GDG sought to narratively discuss and formulate CBRs for suspected suicidal ideation, attempts, and NSSI. The methods for this evidence review can be found in the Technical Evidence Report: Evidence review 1.

## Screening

The GDG introduced new discussion questions to explore whether there are benefits to population screening for suicidal ideation, attempts, or NSSI in children and adolescents. An evidence review was not conducted, and instead, the GDG sought to discuss using a structured framework based on clinical expertise to draft a recommendation on screening [CBR 2.8].

### Co-occurring conditions

The GDG introduced a new discussion question to explore possible co-occurring conditions that may prompt risk assessment. An evidence review was not conducted, and instead, the GDG sought to discuss using a structured framework based on clinical expertise and the work of the NICE group to draft recommendations for co-occurring conditions [CBR 2.6-2.7].

## Discussion and context

**In addition to the above evidence review questions, discussion was centred around the following questions:**

- What are the benefits and harms of screening for suicide risk or suicidal ideation in children and young people?
- What is the appropriate method of screening for suspected NSSI in children and young people?
- Are there existing reliable and valid screening instruments in emergency departments for use by clinicians and other acute care providers, to screen suicide risk and suicidal ideation in children and young people?
- Are there existing reliable and valid screening instruments in non-emergency settings for use by clinicians to screen for suicide risk and suicidal ideation in children and young people?
- What conditions co-occur with NSSI, suicidal ideation or attempt in children and young people? for children and young people who have engaged in NSSI?

In discussion of identification of risk, the GDG acknowledged that healthcare professionals may recognise potential suicidal ideation, attempts, or NSSI but not feel qualified to conduct a formal assessment. The group emphasised that identifying risk does not require specialist qualifications. Rather, it requires clear, direct, and developmentally appropriate questions that can allow them to understand a child/adolescent's experience [CBR 2.1]. Identification of risk should focus on establishing safety for the child/adolescent and does not need to be a comprehensive clinical assessment. If risk is identified, professionals should follow organisational pathways to escalate concerns to appropriately trained mental health professionals.

The GDG agreed that screening for suicide should not adopt a "one size fits all" approach when working with children and adolescents, therefor population-level screening is not recommended [CBR 2.8]. Instead, assessment of risk should be adaptable and responsive to diversity across age, gender, culture, religion, language, disability, setting, and other individual characteristics and is not generalisable to large population groups. Population-level screening using rigid, checklist-based tools carries potential harms, including over-identifying risk where it may not be clinically meaningful, and under-identifying children and adolescents whose distress does not align with traditional definitions of risk. This can increase distress, lead to inappropriate responses by untrained professionals, or limit help-seeking behaviours and access to required supports.

Risk assessment plays an important role in identifying potential harm and guiding appropriate next steps in care. As no single instrument was identified as having sufficient evidence to reliably predict suicide risk, the GDG recommends against using screening or risk assessment tools and scales as the sole indicator for risk or triage [CBR 2.9]. To reduce the risk of misinterpretation, incorrect application, and unintended harm, these tools should be used cautiously and only to support further clinical

discussion. The GDG recommends the use of collaborative risk formulation as an alternative to reliance on traditional risk assessment using structured tools [CBR 2.2-2.3]. Tools and scales can be used to inform and guide formulation discussions led by trained mental health professionals who can interpret results within the child/adolescent's broader clinical and biopsychosocial context.

Risk formulation typically considers historical experiences, recent stress, developmental and contextual factors, and available resources to understand the broader context of a behaviour and dynamic risk a person may experience [CBR 2.3]. Risk formulation is a newer concept that still has developing evidence, and no tools have been developed for use in children and young people. The Royal Children's Hospital and Murdoch Children's Research Institute are currently conducting research to adapt a risk formulation framework developed by Pisani et al. for use in children and adolescents. The framework informs risk formulation that considers preventative steps and moves away from predictive mindsets.[14]

The GDG discussed the use of risk stratification (categorising risk as low, medium, or high), noting that this approach can be misleading and potentially harmful. Risk stratification categorises patients based on perceived or assumed risk, which can limit timely care. Further, risk stratification can perpetuate stigma and contribute to patient distrust. Therefore, the GDG agreed that risk stratification should not be recommended [CBR 2.10]. Instead, risk should be understood in relation to the individual's unique context, circumstances, and needs, rather than compared against population-level or relative risk thresholds.

The experience of suicidal ideation, attempts, and NSSI is shaped by a wide range of socioeconomic and environmental factors and experiences. The recommendations relating to risk factors are informed by evidence review [EBR 2.4], and clinical consensus and experience [CBR 2.5] where limited evidence was identified. The GDG noted the complex role of gender in risk. Evidence suggests that female children and adolescents are more likely to report suicidal ideation and suicide attempts, whereas the male gender is associated with a higher risk of death by suicide.[1,15] These factors are influenced by social norms, help-seeking behaviours, access to means, and expectations around emotion, and should not be interpreted as fixed or deterministic. Risk must always be understood in context, acknowledging that gender intersects with culture, sexuality, neurodiversity, socioeconomic status, and other factors that can increase or buffer vulnerability.

> *"Each year, I wrote myself a letter on my birthday – and it would always open with something along the lines of, 'Oh, we're still alive'. I think it started in my late teens and I remember writing one on my 23rd birthday. I can't remember when it stopped – only that one year I realised it had been a few years since the last. Later, I learned these experiences had names, and these names had meanings and held relative importance. My experiences were those of chronic suicidality and non-suicidal self-injury. Not of suicide attempts. And in the hubbub of triage and risk assessments, I was not of primary concern. It felt like my experiences were less valid and didn't matter. Yet all the same, I held a strong ambivalence for life. I wanted to feel different. It felt like I wasn't sick enough – I didn't want to die enough. Sometimes I wonder how we can hold both the need to prioritise limited resources in our health system and the whole person right in front of us, as they are."*
>
> – young person

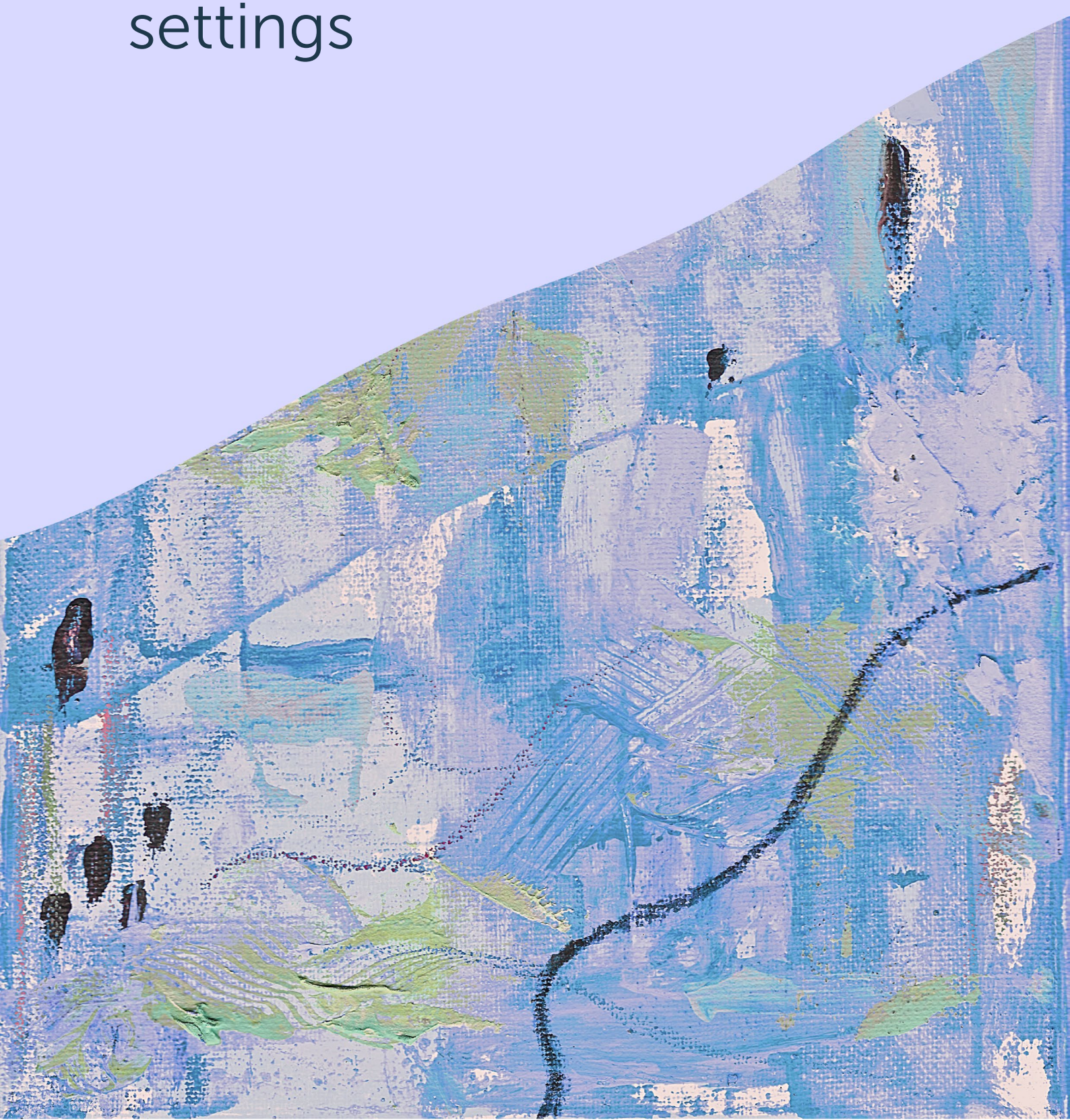
Further, certain identities are associated with increased exposure to risk as a result of structural inequities, discrimination, and trauma, rather than inherent vulnerability. Specifically, Aboriginal and Torres Strait Islander people, LGBTQIA+ people, gender diverse people, or people with disabilities are exposed to marginalisation, racism, violence and exclusion that contribute to disproportionate prevalence of suicide and NSSI in these communities. The GDG agreed that listing specific demographic characteristics as risk factors risks conflating identity with pathology and may contribute to stigma [CBR 2.5]. Identity should instead be understood in the context of both strengths and protective cultural, familial, and community connections. Elevated risk arises from experiences, and care should focus on addressing inequities while affirming identity and supporting culturally safe and inclusive practice.

In addition to risk factors, the GDG discussed co-occurring conditions based on clinical consensus, recognising that many children and adolescents who experience suicidal ideation, attempts, or NSSI present with multiple, interacting difficulties rather than a single condition. These co-occurring conditions can influence how suicide risk is expressed, perceived, and managed, and should be considered as part of identifying risk [CBR 2.6]. Further, conditions that co-occur may affect engagement with care, treatment response, and recovery. Their presence may increase vulnerability during periods of stress, complicate assessment, or require adaptations to standard interventions [CBR 2.7].

# Implementation considerations

The GDG acknowledged significant implementation challenges surrounding the use of risk assessment tools, noting that risk assessment tools and risk stratification frameworks are deeply embedded within many healthcare systems and are often used to direct care pathways, access to services, and documentation requirements. Shifting away from tool-driven or categorical approaches may be difficult where electronic medical records, service thresholds, funding models, or organisational policies rely on predefined risk scores or classifications. These system-level constraints can inadvertently prioritise administrative processes over individualised clinical judgement.

# Section three
# Care in non-mental health settings



The recommendations below [CBRs 3.1-3.7] apply to healthcare professionals, including GPs, allied health, and ambulatory staff, and non-health professionals, such as educators. Each professional should refer to the recommendations within their role or capacity.

## 3. Care in non-mental health settings

| No. # | Type | Recommendation |
|---|---|---|
| 3.1 | CBR | If suicidal ideation, attempt, or NSSI is identified or suspected during care or other points of contact by a non-health professional, they should establish the following as soon as possible:<br>• the severity of any physical injury, and if urgent medical treatment is needed<br>• the child/adolescent's emotional and mental state, and level of distress<br>• whether there is immediate concern about the child/adolescent's safety<br>• whether the child/adolescent has a safety plan and/or an established relationship with a mental health service or GPs |
| 3.2 | CBR | The child/adolescent should be referred to healthcare professionals for physical injury and mental healthcare as soon as possible after a suicide attempt, or NSSI is identified. |
| 3.3 | CBR | When supporting a child/adolescent who experiences suicidal ideation, attempts, or NSSI, non-health professionals should:<br>• discuss with the child/adolescent and their support system the best way to help in their role/capacity<br>• follow the child/adolescent's safety plan, if available<br>• seek advice from healthcare professionals<br>• communicate with relevant people involved in ongoing care, including support person(s) or healthcare professionals, with consent from the child/adolescent if safe to do so<br>• empower the child/adolescent to support themselves independently, where developmentally appropriate |
| 3.4 | CBR | GPs caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI in primary care should consider referring to mental health services for a biopsychosocial assessment or informing their existing mental health team, with consent from the child/adolescent and their support system.<br><br>Make referral to mental health professionals a priority when:<br>• the child/adolescent or their support system asks for further support from mental health services<br>• the child/adolescent's levels of concern or distress are increasing, they are a risk to self and others, or are not otherwise manageable in the community<br>• the frequency or degree of suicidal ideation, attempt, or NSSI is increasing<br>• levels of distress in their support system are increasing or not improving, despite attempts to help |

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| **3.5** | CBR | When communicating with relevant healthcare professionals or referring to specialised mental health services, collect and document relevant information about the child/adolescent's:<br>• home environment<br>• social and family support network<br>• community involvement (eg school, sport, religion)<br>• history of NSSI or suicide attempts<br>• current emotional and mental state, and level of distress<br>• access to means of self-harm, including medications |
| **3.6** | CBR | GPs supporting children and adolescents who experience suicidal ideation, attempts, or NSSI in primary care should ensure that the child/adolescent has:<br>• regular appointments for review of symptoms and their impact<br>• a medicines review (see recommendations 9.1-9.4 for considerations about prescribing medications)<br>• information about available supports, including lived experience workers, community supports, or peer groups, and how to utilise these<br>• care for any co-occurring conditions<br>• information about safety planning, including harm minimisation or appropriate coping strategies |
| **3.7** | CBR | Healthcare professionals caring for a child/adolescent after an episode of NSSI or suicide attempt should:<br>• establish the means of self-harm and, if accessible to the child/adolescent, discuss removing with therapeutic collaboration or negotiation to keep them safe<br>• gather information to understand the full context and function of the behaviour<br>• seek consent to liaise with the support person(s)<br>• discuss with the child/adolescent and their support system, about safety plan(s) or appropriate coping strategies |

# Evidence summary

The GDG formulated the recommendations for care in non-mental health settings [CBRs 3.1-3.7] based on comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations,[9] and discussion of the below evidence review questions.

### An evidence review was conducted for the following questions:

- How should assessment for suicidal ideation, behaviours or attempt in children and young people be undertaken in non-specialist settings such as primary care, social care, community pharmacy, ambulances, emergency departments (by non-specialist staff), schools, colleges and universities, the criminal justice system, immigration removal centres, and acute general hospitals?
- How should assessment for suspected NSSI in children and young people be undertaken in non-specialist settings such as primary care, social care, community pharmacy, ambulances, emergency departments (by non-specialist staff), schools, colleges and universities, the criminal justice system, immigration removal centres, and acute general hospitals?

The search developed by NICE was adopted to update the evidence review in October 2024 to answer the above questions; however, no eligible studies were identified. The GDG sought to narratively discuss and formulate CBRs. The methods for this evidence review can be found in the Technical Evidence Report: Evidence review 1.

# Discussion and context

The GDG considered it essential to provide clear guidance for professionals working in non-mental health settings, such as GPs, school counsellors, teachers, youth workers, ambulance staff, and other community-based practitioners, who are often the first to identify mental health concerns or risk of suicidal ideation, attempts, or NSSI in children and adolescents. These professionals play a pivotal role in early identification, initial response, and facilitating access to appropriate physical and mental health care. They also often have established, trusted relationships with young people and support systems, and may remain involved throughout the care journey.

Professionals in non-mental health settings should focus on establishing immediate safety while seeking to understand the broader context of the young person's distress. This includes recognising potential risks for further suicidal behaviours or NSSI, but also environmental and contextual risks such as family violence, abuse, bullying, or unsafe living environments [CBR 3.1-3.3, 3.7]. The GDG acknowledged that professionals are not expected or required to undertake a comprehensive assessment, noting that this is neither appropriate nor within the scope of training for non-health professionals. Once safety is established, professionals are encouraged to engage with curiosity to understand what has happened and why before reacting harshly. Non-health professionals are also encouraged to seek advice and support from healthcare professionals or social supports.

For GPs, the GDG agreed that harm minimisation strategies, community supports, coping mechanisms, and practical resources should be included as part of routine care, as these often have long-term benefits that extend beyond the immediate episode and remain helpful after formal follow-up concludes [CBR 3.4,3.6].

> *"Being referred to a peer worker was an incredible resource for not only myself but for my family too. For me, being able to connect with a young person who had a lived experience of mental health and recovery and made it through the hard times widened my lens and helped with my future thinking. My dad was able to have phone calls with a peer worker who had also cared for their child with mental health lived experience. This provided not only a space for my dad to talk and get support and advice when he wouldn't have usually reached out to a professional, but a space to receive education and reassurance that I was not the only child who experienced these things. He learned that despite lots of parents' great efforts, children may still go through struggles with their mental health, and it wasn't completely personal to him and how he parented me, making an important impact on our relationship."*
>
> – young person

Clear communication and collaboration among professionals caring for and supporting children and adolescents arose as a topic throughout GDG discussions. For consistent care across services, information between healthcare professionals should be clear and consistently documented in medical records [CBR 3.5]. Often, children, adolescents and their support systems are required to repeat information to healthcare professionals, recounting distressing experiences. By initiating clear communication with other services, re-traumatisation and distress can be avoided.

# Implementation considerations

The GDG acknowledges that often, current health system structures do not consistently support timely or immediate access to mental health care, putting primary care professionals and others in difficult positions. Pathways to care are often fragmented with long wait times, limited-service availability, and reliance on emergency departments (ED) or urgent care settings that may be difficult, costly, or distressing for families to access. Attendance frequently depends on the availability of transport, financial resources, or extended support from the support system, creating additional barriers for those already experiencing disadvantage. These limitations highlight the need for coordinated, flexible pathways that facilitate access to both physical and mental health assessment, reduce reliance on emergency services, and increase access to specialist mental health services.

## Section four

# Care in emergency or urgent care settings

## 4. Care in emergency or urgent care settings

| No. # | Type | Recommendation |
|---|---|---|
| 4.1 | CBR | Healthcare professionals in an ED or urgent care clinic caring for a child/adolescent after an episode of suicidal ideation, attempt, or NSSI, should establish the following as soon as possible:<br>• information included in CBR 3.7<br>• the child/adolescent's willingness to accept medical treatment and mental healthcare |
| 4.2 | CBR | When a child/adolescent attends the ED or urgent care clinic with risk of suicidal ideation, attempts, or NSSI, a referral should be offered to a specialist mental health service as soon as possible after arrival, for a biopsychosocial assessment, support, and assistance concurrent with physical healthcare. |
| 4.3 | CBR | A mental health professional should consult with the child/adolescent and their support system during an ED attendance, after an episode of suicidal ideation, attempt, or NSSI.<br><br>If a mental health professional is not available to consult with the child/adolescent directly, the treating team should liaise with a mental health professional for advice in the interim. |
| 4.4 | CBR | EDs or urgent care clinics should have:<br>• a quiet, designated area for biopsychosocial assessments to take place, where it is possible to speak in confidence with the child/adolescent and their support system without being overheard<br>• waiting area(s) close and visible to staff who can provide care, support, and observation |
| 4.5 | CBR | EDs or urgent care clinics should ensure that physical and mental health care can be delivered concurrently.<br><br>This can include:<br>• access to electronic document systems for both mental health services and medical treatment at the point of care<br>• agreed referral pathways for concurrent physical and mental healthcare<br>• jointly agreed approaches to initial assessment and triage<br>• shared understanding of relevant organisation and legal frameworks<br>• jointly agreed observation policies<br>• referral pathways to appropriate community services |
| 4.6 | CBR | The use of restrictive interventions in EDs or urgent care clinics should be prevented wherever possible and used only in accordance with federal and state legislation (eg mental health and wellbeing acts), including relevant authorisation, observation, and reporting obligations. |

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|---|---|---|
| 4.7 | CBR | Short-term extended stay in an ED should be avoided where possible. Short-term extended stay could be considered when:<br>• there are concerns about the safety of the child/adolescent (eg risk of violence, abuse, homelessness, or exploitation)<br>• the child/adolescent requires further care or surgery and cannot yet be admitted<br>• the child/adolescent requires support while being referred to specialist mental health supports or transferred to a mental health inpatient unit |

# Evidence summary

The GDG formulated the recommendations for care in emergency or urgent care settings [CBRs 4.1-4.7] informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations,[9] and discussion of the below evidence review and discussion questions.

### An evidence review was conducted for the following questions:

- How should assessment for suicidal ideation, behaviours or attempt in children and young people be undertaken in non-specialist settings such as primary care, social care, community pharmacy, ambulances, emergency departments (by non-specialist staff), schools, colleges and universities, the criminal justice system, immigration removal centres, and acute general hospitals?
- How should assessment for suspected NSSI in children and young people be undertaken in non-specialist settings such as primary care, social care, community pharmacy, ambulances, emergency departments (by non-specialist staff), schools, colleges and universities, the criminal justice system, immigration removal centres, and acute general hospitals?

The search developed by NICE was adopted to update the evidence review in October 2024 to answer the above questions; however, no eligible studies were identified. The GDG sought to narratively discuss and formulate CBRs. The methods for this evidence review can be found in the Technical Evidence Report: Evidence review 1.

# Discussion and context

### In addition to the above evidence review questions, discussion was centred around the following questions:

- What is the best practice response for management of an acute suicidal or NSSI crisis?
- What are the benefits and harms of common responses for management of an acute suicidal crisis or disclosure of suicidal ideation or behaviours, including admission to an inpatient unit, use of restraint, and pharmacological methods?
- What are the benefits and harms of common responses for management of an acute NSSI crisis or disclosure of NSSI, including admission to an inpatient unit, use of restraint, and pharmacological methods?

EDs and urgent care services are frequently the first point of contact for children and adolescents experiencing acute distress, suicidal ideation, attempts, or NSSI. These settings play a critical role in ensuring immediate safety, providing timely assessment, and initiating appropriate pathways of care. Presentations are often driven by crisis rather than planned help-seeking, highlighting the importance of ED and urgent care services being equipped to respond effectively and compassionately.

Care in these settings requires a careful balance between addressing immediate physical health needs (such as injury, overdose, or poisoning) and providing appropriate mental healthcare. The GDG highlighted the importance of ensuring that access to mental healthcare is not delayed by the presence of physical injuries or by the logistics of seeking urgent care [CBR 4.5]. Further, treatment for physical injury, including wound care, should be provided regardless of repeated or assumed risk of further injury, including NSSI. All treatment for physical injury should be taken seriously and provided without judgment or dismissal.

The GDG agreed that consultation by a mental health professional at every ED attendance following a suicide attempt or episode of NSSI should be the standard of care [CBR 4.2-4.3]. Though many emergency professionals are trained in mental health and responding to distressed individuals, they may lack the nuanced and specialised knowledge required to appropriately care for and assess a child/adolescent experiencing suicidal ideation, attempts, or NSSI. Inappropriate or insensitive care following an episode can further distress and traumatise a young person and prevent help-seeking in the future.

EDs and urgent care professionals should consider the impact of the physical and sensory environment on assessment and engagement. Attention to privacy and confidentiality is essential, while also minimising factors that may overwhelm or distress the child/adolescent, such as bright lighting, loud noise, or echoes [CBR 4.4]. The GDG agreed that consideration of neurodivergence is particularly important. Where possible, flexibility in how and where conversations occur, such as side-by-side seating, use of quieter or more homely spaces, or semi-private environments, may reduce feelings of intimidation or formality and support more open communication.

> *"I think we should always make an effort to try to improve things. This is something we have to do. It's our professional duty. I'm speaking as a clinician, as a head of a service. I should and will always keep looking to improve things, and even if they are small steps. We should continue to keep making those small steps and keep walking those small steps towards what might be a better and more inclusive service."*
>
> – senior clinician

The GDG discussed the risk associated with extended stays in ED and agreed that it is to be avoided where possible [CBR 4.7]. EDs are not a conducive environment for healing and can increase distress and agitation, and contribute to feelings of stigma or punishment. Unfortunately, there are some circumstances when children and adolescents will be in an ED for extended periods due to the availability or capacity of other services. These risks must be weighed against the benefits of ongoing observation and safety, with active efforts to minimise length of stay and transition the child/adolescent to a more appropriate setting as soon as available.

Consistent with legislation in many Australian states and territories, the use of restrictive interventions, including chemical, mechanical, and physical restraint, is not recommended and is only to be used as a last resort [CBR 1.14, 4.6]. The GDG agreed that the use of restraints often results in trauma, increased distress, and risk, and should be avoided. If used, considerable legal and ethical justification must be reported in line with local legislation (eg mental health and wellbeing acts).

# Implementation considerations

The GDG acknowledges the limited national availability of mental health professionals, and it is recognised that mental health support may not always be immediately feasible to respond to every presentation in an ED, particularly during periods of limited staffing, high service demand, or in rural and remote settings. In these circumstances, ED and urgent care clinicians should provide interim assessment, risk management, and safety planning, with clear arrangements for follow-up and linkage to specialist services in the community.

# Section five
# Care in specialist mental health settings

## 5. Care in specialist mental health settings

| No. # | Type | Recommendation |
|---|---|---|
| 5.1 | CBR | Mental health professionals caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI should carry out a biopsychosocial assessment as soon as possible to:<br>• build rapport and develop a collaborative therapeutic relationship with the child/adolescent<br>• begin to develop a shared understanding of why the child/adolescent is at risk of, or experiencing suicidal ideation, attempts, or NSSI<br>• ensure that the child/adolescent receives the mental and physical healthcare they need |
| 5.2 | CBR | Biopsychosocial assessment should not be delayed due to physical injury or until treatment for physical injury is complete. |
| 5.3 | CBR | Mental health professionals should focus the assessment on the child/adolescent's needs and how to support their immediate and long-term psychological and physical safety. |
| 5.4 | EBR | Biopsychosocial assessments should be carried out in a quiet area where the child/adolescent feels comfortable and can speak in confidence without being overheard. |
| 5.5 | CBR | Mental health professionals conducting a biopsychosocial assessment should ask about the child/adolescent's:<br>• social, peer group, education, and home situation<br>• caring responsibilities, if any<br>• use of social media and the internet to connect with others, and the effects of these on their mental health and wellbeing<br>• issues or concerns regarding their safety<br>• historic factors or past experiences<br>• changeable and current factors, including current symptoms or substance use<br>• future factors, including specific upcoming events or circumstances<br>• protective or mitigating factors |
| 5.6 | CBR | Mental health professionals conducting the biopsychosocial assessment should explore the function, motivation, or purpose of the child/adolescent's suicide attempt(s) or NSSI.<br><br>Consider:<br>• their values, wishes, what matters to them and their support system<br>• the need for psychological interventions, social care and support, or occupational rehabilitation<br>• any learning disability, neurodevelopmental condition, or mental health concerns<br>• their treatment preferences<br>• that each episode should be treated in its own right, and the reasons for self-harm may vary from episode to episode, individual to individual<br>• involvement of their support system and who their trusted persons are<br>• existing safety plans or plans for treatment and management |

| | | |
|---|---|---|
| **5.7** | CBR | Mental health professionals conducting biopsychosocial assessments should consider the needs and preferences of the child/adolescent and their support system as much as possible, including:<br>• making appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition they may have<br>• the child/adolescent's preferences regarding the demographics of the treating clinician (eg gender) and accommodate this where possible<br>• involvement of other appropriately trained professional(s) with whom the child/adolescent trusts or has an existing relationship with |
| **5.8** | CBR | If the child/adolescent is not able to or does not want to participate in a biopsychosocial assessment, mental health professionals should:<br>• assess their physical and psychological safety using available sources of information (eg level of distress)<br>• continue to build rapport and develop a collaborative therapeutic relationship with the child/adolescent<br>• ensure that they have regular reviews<br>• complete the assessment when possible |

# Evidence summary

The GDG formulated the recommendations for care in specialist mental health settings [EBR 5.4, CBRs 5.1-5.3, 5.5-5.8] informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations,[9] and discussion of the below evidence review questions.

**An evidence review was conducted for the following questions:**

- How should assessment for suicidal ideation, behaviours or attempt in children and young people be undertaken in specialist settings such as community mental health services, EDs (by specialist staff), inpatient mental health services?
- How should assessment for suspected NSSI in children and young people be undertaken in specialist settings such as community mental health services, EDs (by specialist staff), inpatient mental health services?

The search developed by NICE was adopted to update the evidence review in October 2024 to answer the above questions; however, no eligible studies were identified. The GDG sought to narratively discuss and formulate CBRs. The methods for this evidence review can be found in the Technical Evidence Report: Evidence review 1.

# Discussion and context

A core component of specialist mental health care is a comprehensive assessment that adopts a biopsychosocial framework. The GDG agreed that biopsychosocial assessments should be undertaken by mental health professionals with the appropriate clinical knowledge, skills, and experience to respond safely and effectively. These clinicians are best equipped to explore the complex interplay of biological, psychological, and social factors contributing to distress, and assess risk and protective factors within the child/adolescent's broader context [CBRs 5.1, 5.3, 5.5]. Such assessment enables care that goes beyond symptom description to understand the young person's needs, strengths, and risks over time.

The GDG agreed that it is important for mental health professionals to establish an understanding of the function of NSSI or suicidal behaviours for the child/adolescent [CBR 5.6]. These behaviours often serve a purpose in the young person's life or serve as a coping mechanism for emotional regulation, relief from distress, or communication of unmet needs. Understanding this function is essential to ensure that treatment can address the underlying drivers of behaviour, rather than focusing solely on risk reduction or stopping a behaviour.

Consistent with all other stages of care, the GDG emphasised that mental health professionals conducting biopsychosocial assessments should respect the needs and preferences of the child/adolescent and their support system. This includes making reasonable adaptations to accommodate the preferences and needs of the child/adolescent and inclusion of other professionals if requested. As assessment and early engagement with specialist mental health services is a particularly vulnerable period for children and adolescents seeking care, it is especially important that care is culturally safe and person-centred, supporting the early development of collaborative therapeutic relationships and trust [CBR 5.1, 5.7]. The GDG also recognised that some children and adolescents may be unable to communicate their needs, overwhelmed, or otherwise unable to participate fully in assessment due to distress, trauma, developmental factors, or co-occurring conditions. In these circumstances, flexibility in assessment processes, use of alternative communication methods, and adaptation can ensure care remains respectful and the child/adolescent is safe [CBR 5.8].

There is increasing recognition of the value of mental health spaces designed to feel "cozy" and welcoming rather than overtly clinical, especially in paediatric settings.[10] Such environments can reduce anxiety, promote calm, and reinforce person-first, collaborative care. Creativity and flexibility in engagement should be encouraged where safe and appropriate [EBR 5.4].

## Implementation considerations

The GDG noted that the limited availability of mental health professionals, coupled with long wait times, may delay access to comprehensive assessment and mental health care, particularly in regional, rural, and remote settings. As a result, services may need to prioritise presentations associated with higher levels of risk and provide interim supports, including safety planning, while awaiting specialist assessment. The GDG discussed the role of shared-care arrangements, consultation, and clinical supervision in supporting non-specialist clinicians when specialist capacity is constrained, especially in acute and primary care settings. Telehealth was also recognised as a potential mechanism to improve access to specialist expertise; however, it may not be appropriate, accessible, or effective for all children and adolescents.

## Section six

# Aftercare and safety planning

## 6. Aftercare and safety planning

| No. # | Type | Recommendation |
|---|---|---|
| **6.1** | CBR | After an episode of suicidal ideation, attempts, or NSSI, healthcare professionals should discuss and agree with the child/adolescent and their support system the purpose, format, and frequency of initial aftercare and which professionals/services will be involved in their care.<br><br>These decisions should be documented in the child/adolescent's medical record. Ensure that the child/adolescent and their support system have contact details for the care team providing the aftercare. |
| **6.2** | CBR | If there are ongoing safety concerns for the child/adolescent after an episode of suicidal ideation, attempts, or NSSI, the team that carried out the initial biopsychosocial assessment or the team responsible for care should provide initial aftercare as soon as practically possible, ideally within 24 hours of the biopsychosocial assessment. |
| **6.3** | EBR | Healthcare professionals caring for a child/adolescent who experiences suicidal ideation, attempts, or NSSI could consider developing a safety plan in partnership with the child/adolescent and their support system.<br><br>Safety plans should be used to document ways to keep the child/adolescent safe in times of distress or crisis, including:<br>• identified triggers and warning signs of increased distress, or further episodes of suicidal ideation, attempts, or NSSI<br>• identified appropriate coping strategies, including problem-solving and any factors that may act as a barrier to these<br>• identified people in the support system who can provide support and/or help resolve a crisis<br>• contact details for healthcare services, including existing links to mental health professionals and emergency contact details<br>• established intended means of self-harm<br>• making their environment psychologically and physically safe, including managing access to means of self-harm |
| **6.4** | EBR | The safety plan should be:<br>• developed in collaboration with the child/adolescent and their support system<br>• in a format that is accessible and understandable to the child/adolescent (eg digital or visual)<br>• developed using a problem-solving approach<br>• held by the child/adolescent or their support system, where appropriate<br>• shared with relevant professionals involved in their care, with consent from the child/adolescent<br>• accessible to the child/adolescent, their support system, and professionals involved in their care at times of crisis or distress |

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| **6.5** | CBR | The use of digital safety plans or phone safety apps could be used to increase access for the child/adolescent and their support system. |
| **6.6** | CBR | Together with the child/adolescent and their support system, the mental health professional should develop or update a plan for ongoing treatment and management (sometimes called a care plan) using the key areas of need and safety considerations identified in the biopsychosocial assessment and follow as closely as possible.<br><br>The child/adolescent and their support system should understand and have access to written information about the plan for treatment and management. Document this in the child/adolescent's medical record (including MyHealthRecord, if available) and, as soon as possible, share necessary information with all professionals involved in their care, with consent from the child/adolescent or their support system. |

# Evidence summary

The GDG formulated the aftercare and safety planning recommendations [EBRs 6.3-6.4, CBRs 6.1-6.2, 6.5-6.6] based on evidence review and clinical discussion, and informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations.[9]

**An evidence review was conducted for the following questions:**

- How should initial after-care be provided to children and young people following a suicide attempt or acute suicide crisis?
- How should initial after-care be provided to children and young people following an episode of NSSI or acute crisis?
- What length of follow-up is needed to reduce the risk of repeated suicide attempts or completed suicide in children and young people?
- What are the most effective ways of supporting children and young people to be safe after they have engaged in NSSI?

The NICE group searched for evidence in April 2021 and did not identify any studies about aftercare in children and adolescents. The search developed by NICE was adopted to update the evidence review and respond to the above questions in December 2024. 4403 articles were identified, and 18 full-text articles were reviewed. From this, 3 retrospective cohort studies were eligible for inclusion and were extracted. A summary of them follows. For the full evidence review methods and results, see the Technical Evidence Report: Evidence review 3.

Adrian 2020 compared retrospective data for 6 to 18-year-olds in the United States with (n=2,027) and without (n=29,120) hospitalisation in a psychiatric hospital in the 7 days before or the 7 days after self-injury. At the 12-month follow-up, the risk of subsequent self-injury was twice as likely in the hospitalised group (5.4% v 1.4% p<0.001; hazard ratio HR 2.13; 95% CI 1.72–2.67 p<0.001, adjusted for age, gender, region, insurance, year, and psychiatric disorders). The hospitalisation group also demonstrated higher service use in terms of: ≥1 in-patient hospitalisation at any location (31% v 11% p<0.001); ≥1 ED visit (49% v 35% p<0.001); ≥1 outpatient visit at any psychiatric facility (25% v 3% p<0.001); ≥1 outpatient visit at any type of facility (98% v 95% p<0.001). There was no statistically significant difference between the 2 groups for time to subsequent self-injury.[16]

Doupnik 2021 compared retrospective data for 6 to17-year-olds in the United States who reported to ED with suicide ideation or suicide attempt, and were either treated and immediately discharged (n=62,139) or hospitalised and treated as an inpatient (n=30,312). Service use in the 30 days after discharge between the 2 groups was not statistically analysed and are unlikely to be statistically significantly different for any visit (64% v 77%); outpatient mental health visit (49% v 67%); outpatient general visit (23% v 20%); ED or hospital visit (14% v 15%); or no health care encounter (36% v 23%).[17]

Fontanella 2020 compared retrospective data for 1 to 18-year-olds in the United States with (n=74,632) and without (n=65,062) a mental health visit with 7 days of discharge from a length of stay of 1 to 7 days long (77.2%), with mood disorders, such as depression (36.4%), and bipolar disorder (33.3%), the most common primary admission diagnoses. Youths with self-harm (n=1821, 1.3%) had 18% lower odds of receiving follow-up care within 7 days of discharge (odds ratio OR, 0.82; 95% CI, 0.74-0.90; adjusted for covariates: demographic and clinical characteristics and mental health service history). Females were more likely to receive follow-up care within 7 days of discharge when compared with males (unadjusted odds ratio OR, 1.03; 95% CI, 1.01-1.05). At the 6-month follow-up, of the 22 suicide events, there was no statistically significant difference between the 2 groups for risk of suicide (unadjusted relative risk RR, 0.49; 95% CI, 0.21-1.17; P = 0.11).[18]

# Discussion and context

The GDG emphasised the importance of timely aftercare and safety planning following a suicide attempt or episode of NSSI, particularly where there are ongoing safety concerns. During discussions, the GDG identified follow-up within 24 hours as a desirable standard of care due potential increased risk within that period [CBR 6.2]. Timely communication after a suicide attempt or NSSI is important to maintaining engagement, reinforcing a sense of safety for the child/adolescent, and providing reassurance and support for the support system.

Identifying an appropriately trained professional whom the child/adolescent knows and trusts to coordinate their care and aftercare was considered critical to continuity and quality of care. The GDG agreed that a clearly identified point of contact supports therapeutic engagement, reduces fragmentation across services, and helps ensure that care is coordinated and responsive over time [CBR 6.1,6.2]. Having a consistent professional involved can minimise the need for children and adolescents to repeatedly recount distressing experiences, which was recognised as potentially re-traumatising and a barrier to ongoing engagement. This role also supports clearer communication between services, the child/adolescent, and their support system, helping to maintain a shared understanding of risk, safety planning, and follow-up arrangements. Specifically, the GDG recognised that this should be a professional who is trusted by the young person and their family.

A core component of aftercare is safety planning and should be offered where there are ongoing safety concerns [EBR 6.3]. Qualitative evidence synthesised by NICE indicated that safety plans and individualised coping strategies play an important role in staff and patient management of self-harm. The NICE committee synthesised evidence for adults and used this to inform the suggested components of a safety plan.[9,19] The GDG agreed, reflecting that safety plans can equip children and adolescents who experience NSSI or suicide attempts with practical strategies to identify warning signs and access sources of support during crisis, reducing the likelihood of further harm.

As with other stages of care, collaborative decision making with children and adolescents can improve engagement and adherence. Ensuring that the child/adolescent has access to a copy of their safety plan was viewed as an important step in reinforcing this collaborative approach. Where appropriate

and with consent, sharing the safety plan with trusted support people was considered beneficial in strengthening social connectedness, and is a recognised protective factor against self-harm behaviours. The GDG also agreed that safety plans should be readily accessible to healthcare professionals involved in supporting the child/adolescent to ensure continuity of care, particularly in situations where they may be too distressed to recall their plan [EBR 6.4, CBR 6.6]. Clinicians involved with the GDG recalled success with digital or app-based safety plans that increase accessibility and adherence to plans [CBR 6.5].

> *"Tragically, we learn from some suicides of young people and the process of reviewing the care [we] provided. Decisions would be made regarding discharge or acceptance into a service or a certain frequency of appointments without providing any information to the young people and the families about why. One of the things that we learned was the importance of communicating in a way that would make sense to young people and families. Written in a language that is non-technical and something that resonates with young people and their family. That's very important. So that's what we've sort of landed on, a plan that is able to be printed off from the [medical record] and is developed with the young person and the family. It's printed off and shared with them."*
>
> – senior clinician

# Implementation considerations

The GDG acknowledged implementation challenges associated with providing universal follow-up and aftercare within 24 hours, particularly in the context of variable service capacity, workforce constraints, and resource limitations. While follow-up for all children and adolescents is important, the GDG recognised that this may not be feasible in every situation. As a result, the recommendations prioritise follow-up for children and adolescents with ongoing safety concerns or elevated risk, while noting the need for services to consider local resourcing and capacity when implementing aftercare pathways.

# Section seven
# Treatment

## 7. Treatment

| No. # | Type | Recommendation |
|---|---|---|
| 7.1 | CBR | Mental health professionals should offer psychological interventions without delay to children and adolescents who present with suicidal ideation, attempts, or NSSI, regardless of age, diagnosis, substance use, or co-occurring conditions. |
| 7.2 | CBR | When offering any intervention to children and adolescents, their age, culture, neurodiversity, gender diversity, support system or structure, available resources, rurality, and any planned transition between services should be taken into consideration. |
| 7.3 | EBR | If a psychological intervention is considered, dialectical behavioural therapy (DBT) tailored for children and adolescents should be offered first-line. |
| 7.4 | CBR | Alternative psychological interventions, such as cognitive behavioural therapy (CBT) based approaches, could be considered to engage children and adolescents where developmentally appropriate. |
| 7.5 | EBR | Pharmacological treatment should not be offered as a first-line intervention specifically to reduce suicidal ideation, attempts, or NSSI. |
| 7.6 | CBR | Therapeutic risk-taking, which includes independent decision-making around taking risks, and sometimes called dignity of risk, can be considered after a biopsychosocial assessment and should be:<br>• discussed in collaboration with the child/adolescent, their support system, and other relevant professionals involved in their care<br>• draw on the child/adolescent's strengths, appropriate coping strategies, and what matters to them<br>• focus on positive outcomes<br>• part of ongoing care and management<br>• reviewed as part of regular ongoing care |
| 7.7 | CBR | If a child/adolescent is engaged in ongoing care and treatment for a suicide attempt(s) or NSSI but is not yet in a position to resist the urge to harm themselves, harm minimisation strategies could be considered:<br>• in the spirit of hope and optimism, and to reduce the severity and/or recurrence of injury<br>• as part of an overall approach to the child/adolescent's ongoing recovery-focused care and support, and not as a standalone intervention<br>• after being discussed and agreed upon collaboratively with the child/adolescent, their support system, and the wider multidisciplinary care team |
| 7.8 | CBR | Mental health professionals should discuss with the child/adolescent and their support system harm minimisation strategies that could help to avoid, delay, or reduce suicide attempts or NSSI.<br><br>For example:<br>• alternate distraction techniques or coping strategies<br>• approaches to self-care |

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| | | • wound hygiene and aftercare<br>• providing factual information about the potential complications of injury<br>• discussing the impact alcohol and recreational drugs have on the urge to harm oneself<br>• information about available supports, including lived experience workers, community supports, or peer groups |
| **7.9** | CBR | If a child/adolescent presents with frequent episodes of suicidal ideation, attempts, or NSSI, because treatment has not been effective, the care team should conduct a multidisciplinary review with the child/adolescent, their support system, professionals involved in their care, and others who need to be involved, to agree upon a joint plan and approach.<br><br>This involves:<br>• identifying an appropriately trained professional whom the child/adolescent trusts to coordinate their care and act as a point of contact<br>• reviewing existing care and support, and arranging referral to any necessary services<br>• developing or updating the plan for treatment and management<br>• developing or updating the safety plan, which should be written with and agreed upon by the child/adolescent and their support system |
| **7.10** | CBR | Co-occurring conditions that may be related to or contributing to symptoms of suicidal ideation, attempts, or NSSI should be investigated and managed according to condition-specific evidence-based guidelines.<br><br>See CBR 2.6 for common co-occurring conditions.<br><br>See CBRs 9.1-9.4 for considerations on prescribing medication for co-occurring conditions. |

# Evidence summary

### Evidence reviews were conducted for the following questions:

- What psychological and psychosocial interventions (including safety plans and electronic health-based interventions) are effective for children and young people who engage in suicide and NSSI?
- What pharmacological interventions are effective for children and young people who have engaged in suicide and NSSI?
- What is the effectiveness of harm minimisation strategies for children and young people who engage in suicide and NSSI?

**Psychological and pharmacological treatment**

The GDG formulated the recommendation for psychological and pharmacological treatment [EBR 7.3, 7.5; CBRs 7.1, 7,4] based on evidence review as well as comprehensive review, discussion, and adaptation of the Cochrane review by Witt 2021,[20] and the NICE guideline evidence review and recommendations.[9] The NICE group adopted the results of the Cochrane review by Witt 2021.[20]

Witt 2021 searched for evidence up to 4 July 2020 and identified 17 studies with a total of 2280 participants. The included studies addressed the effectiveness of various forms of psychosocial interventions. None of the included trials evaluated the efficacy of pharmacological interventions in children and adolescents. The search developed by Witt 2021 was adopted to update the evidence review in November 2024. From this, 2040 articles were identified. After removal of duplicates across databases, 1300 article titles and abstracts were screened, and 63 full-text articles were reviewed. 9 additional study articles were eligible for inclusion and were extracted. Given the limited volume and quality of evidence for each intervention type, as identified in the Cochrane review and in the updated search, it was not appropriate to perform a meta-analysis. Instead, results have been detailed in tables by intervention type and can be found in the Technical Evidence Report: Evidence review 2. Of the interventions addressed, DBT was found to be of benefit over all other interventions.

**Harm minimisation**

The GDG formulated the recommendations for harm minimisation [CBR 7.7-7.8] based on evidence review and informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations.[9] The NICE group searched for evidence in August 2020 and did not identify any studies in children and adolescents. The search developed by NICE was adopted to update the evidence review in October 2024; however, no new evidence was identified. The methods for the evidence review can be found in the Technical Evidence Report: Evidence review 3.

# Discussion and context

**In addition to the above evidence review questions, the discussion was centred around the following question:**

- What is best practice in the clinical management of suicide risk, suicidal ideation, and NSSI in children and young people from special populations, including First Nations people, culturally and linguistically diverse communities, LGBTQIA+, neurodivergent people, and those with co-occurring conditions?

The GDG emphasised that ongoing treatment for children and adolescents experiencing suicidal ideation, attempts, or NSSI should consider their unique developmental, psychological, social, and cultural factors. Although the primary goal of intervention is to reduce the risk of further self-harm, this should be done by tailoring treatments to the underlying drivers of their distress and behaviours. The GDG agreed that treatment should be offered without delay, even when the specific therapeutic approach may need to be adapted to the individual's immediate presentation and circumstances [CBR 7.1-7.2].

In line with current evidence, the GDG agreed that the use of medications specifically to reduce the incidence of self-harming behaviours is inappropriate due to the common adverse effects of some medications and the limited evidence for their efficacy in reducing symptoms [EBR 7.5].[21,22] If suicidal ideation, attempts, or NSSI are caused or exacerbated by a mental health condition (eg depression, anxiety, personality disorders, etc) that has appropriate pharmacological interventions, these medications could be effective for treatment/management if clinically indicated [CBR 7.10]. See page 70 for recommendations and information on prescribing medications for co-occurring conditions.

The GDG discussed several therapeutic approaches that may be appropriate in different circumstances. DBT is recognised as an evidence-based intervention [EBR 7.3]. Other approaches discussed included CBT-based approaches (cognitive analytic therapy and CBT for suicide), family-based therapies, mindfulness, and skills training to improve distress tolerance and interpersonal problem-solving skills [CBR 7.4]. The GDG also noted that for younger children, developmentally appropriate modalities such as play-based or creative therapies (eg art therapy) may be more engaging, although the evidence base for these approaches is less well established.

In considering the balance of benefits and harms of certain treatments, the GDG highlighted the importance of health professionals engaging in detailed, developmentally appropriate discussions with the child/adolescent and their support systems to create an individualised approach. In practice, clinicians often integrate components from multiple therapeutic approaches to meet the needs of the individual child/adolescent. Discussions should include the potential benefits and harms of proposed interventions, likely costs, availability of services, and expected timeframes for access. The GDG recognised that while evidence supports some psychological interventions, the acceptability and effectiveness of treatment are strongly influenced by therapeutic alignment, shared goal-setting, and shared trust with the child/adolescent.

> *"We may pick up that there might be other things that are either driving [behaviours] or co-occurring with it. So, sometimes we target the interventions into those areas, and we might choose an intervention based on the formulation and how the person came to develop these symptoms. And then based on that, we might choose different clinical practice elements from different therapies and do something that's quite eclectic."*
>
> – senior psychiatrist

The GDG discussed harm minimisation as a pragmatic and compassionate approach for children and adolescents who use NSSI or suicide attempts to manage overwhelming emotions. The GDG acknowledged that while the longer-term goal of care is to support young people to reduce and eventually cease self-harming behaviours through the development of alternative coping skills, harm minimisation strategies can play a useful interim role. Harm minimisation approaches may help reduce the severity of injury by teaching safer alternatives that provide similar physical sensations or emotional relief [CBR 7.8-7.9]. This guideline does not include recommendations supporting the practice of safer self-harm, which is sometimes considered a harm minimisation strategy. When used alongside therapeutic interventions and clear goals for skills development, harm minimisation was viewed as a supportive strategy that prioritises safety while recognising the young person's current needs.

The GDG also discussed the concept of therapeutic risk-taking, noting the need for careful consideration of its appropriateness when working with children and adolescents. Therapeutic risk-taking involves supporting and empowering a child/adolescent to make decisions about risks and their own safety.[23] Recognising developmental and legal considerations, the GDG supported the use of therapeutic risk-taking in children and adolescents as a principle grounded in the dignity of risk and respect for autonomy. The GDG agreed that proportionate and collaborative risk-taking can support recovery by promoting agency, confidence, and skill development, while avoiding overly restrictive or risk-averse practices that may inadvertently reinforce stigma or dependency [CBR 7.6]. Therapeutic risk-taking was also viewed as an opportunity to enhance shared understanding of risk between the

child/adolescent, clinicians, and their support system. The support system, especially primary carers, is central to this process, as they often carry and manage much of the risk outside of clinical environments. When undertaken transparently, with appropriate safeguards and support, therapeutic risk-taking was considered an important component of person-centred, recovery-oriented care.

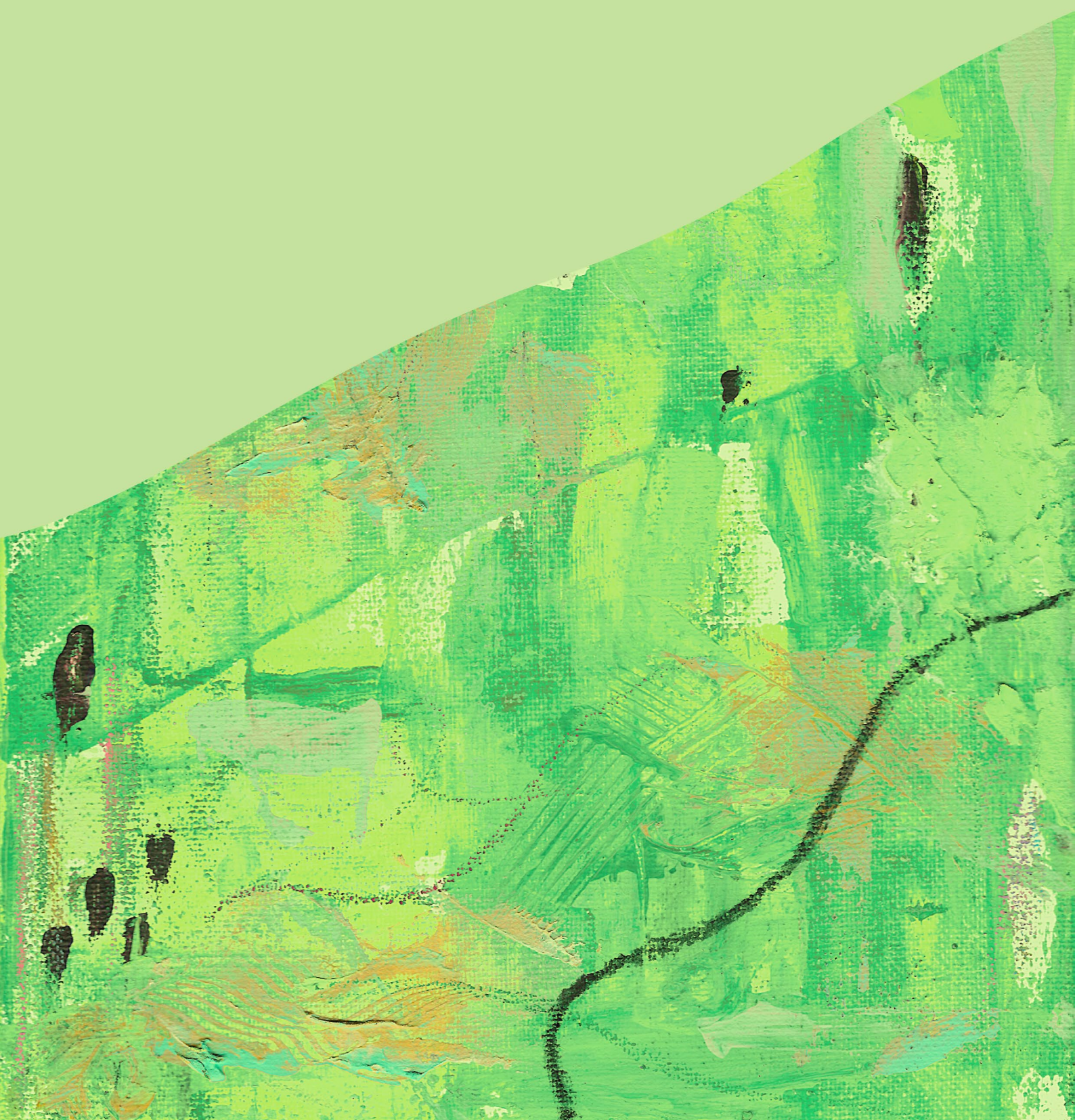
# Implementation considerations

The GDG acknowledged implementation challenges that may limit access to recommended psychological interventions, particularly DBT. DBT requires specialist training and supervision, and access to trained providers and training opportunities for clinicians are limited, making widespread access challenging. Inequities in access to many therapies and mental health services are further exacerbated by catchment boundaries, transport limitations, and rural or remote locations. Additional financial burdens may be experienced by families accessing private services, alongside ongoing difficulties referring children and adolescents into publicly supported systems.

Harm minimisation and therapeutic risk-taking are recommended in this guideline as safe practices for supporting children and adolescents experiencing suicide attempts and NSSI. However, the GDG acknowledged that some professionals and support people might have safety concerns about using these strategies, especially in children and adolescents. As with all interventions, collaborative decision-making is important for building trust and ensuring person-centred care. Healthcare professionals are encouraged to discuss the benefits and harms of these strategies with the child/adolescent and their support system to understand and recognise their potential impact.

## Section eight

# Admission to hospital



| 8. Admission to hospital | | |
|---|---|---|
| **No. #** | **Type** | **Recommendation** |
| **8.1** | CBR | Admission to a non-mental health hospital ward after an episode of suicidal ideation, attempt, or NSSI should only be considered if there is clear clinical justification, including treatment for physical injury. |
| **8.2** | CBR | The child/adolescent and their support system should be involved in making decisions about hospital admission, considering:<br>• specific goals for the child/adolescent at that point in time<br>• the home and social environment that will be supporting the child/adolescent<br>• existing links to mental health and community outpatient supports<br>• existing safety plans, and plans for treatment and management |
| **8.3** | CBR | Children and adolescents who have been admitted to hospital and who are at risk of suicidal ideation, attempts, or NSSI should have:<br>• access to specialist mental health services 24 hours a day<br>• a joint daily review by both the paediatric team and the mental health team<br>• daily access to a support person(s), ideally 24 hours a day<br>• regular multidisciplinary meetings between the paediatric team and mental health team |
| **8.4** | CBR | If a 16 to 19-year-old is admitted to an adult hospital ward, ensure that the ward can meet the needs of adolescents. |
| **8.5** | CBR | Before discharging a child/adolescent who experiences or is at risk of suicidal ideation, attempts, or NSSI from hospital, ensure that:<br>• a biopsychosocial assessment has taken place<br>• a plan for further management has been decided and agreed upon by the child/adolescent and their support system, including a safety plan<br>• a discharge planning meeting with the care team has taken place, including physical healthcare professionals if necessary<br>• arrangements for aftercare have been specified, including clear documentation and written communication with the relevant care or primary care team |

# Evidence summary

The GDG formulated the hospital admission recommendations [CBRs 8.1-8.5] informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations.[9] The evidence review conducted by NICE was not updated, and instead, the GDG sought to narratively discuss the work of NICE in the context of the Australian healthcare setting, led by the discussion questions below.

# Discussion and context

**Discussion was centred around the following questions:**

- What is best practice for decision-making about appropriateness of admission to an inpatient unit for a child or young person who engages in NSSI or suicidal ideation/behaviour?
- What are the benefits and harms of common responses for management of an acute suicidal crisis or disclosure of suicidal ideation or behaviours, including admission to an inpatient unit, use of restraint, and pharmacological methods?
- What are the benefits and harms of common responses for management of an acute NSSI crisis or disclosure of NSSI, including admission to an inpatient unit, use of restraint, and pharmacological methods?

Hospital admission for a child/adolescent at risk of suicide ideation, attempts, or NSSI is a significant intervention and should be carefully justified proportionate to risk and guided by the child/adolescent's individual needs and preferences [CBR 8.1]. The GDG discussed that hospitalisation is frequently experienced as distressing and should not be considered a default response to distress or anticipated risk, but rather a time-limited measure when the benefits clearly outweigh the potential harms. The clinical environment may be intimidating or distressing, particularly for those experiencing their first hospital admission. Further, the experience can cause trauma or re-traumatise those with negative past experiences in hospital or in other clinical settings. The GDG also discussed that inpatient care may be ineffective or harmful when delivered by staff who are not adequately trained in child and adolescent mental health, including over-reactive responses that equate all NSSI with imminent suicidal intent or risk. Additionally, admission can inadvertently reinforce reliance on emergency services, limit the diversity of help-seeking pathways, and contribute to dependency on acute care settings. Time spent in hospital may disrupt engagement with outpatient treatment, community supports, education, and social networks, thereby compromising continuity of care. For many young people, effective assessment and intervention can be delivered in community-based settings that feel safer and more supportive than an inpatient environment.

Conversely, the GDG agreed that admission may be appropriate when there is an immediate and unmanageable risk to a child/adolescent's safety that cannot be adequately addressed in the community, including when limited services are available [CBR 8.1]. In these circumstances, a hospital setting can provide short-term safety, medical and psychological stabilisation, and access to mental health assessment and further supports. For some children and young people, particularly in the immediate aftermath of distress or crisis, the clinical environment may offer a sense of calm and an opportunity to process the event in a safe space. Hospital admission may also facilitate timely linkage to specialist mental health services and the coordination of follow-up care. The GDG agreed that the involvement of the child/adolescent and their support system in decision-making about admission is essential and should be prioritised wherever possible [CBR 8.2]. Admission without meaningful consideration of the child/adolescent's views may be experienced as disempowering and harmful, causing further distress.

Where admission is considered for physical health needs after a suicide attempt or episode of NSSI, clinicians should continue to monitor the ongoing mental health risks, including the increased risk of future attempts or NSSI. Psychological and physical healthcare should be provided in tandem wherever possible, ensuring that admission is not used as a substitute for a comprehensive biopsychosocial assessment and follow-up planning [CBR 8.3]. The GDG stressed that stabilisation alone does not equate to the resolution of underlying distress and risk.

Appropriate support when caring for a child/adolescent in hospital was an important point of discussion for the GDG. Ensuring the ward can meet the specific needs of young people, such as access to trusted support persons during hospital admission, is critically important. The presence of a supportive adult can reduce distress, enhance feelings of safety, and support engagement with care, particularly for younger children or those admitted for the first time [CBR 8.3, 8.4]. Clinicians should recognise that the young person's trusted support person may not always be their legal guardian and should make reasonable efforts to accommodate the involvement of identified trusted support person(s).

*"I was admitted to hospital while physically unable to speak, instead, relying on writing out messages on my phone and showing people. Some of the treatment I received was good, but sadly, quite a few nurses and clinicians were entirely dismissive - not even trying to read, even going so far as to demand I verbally communicate and claiming that if I could type out something, I could just talk. It took so much longer to receive the care I needed, and I spent so much time stressing over whether or not I'd be okay - fearing being ignored to the point of being in critical condition again. I spent significantly more time planning my self-advocacy than focusing on resting and getting through this hospital stay.*

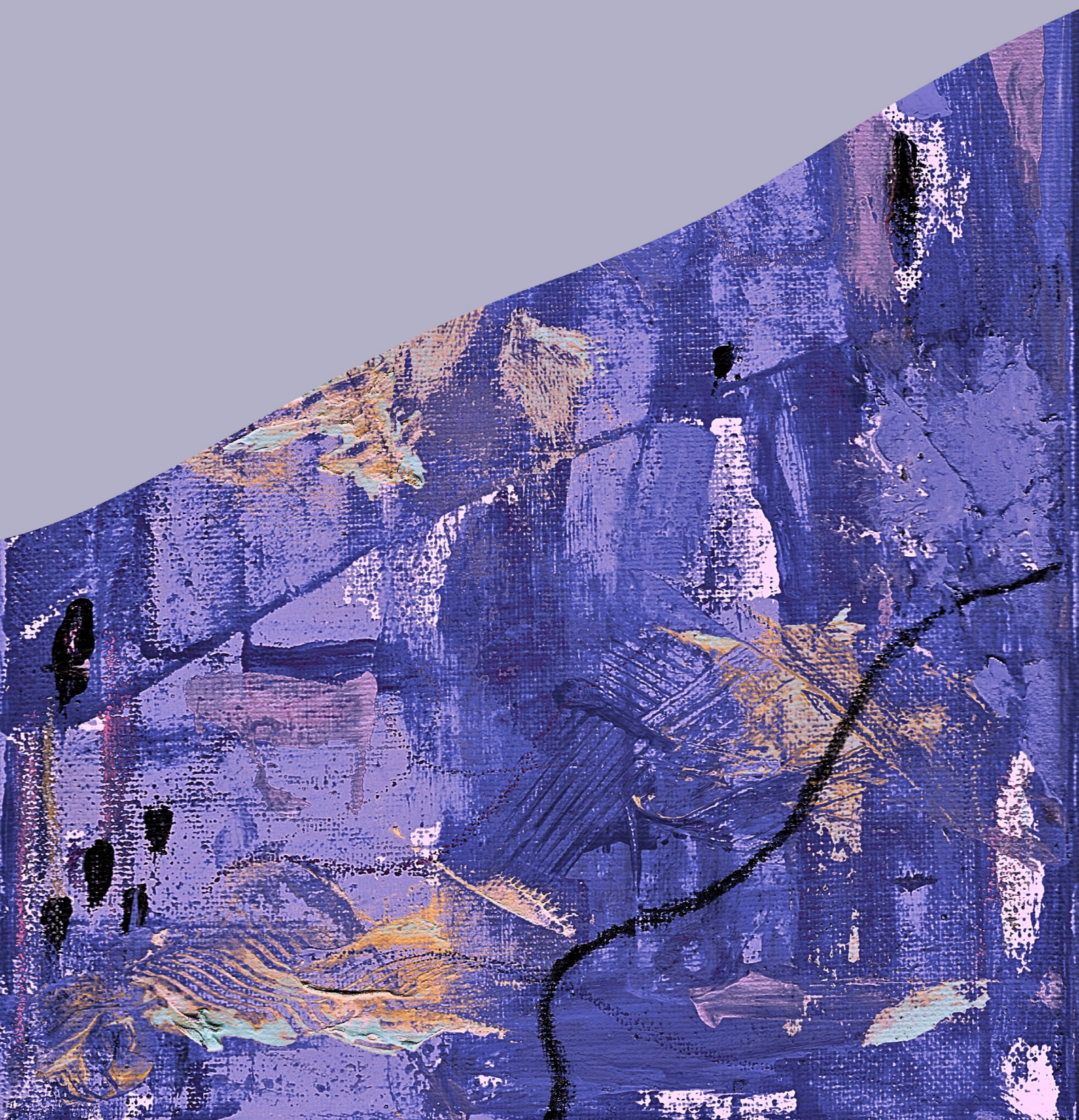
*It goes without saying that no one should have to spend their time in hospital constantly chasing up doctors, nurses, and specialists. [The patient] shouldn't need to have a full document of advocacy plans with backups and redundancies, escalations, and emergency measures when they should be focusing on their own recovery and rest. I was in a lucky position in this case also - I have experience advocating for others in a professional sense. Most individuals who access care absolutely do not have that 'training' for when professionals behave in unprofessional and damaging manners."*

– young person

# Implementation considerations

The GDG acknowledged that decisions regarding hospital admission must be made within the context of practical service constraints, including the availability of appropriate outpatient alternatives, staffing limitations, and cost. In some settings, limited access to timely community or outpatient services may necessitate hospital admission to ensure safety, assessment, and stabilisation. Conversely, resource constraints within inpatient services may restrict admission or limit the care that can be provided. These factors highlight the importance of local service planning, clear escalation pathways, and coordinated discharge and follow-up processes to support the continuity of care and minimise unnecessary or prolonged hospitalisation.

# Section nine
# Safer prescribing



The following recommendations [CBRs 9.1-9.4] are intended for healthcare professionals who prescribe medications to children and adolescents, including GPs. This guideline does not recommend the use of medications specifically to treat suicidal ideation, attempts, or NSSI [EBR 7.5].

## 9. Safer prescribing

| No. # | Type | Recommendation |
|---|---|---|
| 9.1 | CBR | When prescribing medication for co-occurring conditions to a child/adolescent who experiences suicidal ideation, attempts, or NSSI, healthcare professionals should consider:<br>• potential adverse effects and risk of increased suicidal ideation, attempts, and NSSI<br>• the potential toxicity of the prescribed medications if not taken as prescribed, particularly where there is a risk of serious harm or death, including higher doses (eg opiate-containing painkillers, tricyclic antidepressants, and propranolol)<br>• recreational drug and alcohol consumption, the risk of misuse, adverse events, and possible interaction with prescribed medicines<br>• the need for effective communication where multiple prescribers are involved<br>• the preferences of the child/adolescent and their support system |
| 9.2 | CBR | Discuss with the child/adolescent and their support system elements of safe prescribing, including:<br>• a symptom diary to track adverse effects<br>• education on how to manage medications, including medication adherence, and warning signs/symptoms of stockpiling medications<br>• safe medication storage, including who is responsible for and has access to medications<br>• limiting the quantity of medicines supplied (eg staged supply arrangements or weekly prescriptions)<br>• safe disposal of unwanted medications<br>• the child/adolescent's wider access to medicines prescribed for themselves or others |
| 9.3 | CBR | Healthcare professionals prescribing medication should carry out a medicines review after an episode of suicidal ideation, attempt, or NSSI.<br><br>This medicines review should consider:<br>• medications where suicidal ideation/attempts have known adverse effects (eg isotretinoin)<br>• the pharmacokinetic properties of medicines (eg half-life)<br>• the risk of toxicity<br>• the concurrent use of medicines such as benzodiazepines and opiates |
| 9.4 | CBR | Healthcare professionals, including GPs and community pharmacy staff, could use consultations and medicines reviews as an opportunity to identify risk of suicidal ideation, attempts, or NSSI, if appropriate.<br><br>For example:<br>• asking about thoughts of self-harm or suicidal ideation<br>• identifying access to substances that might be taken in overdose (including prescribed, over-the-counter medicines, herbal remedies, and recreational drugs) |

# Evidence summary

The GDG formulated recommendations for safer prescribing [CBRs 9.1-9.4] informed by comprehensive review, discussion, and adaptation of the NICE guideline evidence review and recommendations,[9] and discussion of the below evidence review question.

**An evidence review was conducted for the following question:**

- What are the key principles of safer prescribing for children and young people who engage in NSSI?

The NICE group searched for evidence in January 2021 to answer the above question and did not identify any studies in children and adolescents. The search developed by NICE was adopted to update the evidence review in December 2024, however, no new evidence was identified. The GDG sought to narratively discuss and formulate CBRs for safer prescribing. The methods for this evidence review can be found in the Technical Evidence Report: Evidence review 3.

# Discussion and context

The GDG agreed that prescribing medications specifically to reduce symptoms of suicidal ideation, attempts, or NSSI should not be recommended, in line with current evidence.[22] The role of medication in this population lies in the treatment of co-occurring mental health or physical health conditions, where clear clinical indications exist, and non-pharmacological interventions have been considered.

Given that a broad range of health professionals, including GPs, paediatricians, psychiatrists, non-specialist medical practitioners, and pharmacists, may be involved in prescribing medications for conditions that co-occur with suicidal ideation, attempts, and NSSI, cautious and well-informed prescribing is essential. Many commonly used medications have known adverse effects, including increased suicidal thoughts or agitation in young people, particularly at treatment initiation or during dose change.[21] The GDG agreed that medications used to treat co-occurring conditions should be carefully monitored, noting the known adverse effects of specific medications and the potential for toxicity or overdose [CBR 9.1-9.4].

Community-based health professionals, especially pharmacists, play a key role in safer prescribing for children and adolescents at risk of suicidal ideation, attempts, or NSSI due to their expertise and regular contact with patients and their support system. These roles can support prescribers by identifying potential interactions or duplication and checking doses and quantities. Pharmacists are also well placed to educate young people and support systems about adverse effects, safe storage, and management of medications that carry higher risks.

The potential for toxicity or fatality in overdose is a critical consideration in this population. Several medication classes carry a significant overdose risk, and prescribers must recognise and mitigate these possible harms. For example, propranolol, increasingly prescribed for anxiety symptoms, has rising rates of misuse and overdose in young people, and its lethality in overdose is often underestimated.[24,25]

> *"I was prescribed medication to manage pain after a procedure. Over time, my depression worsened, and I began experiencing thoughts of suicide. I was distressed and alarmed but assumed these thoughts were connected to previous mental health issues and worsening pain, only to later learn that they were actually common side effects of the medication I had been taking. No one told me that this could happen before I took the medication."*
>
> – young person

# Glossary

| Term | Definition |
|---|---|
| Biopsychosocial assessment | A comprehensive assessment, including an evaluation of a person's needs, safety considerations, strengths and vulnerabilities, that is designed to identify biological, psychological, and social factors that may contribute to their condition. |
| Cognitive behavioural therapy (CBT) | Evidence-based psychological therapy that helps identify and change unhelpful thoughts, beliefs, and behaviours. It aims to develop more effective coping strategies and improve emotional regulation and problem-solving. |
| Cultural safety | An environment where people's identities, backgrounds, and lived experiences are respected and never denied, challenged, or diminished. It acknowledges the impacts of discrimination and exclusion, and affirms what individuals need to feel safe. Cultural safety is grounded in shared respect, shared meaning, and shared knowledge, and is created through genuine listening and collaboration. As a practice principle, it is central to delivering person-centred, holistic, and equitable mental health care, and to addressing power dynamics within service encounters. |
| Dialectical behaviour therapy (DBT) | Evidence-based psychological therapy that focuses on building skills in emotional regulation and distress tolerance to help individuals manage intense emotions and reduce harmful or impulsive behaviours. |
| Harm minimisation | An approach to self-harm that accepts the person's continued urge to self-harm while aiming to reduce injury and frequency. It can include suggestions to avoid, delay or reduce self-harm. This guideline does not make recommendations on the practice of safer self-harm. |
| Legal guardian(s) | Parent(s), caregiver(s), or other support person(s) who have the legal authority and responsibility to make decisions on behalf of a child/adolescent. The legal guardian is responsible for providing informed consent for treatment and actively participating in care planning, acting in the best interests of the child/adolescent.<br><br>The legal guardian might not always be the most trusted support person in a child/adolescent's life. |
| Means of self-harm | The method, tool, or action a person uses or intends to use to cause harm to themselves. This can include a wide range of objects, including sharps or medications. |

| Term | Definition |
|---|---|
| Non-suicidal self-injury (NSSI) | An action or behaviour where a person causes harm to themselves in the absence of intent to end their life. NSSI can be chronic or acute in nature. |
| Restrictive interventions | Practices that limit a person's movement or decision-making to prevent harm to themselves or others. This can include seclusion, physical, mechanical or chemical restraints. |
| Safety plan | A document developed with the child/adolescent that outlines personalised strategies, supports, and actions to help them remain safe during periods of distress or crisis. This includes identification of strategies and key contacts. |
| Suicide | An action or behaviour that an individual takes to cause harm to themselves and deliberately end their own life, resulting in death. |
| Suicidal ideation | The experience of thoughts of suicide and ending one's life, or non-specific thoughts of death, especially when these thoughts are persistent in nature. It can vary from a general sense of life being meaningless to a preoccupation with ending one's own life.<br><br>This is often referred to as "suicidal thoughts" or "thoughts of suicide" in a non-clinical environment. |
| Suicide attempt(s) | An action or behaviour where a person causes harm to themselves with the intent to die and survives. |
| Support system or support person(s) | A person or group of individuals in a person's life who provide care, assistance, or emotional support. This may include caregivers, as well as others that may not have a direct caring relationship, such as siblings, friends or extended family members.<br><br>There are instances where the involvement of specific persons may not be safe or appropriate. |
| Therapeutic risk-taking | Supporting a person to engage in age-appropriate levels of independence and decision-making, even when there is some level of risk involved. It recognises a person's right to experience autonomy, growth, and learning while balancing safety and the developmental need for agency. In practice, therapeutic risk-taking involves careful assessment, collaboration with the child/adolescent and their support system, and tailoring strategies to their age, maturity, and circumstances.<br><br>This concept can also be called "dignity of risk". |

# Helplines and support services

## For young people, families, and professionals

*If you or someone you are with is in danger, call 000 for emergency assistance.*

### Lifeline

Call **13 11 14** Text **0477 13 11 14**

24/7 crisis support and suicide prevention services.

Chat online at lifeline.org.au.

### Beyond Blue

Call **1300 224 636**

24/7 support and resources for anxiety, depression, and suicide prevention.

Chat online at beyondblue.org.au.

### Suicide Call Back Service

Call **1300 659 467**

24/7 support for people at risk, concerned about someone, or are bereaved by suicide.

Chat online at suicidecallbackservice.org.au.

### 13YARN

Call **13 92 76**

24/7 crisis support from Aboriginal and Torres Strait Islander Crisis Supporters.

Go to 13yarn.org.au.

### Kids Helpline (ages 12-25)

Call **1800 55 1800**

24/7 confidential support service for children and young people.

Chat online at kidshelpline.com.au.

### Drs4Drs

Call **1300 374 377**

24/7 psychologists and counsellors for doctors, medical students, and their family.

Go to drs4drs.com.au.

### Nurse and Midwife Support

Call **1800 667 877**

24/7 national support service for nurses and midwives.

Go to nmsupport.org.au.

### QLife

Call **1800 184 527**

LGBTQIA+ peer support and referrals from 3pm-9pm everyday.

Chat online at qlife.org.au.

### Translating and Interpreting Service (TIS National)

Call **131 450**

24/7 free interpreting service for non-English speakers.

Go to tisnational.gov.au.

### 1800RESPECT

Call **1800 737 732**

24/7 support for people impacted by sexual assualt, family violence, and abuse.

Chat online at 1800respect.org.au.

# Helpful resources

## Resources to share with children, adolescents, and support systems

**Coping with self-harm: a guide for parents and carers**
*Orygen*
Go to orygen.org.au.

**Support and information for parents and carers**
*Sane*
Go to sane.org.

**Self-harm and Suicide: Teens**
*Raising Children's Network*
Evidence-based information for young people and their support systems.
Go to raisingchildren.net.au.

**Self-harm in children and young people**
*Royal collage of Psychiatrists*
This information was created in the UK but includes helpful information in plain language for children and support people about NSSI.
Go to rcpsych.ac.uk.

**Lived Experience Resources Hub**
*Roses in the Ocean*
A collection of resources (visual, audio, and written) created by those with lived experience of suicide.
Go to rosesintheocean.com.au.

**StandBy Support After Suicide**
Free support and resources for anyone bereaved of impacted by suicide.
Go to standbysupport.com.au.

## Resources for professionals

**Understanding parents' experiences of their child engaging in self-harm and/or suicidal ideation**
*Emerging Minds*
Go to emergingminds.com.au.

**Understanding suicide, suicide attempts and self-harm in primary school aged children**
*Headspace*
Evidence based information for educators.
Go to headspace.org.au.

## Care for Aboriginal and Torres Strait Islander children and young people

**Supporting young Aboriginal people who self-harm: a guide for families and communities**
*Orygen*
Go to orygen.org.au.

**Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention**
*The Manual of Resources*
Manual of resources for preventing suicide in First Nations communities
Go to manualofresources.com.au.

**An Aboriginal and Torres Strait Islander Systems Approach to Suicide Prevention: Framework and Implementation Guidelines**
*Lowitja Institute*
Go to lowitja.org.au.

## Care for children and adolescents from refugee and migrant backgrounds

**Working with Children, Young People and Families from a Refugee and Asylum-seeking Background: A Tip Sheet**
*Child Youth Refugee Community of Practice, Department of Health*
Go to refugeehealthnetwork.org.au.

**Designing mental health services for young people from refugee and migrant backgrounds**
*Orygen, Centre for Multicultural Youth*
Go to orygen.org.au.

**Victorian Refugee Health Network resources for Health Professionals**
Go to refugeehealthnetwork.org.au.

## Resources for researchers

**Guidelines for involving young people with lived and living experience of suicide in suicide research**
*Orygen*
Go to orygen.org.au.

## Further training

**Wesley LifeForce:** provides suicide prevention training that meets international best practice standards and is a CBRedited under Suicide Prevention Australia's Quality Improvement Program (SPA QIP). The program equips participants with practical skills to identify warning signs, engage safely, and connect individuals to appropriate support. Training is culturally adaptable, including tailored programs for Aboriginal and Torres Strait Islander peoples, refugee communities, and at-risk groups such as young people and people living with disability. Wesley LifeForce also facilitates LifeForce Networks, which bring together local community members and services to develop collaborative suicide prevention strategies and strengthen community resilience.

Go to wesleymission.org.au or email, lifeforce@wesleymission.org.au.

**Mental health First Aid:** offers a range of trainings from general mental health response to specialised trainings for Aboriginal And Torres Strait Islander suicide and NSSI.

Go to mhfa.com.au.

**Applied Suicide Intervention Skills Training (ASIST):** a two-day training program designed to instruct individuals in helping those who may be at risk of suicide. While many healthcare professionals utilise ASIST, it is open to anyone aged 16 or older, regardless of their professional background.

Go to asisttraining.com.au.

# Guideline Development Group membership and governance

## GDG members

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# Conflict of interest

Conflict of interest was managed by the chair throughout the guideline development process. All members of the GDG were required to provide declarations of interest as they arose throughout the process as outlined in the GDG Roles and Responsibilities document, which is available on request: Sydney.stevens@mcri.edu.au

For record of conflict of interest, please see the Conflict of Interest Record.

# How the recommendations were developed

See the Technical Evidence Report: Methods for detailed methods of development.

The development of this evidence-based guideline occurred as a sub-project of the Consistent Quality Care program of the Campus Mental Health Strategy (CMHS), a partnership between The Royal Children's Hospital, The Murdoch Children's Research Institute, and The University of Melbourne Department of Paediatrics. The CMHS is funded by The Royal Children's Hospital Foundation and is governed by the CMHS Steering Committee, made up of senior leaders from the three partner organisations and the CMHS Program Director.

## Guideline Development Group (GDG)

A multidisciplinary GDG was convened by the chair and supported by the evidence team. The group comprised of members with lived and living experience, including carers of children and adolescents who have experienced suicide or self-harm, healthcare professionals working in psychology, psychiatry, paediatrics, nursing, clinical pharmacology, community care and health services, and researchers in relevant fields.

## Existing evidence-based guidance

Consistent with international best practice, a systematic search for existing evidence-based guidelines that address the topic of suicide and NSSI in children and adolescents was conducted.[2] An internet search, as well as a guideline-relevant website search, identified one guideline that met criteria for update and adaptation to the Australian setting: *NICE 2022 Self-harm: assessment, management and preventing recurrence in children, young people and adults* (NICE guideline number NG225).[9]

## Scope

The GDG agreed on the following key areas of importance and subgroups were convened to address identification, assessment, care planning, management and monitoring, management of acute crisis, and management of chronic conditions.

## Evidence review questions

Clinical questions were identified and prioritised. An evidence review was conducted for high-priority questions (evidence review questions). For evidence review questions that were addressed in the NICE 2022 guideline, the methods used by NICE were adopted and the NICE 2022 evidence reviews were updated.[9]

The PICO framework (P: population, I: intervention, C: comparison, O: outcomes) was used by the evidence team to design search strategies, criteria for including eligible studies, and data extraction. A systematic search for terms related to the components of each question were combined according to

the selection criteria/PICO developed by the GDG for new questions. The search terms used to identify studies addressing the population were not limited so that studies addressing people in all cultural, geographical, and socioeconomic backgrounds and settings would be identified by the search. The highest form of evidence – the most current (within 5 years), comprehensive (with the most outcomes relevant to the PICO) and high-quality systematic review that meets the benchmark criteria and meets the selection criteria – were used in the evidence reviews. The methodological quality of included studies was evaluated using criteria developed a priori according to study design to assess risk of bias.

Full search strategies, methods, and results for each evidence review question are detailed in respective evidence reviews in the Technical Evidence Report.

# Discussion questions

For questions of lower priority or where there was known to be little high-quality evidence, evidence was not sought and was addressed via discussion by the corresponding guideline development subgroup (discussion questions).

Discussion in guideline development subgroup consensus meetings was structured according to a specified framework and was informed by clinical experience, lived experience, and research where available, including guidelines, systematic reviews or other existing guidance documents deemed suitable to be applied to the question. Discussion points were raised and documented by subgroup members.

# Drafting of recommendations

Specific, unambiguous, actionable recommendations were drafted based on the evidence, and the knowledge and expertise of clinical and lived or living experience advisors. Drafted using a recognised framework, two types of recommendations resulted:

**Evidence-based recommendations (EBR):** recommendations formulated from guideline development subgroup discussion of the research evidence, where a systematic search and evidence reviews were conducted, and evidence was identified and analysed.

**Consensus-based recommendations (CBR):** recommendations formulated by the guideline development subgroups in the absence of research evidence, where a systematic search was conducted and evidence was not identified or was of insufficient quality/quantity; or where there is known to be little high-quality evidence, in which case evidence was not sought, and the guideline development subgroup formulated recommendations based on clinical expertise and experience.

The terms "should", "could", and "should not" are used to reflect the GDG's interpretation of the balance of benefits and harms. The broad range of contextual factors that may contribute to the experience of suicide or self-harm for a child/adolescent (eg social determinants of health such as living situation, environment, family mental health, as well as underlying motivations and coping mechanisms) and also the crucial role of the family unit for that child/adolescent's health and wellbeing were considered.

# Consensus about recommendations

The GRADE evidence to recommendation framework was used to document the discussion, judgments and decisions to reach consensus about the recommendations. Based on the knowledge and expertise of the GDG, the following factors were considered:

- the balance of benefits and harms of the intervention
- available evidence
- resource requirements
- equity
- acceptability
- feasibility
- subgroup considerations
- implementation considerations
- monitoring and evaluation
- research priorities

The GDG acknowledges that lack of evidence is not evidence of lack of effect and have considered this carefully across all recommendations.

# Public consultation

Public and targeted consultation was undertaken on the draft guideline commencing 15 October to 15 November 2025. The draft guideline was available for download and review and an online feedback form was provided. Consultation feedback, including decisions around incorporation of feedback was collated and addressed (available on request).

# Scheduled update

This guideline will be considered for review and update as of January 2031.

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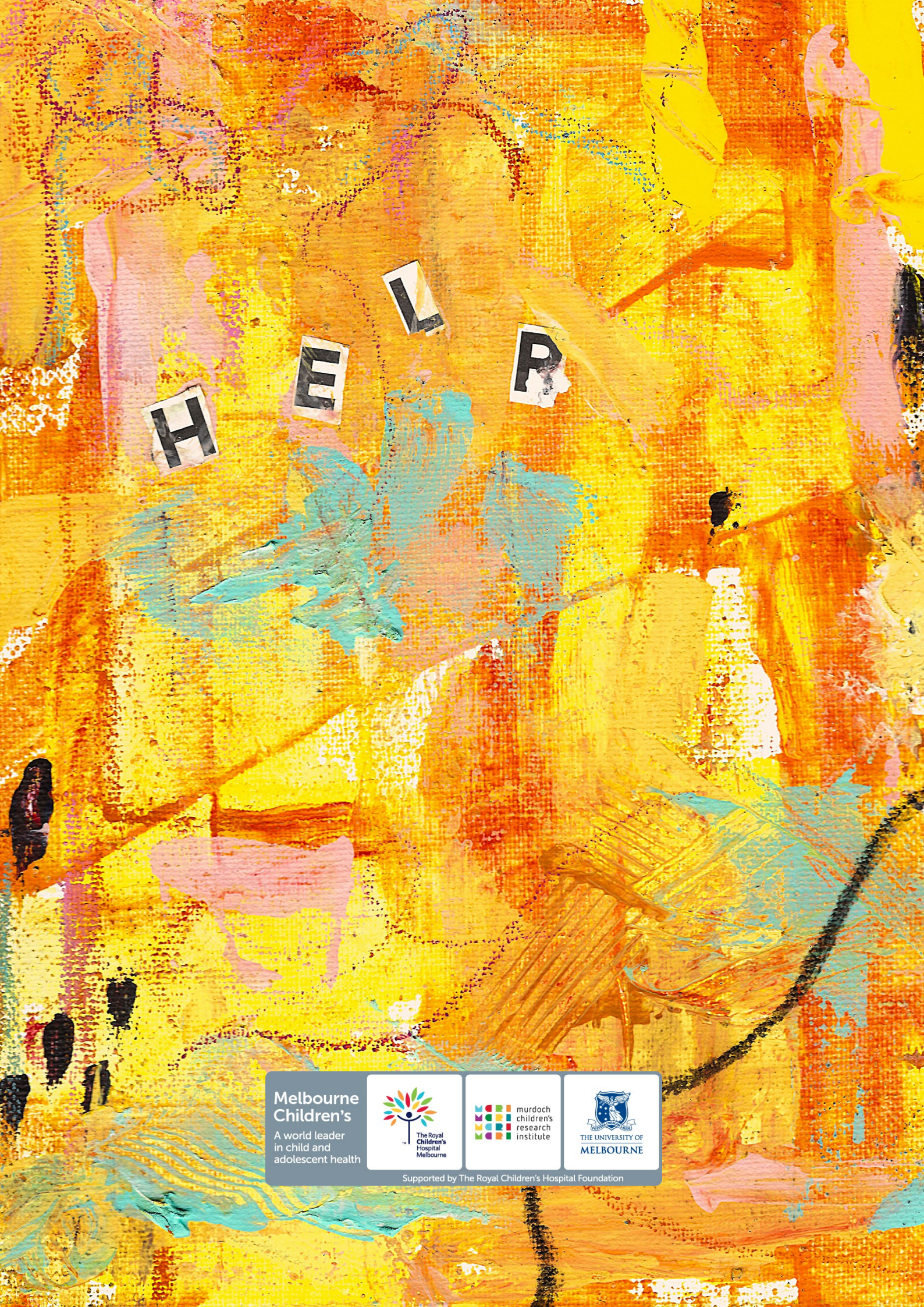


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