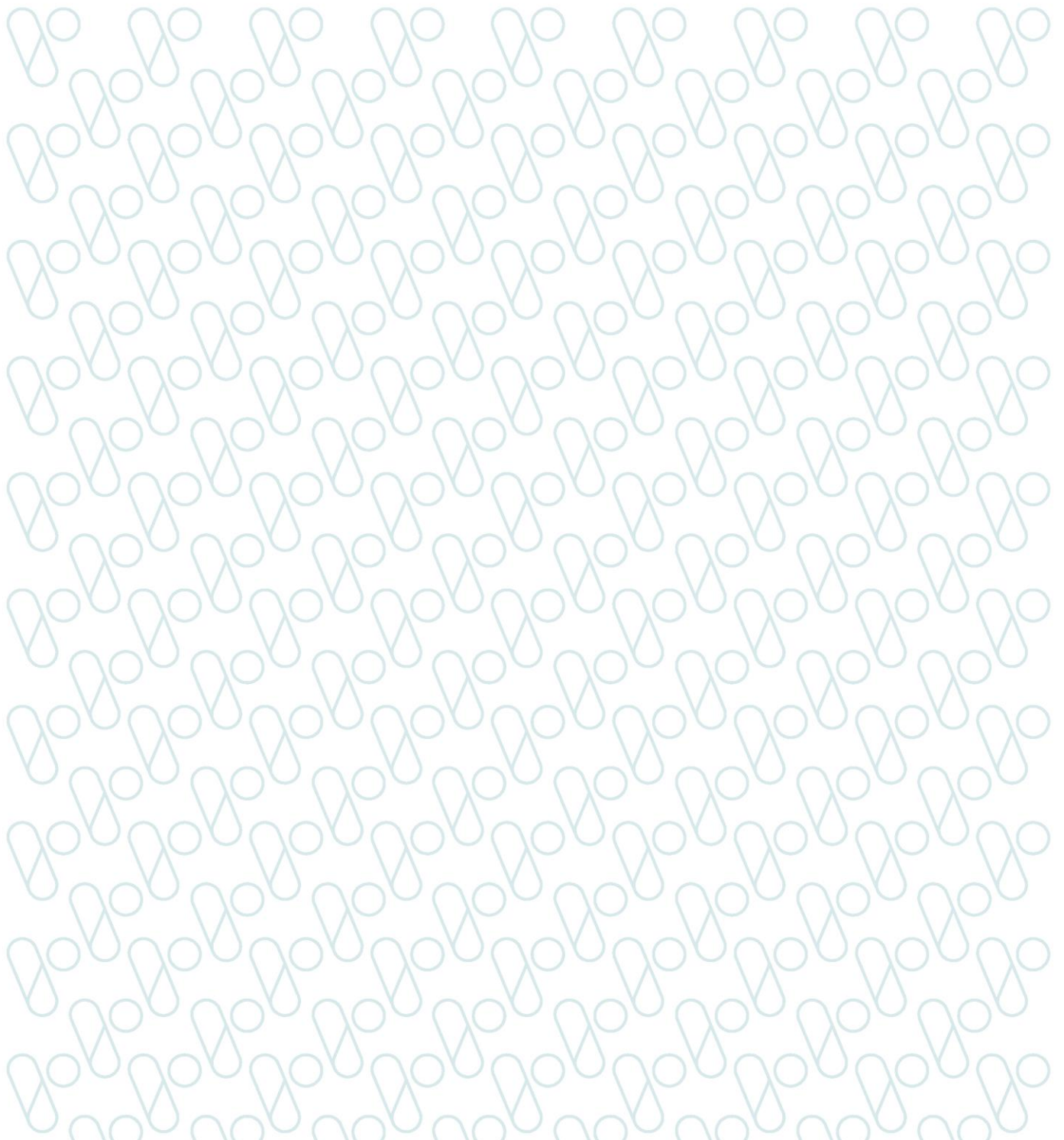


Improving safety for consumers at risk of harm of ligature



This publication discusses sensitive issues of mental distress, self-harm and suicide which may be distressing to some readers. Please take care when considering the publication and seek support if needed.

Reach out to Lifeline (13 11 14), Beyond Blue (1300 224 636), 13YARN (13 92 76) or Rainbow Door (1800 729 367) for support.

To receive this publication in an accessible format [email Safer Care Victoria](mailto:info@safercare.vic.gov.au) <info@safercare.vic.gov.au>

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Key messages

- All levels of a health service have a role in clinical governance and consumer safety. This includes board executive, divisional and clinical workplace levels. Furthermore, all staff have a role in work health and safety.
- Ligation events can occur anywhere in a health organisation.
- Ligation training packages should be considered for the whole of health service response, in addition to the mental health workforce.
- Contemporary clinical practices are essential to ensuring consumer safety. Research shows that engaging effectively with consumers improves their satisfaction with care, boosts staff morale, and leads to better reported outcomes for consumers (Desmet et al, 2023; McAllister et al., 2019).
- Health services should strive to support a 'just culture' in response to ligation events. This means a workplace environment that promotes open discussion, accountability, and learning from mistakes rather than assigning blame (Liukka et al., 2020).
- Ligation incidents require an emergency response. Early intervention and aggressive resuscitation can reduce the risk of serious injury or death (Ganesan et al, 2018).
- The key principles within this guidance document are recommended for all public Area Mental Health and Wellbeing Services (AMHWS). They may also be considered and recommended for a whole-of-health response for improving the safety of consumers at risk of harm of ligation.
- People may use ligation as a way to express extreme distress. To support their recovery, it is important to understand the individual person's needs and provide a person-centred response.
- A comprehensive approach to reducing the risk of deliberate self-harm includes creating a safe and supportive environment, using trauma-informed care, offering individualised treatment and safety or suicide prevention plans, and providing therapy.

"Having spent time in inpatient psychiatric units, I've often experienced distress stemming from feelings of disconnection and being untethered. Positive and meaningful relationships with staff can significantly alleviate these feelings. When someone takes the time to talk with me—not just about clinical matters, but about my emotions, my love for music, or my dog — I feel more grounded and calmer. This connection plays a crucial role in reducing my distress and, in turn, my risk of self-harm."

- **Anna Sowden**, Lived Experience Discipline Lead, Barwon Health

Executive summary

In 2024, I commissioned an expert working group from the state of Victoria to develop key principles to enhance safety for consumers at risk of harm of ligature receiving care in mental health inpatient and residential service settings, in the absence of national standards in Australia. This guidance document is recommended for all Victorian Public Area Mental Health and Wellbeing Services (AMHWS) with a consideration for a whole of health response for improving the safety for consumers at risk of harm of ligature.

This document has been co-produced and co-designed with colleagues from my team, senior mental health nursing leaders, lived experience colleagues and mental health executive leaders from the public mental health and wellbeing sector in Victoria, and with feedback incorporated from external stakeholders.

The principles outlined in this document reflect contemporary practices that are essential for advancing organisational and clinical practice standards in the delivery of mental health care. With a genuine commitment to connection, compassion, and human rights we continue to strive to improve the safety for all Victorians. 'Improving the safety for consumers at risk of harm of ligature' guidance document aims to support in the response to individual vulnerabilities and risks when the severity of symptoms, distress, or other factors such as environment, relationships, trauma history and social determinants affect a person's ability to manage. Creating a culture where consumers feel safe and supported to express their concerns, preferences and needs, and seek safer alternatives to managing their distress should underpin all work in improving ligature safety (Pisani et al., 2022).

Thank you for all your continuing commitment to improve our mental health and wellbeing system in Victoria and striving to provide safe high-quality mental health care for our community.



Anna Love

Chief Mental Health Nurse

Executive Director Clinical and Professional Leadership Unit

Safer Care Victoria

Improving safety for consumers at risk of harm of ligature

Key Principles

OFFICIAL

Introduction

The purpose of this Safer Care Victoria (SCV) guidance document is to outline the fundamental principles that underpin organisational and clinical governance for improving safety for consumers at risk of harm of ligature. It promotes continuous improvement, skill and capability enhancement, and training alignment to foster a culture of learning within Victoria's public mental health and wellbeing services. This document supports public health organisations in Victoria by providing guidance on workforce training, policies and procedures, and compliance with regulations and legislation, particularly in the absence of national Australian standards.

Key principles to be considered for each organisation:

- Principle 1: Organisational and clinical governance
- Principle 2: Engagement, therapeutic relationship and trauma-informed care
- Principle 3: Clinical responses to ligature incidents
- Principle 4: Consumer, workforce, and visitor impact and follow-up support

Glossary of terms

Ligature: "is anything, like a cord or other material, that could be used for the purpose of hanging or strangulation" (Care Quality Commission, 2023, p.5).

Ligature anchor point: "is anything that could be used to attach a ligature" (Care Quality Commission, 2023, p 5).

NOTE: Ligatures do not necessarily need to be attached to a ligature anchor point.

Suspended – where a person has a ligature around the neck, which is attached to an anchor point.

Unsuspected – ligature is tied around part of the body to restrict breathing and/or blood flow.

Principle 1: Organisational and Clinical Governance

Organisational governance and oversight in health care settings ensures that systems are in place to deliver safe, high-quality health care, and that there are processes for continuous quality improvement. Clinical governance is an integrated component of organisational governance in Victorian health service organisations. Robust clinical governance systems at an organisational level ensures that the board has oversight of clinical care, risks and adverse events through monitoring systems. The board directors are responsible for ensuring systems of care in place are effective in preventing harm (ASCQHS, 2021 p.5-12).

At a board executive, divisional and clinical workplace level, everyone has a role in clinical governance and consumer safety. In public mental health and wellbeing services, the authorised psychiatrist is responsible for overall clinical governance; a role which is delegated by the board through a formal appointment process. The authorised psychiatrist ensures all legislative requirements under the Mental Health and Wellbeing Act (2022) and the responsibilities of the Office of the Chief Psychiatrist are met, by themselves and the consultant psychiatrists within the service. This authority, granted by the Mental Health and Wellbeing Act (MHWA 2022) and the Office of the Chief Psychiatrist, along with the use of the best available treatment and evidence, should guide local clinical review and oversight practices.

In 2024, SCV's Chief Mental Health Nurse commissioned an expert advisory working group to inform the development of key principles of 'Improving safety of consumers at risk of harm of ligature' to promote safety for consumers while admitted to inpatient and residential services. This guidance aims to bring together and describe best available evidence in the response to and the management of ligature safety events whilst aligning with other clinical governance requirements, such as National Safety and Quality Health Service (NSQHS) Standards.

The applicable NSQHS standards (version 2) are:

- Standard 1 – Clinical Governance (Criteria 1.01-1.04, 1.07-1.10, 1.11-1.15, 1.19, 1.20, 1.25, 1.29 & 1.30)
- Standard 2 – Partnering with Consumers (Criteria 2.03, 2.05, 2.06, 2.09, 2.14)
- Standard 5 – Comprehensive care (Criteria 5.01-5.07, 5.10-5.14, 5.31 & 5.32)
- Standard 6 – Communicating for safety (Criteria 6.01-6.04, 6.07-6.09, 6.11)
- Standard 8 – Recognising and responding to acute deterioration (Criteria 8.01, 8.02, 8.05-8.10, 8.12)

The health service chief executive and executive team are responsible for ensuring implementation of these guiding principles into all areas of the health service. This includes updating of policy and procedures, education and training packages, and incident response, investigation, improvements and staff post-ligature incident support.

Policy and procedures

Each health service is responsible for maintaining up-to-date policies or procedures that clearly outline their organisational approach to managing ligature safety. This should include protocols for identifying ligature risks through audits, response to a ligature event, workforce training, and supporting the wellbeing of staff, consumers, and visitors following an event. Health services are also obligated to fulfil their health and safety responsibilities, including any "applicable duties" as mandated by the Occupational Health and Safety Act 2004.

The health service policy position does not need to be contained within one policy and/or procedure, rather the information and approach should be outlined in policies and procedures where workforce would naturally seek information about that topic, such as code blue, risk assessment, or any mandatory training procedure.

The policies and procedures should cover training principles, workforce learning requirements inclusive of health and safety considerations, audit requirements, and processes for acting on audit findings. They should also include guidelines on the use of ligature cutters*, escalation procedures, and steps for preserving the environment when required for the police, Coroner's Office or WorkSafe.

**It is important to note that there are four types of ligature cutters available for purchase at the time of writing this guidance in Victoria. If a health service has multiple ligature cutters available for use, then the organisation is responsible for ensuring training occurs for all available cutters.*

Education and training

The organisation retains responsibility for the governance and oversight of workforce training implementation. The board and executive are responsible for ensuring that all clinical and non-clinical staff are appropriately trained in responding to and managing a ligature event.

The training on the four key principles should be embedded into each organisation's training package provided to the mental health workforce. These principles are:

1. Organisational and clinical governance
2. Engagement, therapeutic relationship, trauma informed care
3. Clinical responses to a ligature incident
4. Consumer, workforce and visitor impact and follow-up support

Consideration should also be given to training the entire health service workforce, as ligature events can and do occur in areas outside mental health services. Due to the skills-based nature of this training, face-to-face delivery is recommended to ensure effective learning and skill development.

It is recommended that the education and training package be conducted at least annually and be linked in with existing skills-based training, such as Basic Life Support, Manual Handling, Occupational Violence and Aggression, Therapeutic Engagement, and Trauma-Informed Care. Training should incorporate face-to-face simulation.

Accurate training records that track completion rates for ligature event response should be maintained and monitored as part of overall training compliance within the Clinical Governance Framework. This process should align with the health service's procedure for training the mental health workforce.

SCV recommends that education and training is co-designed, with consideration for co-delivery where appropriate, to ensure a trauma-informed approach that incorporates the experiences of consumers, kin, families and carers. Employers should support all colleagues within mental health bed-based services to access mandatory education and training during working hours.

Reporting

It is the responsibility of the clinical workforce to complete the Victorian Health Incident Management System (VHIMS) incident report as soon as practicable following a clinical ligature event and during work hours.

Due to the actual and potential impact on consumers by these events, it is recommended that all ligature events be recorded as soon as possible on the VHIMS with a minimum Incident Severity Rating (ISR) of 2. Each incident must be reported at the service's clinical risk meeting for discussion and is required to be reported and investigated.

Recommended improvement actions should be monitored through the health service Clinical Governance Framework.

The investigation should include a review of any pre- and post-event (if non-lethal) risk assessments of the consumer, training compliance rates of the unit where the incident occurred, and the identification of where and how the ligature entered the clinical setting. If the service feels that the ISR is to be downgraded following internal review, this can be completed with a rationale clearly documented in VHIMS as per the health service organisational process for downgrading incidents.

Where there has been a serious adverse consumer safety event, the health service must follow the Serious Adverse Patient Safety Event (SAPSE) process to investigate and report the outcomes of the investigation in the timeframes prescribed in the SAPSE reporting framework (Victorian Duty of Candor Framework, 2022). In addition, services must seriously consider whether the event meets criteria for notification as a Sentinel Event, if unsure please contact the sentinel events program at sentinel.events@safercare.vic.gov.au.

Composing a ligature audit team and completing a ligature identification audit

Each health service organisation is responsible for ensuring that all public bed-based Area Health and Wellbeing service complete a ligature identification audit in inpatient settings at least annually.

The ligature identification audit team is recommended to comprise of the following members:

- Mental health executive
- Workplace health and safety (inclusive of health and safety representatives)
- Engineering
- Lived experience colleagues
- Program or unit-manager of audit site
- Staff member from the audit site

The ligature identification audit team should receive briefing on preparing to be an audit team member, the scope of the audit and the responsibilities during and after the audit. The audit should be recorded in real time using an organisational-endorsed ligature identification audit tool.

The summarised findings of the ligature identification audit and any rectification action plans required should be tabled at committee meetings and documented on risk registers within the health services Clinical Governance Framework. These findings should be escalated to committees with delegation to authorise rectification actions and associated costs, or to accept the remaining risk, such as the Executive Quality and Safety Committee or the Board sub-committee for health and safety.

It is also recommended that findings from individual ligature identification audits be discussed at business or local unit meeting so that colleagues working in the area are aware of the identified ligature points in their workplace.

Annual ligature identification audits are a risk mitigation mechanism supporting prevention. The annual ligature identification audit supports individual consumer risk assessments, shift-to-shift environmental audits, restrictions on bringing in items that could be used as a ligature, and heightened staff awareness, all of which occur routinely in mental health inpatient and residential units and contribute to consumer safety.

Principle 2: Engagement, therapeutic relationship and trauma informed care

Governance and oversight

The rate of suicide in mental health inpatient units is 50 times higher than in the general population. Despite safety being an organisational and clinical priority, there is no consensus on effective suicide prevention measures in these settings (Chammas et al, 2022). Although suicide risk factors are well known at the collective level, predicting risk at the individual level remains low (Chammas et al, 2022). Hanging is reported to be the most common method of fatal and non-fatal deliberate self-harm behaviours in the inpatient setting (Groves et al., 2023).

International evidence suggests the use of a ligature is a common form of deliberate self-harm in the inpatient setting, as other methods can be more effectively controlled, such as access to medication and sharps (Groves et al., 2023). Importantly, minimising the risk of self-harm and suicide by ligature extends far beyond merely managing ligature risks. As well as removing as many ligature points as possible, ensuring timely and efficient response to any self-harm attempt, along with therapeutic engagement, constitutes the most effective means of preventing deliberate self-harm using a ligature.

Policies and procedures

The policy and procedures of the organisation should outline the multimodal and multidisciplinary approach to the prevention of deliberate self-harm in inpatient and residential mental health units.

Health service policies and procedures should emphasise that minimising the risk of self-harm and suicide extends well beyond simply managing ligature risks. Establishing a safe and therapeutic environment, offering trauma-informed support, and providing individualised treatment, personal safety or suicide prevention plans, and therapy form a comprehensive approach to reducing these risks.

Additionally, an approach tailored to individual and cultural needs can identify additional or modified strategies. For instance, managing self-harm and suicide risks for Aboriginal and Torres Strait Islander People might require incorporating elements such as connection to country, access to outdoor spaces, addressing individual and cultural grief and trauma, language considerations, involvement of Elders and traditional healers, and broader definitions of kin and family.

Education and training

Inpatient units require organisational support to provide the necessary allocation of resources and interventions aimed at reducing suicide and self-harm ligature risk (Pisani et al, 2022). Stronger organisational support, such as resourcing workforce colleagues to attend education, can help promote an understanding of the impact of adversity, trauma and trauma-informed care. This enables a workforce who feels confident to respond to consumers experiencing distress or hopelessness and a culture of recovery-focused mental health practice (Heffernan et al, 2024).

Training on the use of engagement techniques, developing therapeutic relationships and trauma-informed care should be embedded in each organisation's training packages provided to the mental health workforce. Education and training may be delivered as part of early career development workshops and for existing staff on an annual training and professional development calendar.

Therapeutic engagement

Contemporary clinical practices are essential to managing consumer safety with research clearly demonstrating the importance of therapeutic engagement for improving satisfaction with care received, staff morale and consumer reported outcomes (Desmet et al, 2023; McAllister et al., 2019). Therapeutic engagement is understood to be a powerful tool for reducing the risk of someone who is experiencing overwhelming emotional distress from creating or using a ligature (Care Quality Commission [CGC], 2023). Reducing harm from ligatures is possible when the workforce is resourced to tailor engagement and activities underpinned by the principle of shared decision-making, based on a foundation of mutual respect and trust.

Creating a culture where consumers feel safe and supported to express their concerns, preferences and needs, and seek safer alternatives to managing their distress should underpin all work in improving ligature safety (Pisani et al., 2022). Consumers may contemplate or use ligatures during times of extreme distress, when they perceive no other way to reduce this distress, or when they have decided to die. These situations typically present distinct indicators, which can be recognised to help reduce risk and ensure safety for all. Strong therapeutic engagement is generally associated with a better ability to recognise suicidal intentions and intervene effectively.

Effective therapeutic engagement is viewed as a partnership relationship between staff and consumers, with recovery-focused goals and shared decision-making at the core of the relationship (CQC, 2023). The establishment and sustainability of an effective therapeutic relationship is the cornerstone of mental health practice and plays a fundamental role in the provision of safer care (Martinez-Martinez et al, 2022). An effective therapeutic relationship is viewed as the linchpin of effective person-centred, recovery-oriented mental health care, and positive consumer outcomes (Desmet et al, 2023; El-Abidi et al, 2024).

Therapeutic relationships

Documentation in the consumers medical record should outline the useful strategies to develop a therapeutic relationship, previous trauma history and individual safety plans. Documentation by all disciplines should be regarded and discussed at multidisciplinary team meetings to inform this process.

The inpatient admission itself may lead to a consumer reporting worsening symptoms of distress, as admissions can be highly anxiety provoking (Desmet et al, 2023). The literature suggests that clinicians generally rate their perceptions of the quality of the therapeutic relationship higher than consumers within the first few days of admission (El-Abidi et al., 2024). This may indicate a need for greater clarity of how the quality of a therapeutic relationship is perceived and understood. Desmet et. al (2023) demonstrated the 'meaningful' nurse-consumer relationship can contribute to positive consumer reported outcomes (using the Mental Health Nurse-Sensitive Patient-Outcome Scale [MH-NURSE-POS]) such as effective problem-solving, promotion of safety, and aspirations for hope (Desmet et al, 2023).

Consumers highlight that positive relational factors, beyond departmental-determined clinical outcome measures, support them to feel comfortable, share their experiences, and make sense of their distress (McAndrew et al, 2013). Consumers report being seen and listened to by colleagues who are available, responsive and have positive attitudes ("little acts of kindness") as significant enablers to be able to develop greater trust in service providers and disclose their most intimate moments safely (Cutler et al, 2020; McAndrew et al, 2013; Proctor et al, 2024). It is not simply nursing practice focused on clinical outcome measures or risk management, but rather prioritising the promotion of safety and consumer-reported satisfaction, that can ultimately enhance consumer's feelings of safety and ensures effective care and treatment in the inpatient setting (Cutler et al, 2020; Department of Health [DH], 2023).

Trauma informed care

“Trauma-informed approaches recognise the possibility of the ongoing effects (and impacts) of past and current trauma in the lives of everyone seeking support and how this can affect the way people seek help. (for the workforce to) understand the neurological, biological, psychological and social effects of trauma” (DH, 2023)

A trauma-informed perspective is founded in the awareness of how trauma can affect an individual. Particularly, individuals may experience distress responses as unmet emotional, psychosocial, or physical needs, which can result in hopelessness, psychological pain, suicidal thoughts or self-harming behaviour (Chammas et al, 2022; DH, 2023; Heffernan et al., 2024). Exposure to trauma is correlated with increased suicidality (Proctor et al., 2023). While evaluations of trauma-informed suicide prevention are still in their early stages and require further investigation, there is evidence suggesting that these practices help prevent re-traumatisation, enhance physical and psychological safety, and reduce distress as consumers and staff collaborate therapeutically (Proctor et al, 2023).

Recognising the prevalence of trauma and its effects on consumer’s experiences is critical when caring for consumers experiencing distress and increased suicidality (DH, 2023; Proctor et al, 2023). Trauma-informed practices emphasise autonomy, collaboration, self-determination and strength-based approaches (DH, 2023). Engaging in trauma-informed care is consistent with respectful, compassionate therapeutic engagement and supports collaborative, recovery-oriented care that is valued by consumers, their families and carers, the lived experience workforce, and clinical staff (DH, 2023; Proctor et al, 2023). Importantly, seeking to support consumers in articulating their distress will enable them to recover a sense of empowerment and self-regulation (DH, 2023).

Consumers report that an environment promoting responsiveness, inclusivity and trust allows them to feel safe and supported in their experience of trauma and prevents re-traumatisation (DH, 2023). To reduce the risk of self-harm and suicide via ligature in the inpatient environment, it is essential to balance service-driven outcomes with consumer rights, while emphasising the importance of the therapeutic relationship in consumer care.

Principle 3: Clinical responses to ligature incidents

Governance and oversight

“Use of ligatures is common within inpatient mental healthcare settings and is a dangerous method of self-harm. Most fatal and non-fatal suicidal behaviours in inpatient settings are a result of ligature use” (Groves et al., 2023, p.1). Literature also identifies “suicide attempts are up to 30 times more common compared to suicides” (Bachmann, 2018). Staff working within mental health bed-based services will at times need to provide an emergency response to ligature incidents. However, peer-reviewed publications continue to highlight an absence of specific education and training for healthcare staff responding to these emergency incidents within hospital settings (Croft et al., 2023; Donaldson & Nizam, 2022; Groves et al., 2023; Mitchell et al., 2024; Molloy et al., 2014). The intention of this principle is to provide evidence-informed guidance that will enable organisations to implement mandatory education and training for Victorian public health service workforces, ensuring a safe and effective emergency response to ligature incidents.

In 2023, a Victorian forum hosted by the Chief Mental Health Nurse at Safer Care Victoria identified the ongoing gap: an absence of evidence-informed training for workforce colleagues responding to ligature incidents within mental health wards. Emergency trainings, such as fire training, is well established across mental health and wellbeing services. The expert working group recommends raising the importance of standardised guidance for training in relation to “Improving safety for consumers at risk of harm of ligature”.

Colleagues working within mental health bed-based services will need to be aware of the specific risk of ligatures and supported by their employers through mandatory education and training to effectively provide emergency responses to ligature incidents. To support the mandatory annual competency outlined in Principle 1, Victorian public health services are expected to implement education and training for clinical responses to ligature incidents, based on evidence that “early intervention and aggressive resuscitation can decrease the morbidity and mortality associated with near hanging” (Ganesan et al., 2018, p. 205).

In all designated public bed-based Area Mental Health and Wellbeing services, education and training should be led by mental health educators, who will utilise this guidance to provide consistent learning and development for healthcare staff responding to a ligature incident. It is the responsibility of the health service board to ensure that all workforces receive adequate training to allow them to respond to emergency situations which can be reasonably be expected to occur in the workplace (WorkSafe 2023).

Policies and procedures

To ensure a comprehensive and consistent emergency response to ligature incidents, health services must ensure that they have clear and comprehensive policies and procedures which directly and indirectly support these responses. These include, but are not limited to:

- Pathways for consumers and family members to escalate distress and seek support
- Clinical escalation pathways for health care professionals
- Medical emergency response procedures, including safe use of equipment
- Incident scene preservation procedures
- Reportable deaths procedures, including the additional specific requirements for designated mental health services.

Education and training for clinical responses to ligature incidents

SCV recommends education and training is co-designed, ensuring trauma-informed use of consumer, kin, family, and carer experiences. Health services are encouraged to align the 'Clinical response to ligature incidents' education and training with annual basic life support mandatory competencies. All colleagues working within mental health bed-based services will need to be supported by the employer to access mandatory education and training as outlined in Principle 1.

While the literature for working with people experiencing suicidality is vast, this principle specifically focuses on the emergency clinical response to ligature incidents. It recognises recent publications that have highlighted an immediate need to strengthen emergency responses and medical management of near lethal incidents within healthcare environments, including post-ligature care (Donaldson & Nizam, 2022; Sabrinskas et al., 2022).

Education and training core content for emergency responses to ligature incidents must include, at a minimum:

- Recognising and responding to ligature incidents, consistent with organisation's emergency responses
- Safe use of emergency equipment, including ligature cutting tools and where these are located. The face-to-face training must incorporate both demonstration of safe use, and participant practice/simulation within the education and training session
- Evidence regarding potential injury associated with ligature incidents, including anatomy and pathophysiology considerations
- Preservation of environment requirements to ensure compliance with legislative requirements and coroner processes
- Documentation and associated incident reporting
- Psychological care of all involved
- Making references to, and ensuring connections with, other essential learning and development provided by the organisation. This may include recognising and responding to suicidality, safety planning, undertaking mental status examinations, undertaking environmental checks and ligature audits, and post-incident support for all.
- Manual handling, infection control, and other work, health and safety requirements
- Minimum recommendations for sharpening or replacement of ligature cutting tools after each use.

Mandatory education and training should be available to clinical workforces in face-to-face mode, recognising the core content will include demonstration and practice of responses. Attendance records support organisations collection of evidence against their obligations outlined in 5.31 and 5.32 of the Comprehensive Care Standard (ACSQHS, 2021, p. 51), as outlined in Principle 1.

Several peer-reviewed articles highlight that healthcare workforce training should extend beyond teaching techniques for the safe use of ligature cutters and effective resuscitation and should also incorporate consideration of the psychological impacts on staff responding to ligature incidents (Groves et al., 2023; Large & Nielssen, 2021; Van Hasselt & Hartshorn, 2018). Refer to principle 4 for more details.

Reporting

Accurate training records that track completion rates for emergency response to ligature event education and training should be monitored as part of overall training compliance, through the Clinical Governance Framework, and aligned to the health service's procedures for staff training.

Roles and responsibilities

Effective emergency management strategies emphasise the importance of preparation and awareness of roles and responsibilities to effectively respond to emergency situations (Victorian State Emergency Management Plan, 2023).

Following the Royal Commission into Victoria's Mental Health System, which supported the expansion of both clinical and non-clinical workforces, inpatient units now have a dynamic and diverse range of health care professionals collaborating with consumers throughout their recovery. While the clinical response to ligature incidents emphasises medical and nursing interventions provided directly to the consumer during the incident, all healthcare workers play a role in ensuring safety. They can be assigned specific responsibilities in an emergency, consistent with their scope of practice and position descriptions. When staff are aware of their roles and responsibilities, there is a greater opportunity for team members to feel more confident and responsive in the care they are providing (Mitchell, A., Hill, B., & Murray, J., 2024).

Attention to cultural diversity, individual customs, belief systems, and past experiences, should also be at the forethought when defining and delegating roles and responsibilities in responding to ligature incidents in healthcare settings. Failing to account for these factors may hinder the team's response in an emergency, potentially compromising the care provided to consumers and having a psychological or spiritual impact on the team.

Examples of team members' roles and responsibilities are outlined, but not limited to, in Table 1.

Table 1. Roles and responsibilities for emergency response to ligature incidents in hospital settings

Roles and responsibilities for emergency responses to ligature incidents in hospital settings	
Role	Responsibility
OH&S (Vic) 2004 Duty Holder or delegate	<ul style="list-style-type: none"> Section as per OH&S Victoria (2004) Act
Consumers, patients, families & carers	<ul style="list-style-type: none"> Alert staff to any worries or concerns.
Non-Clinical Workforce Including: <ul style="list-style-type: none"> Administration Domestic staff 	<ul style="list-style-type: none"> Participate in appropriate education and training opportunities related to ligature response. Alert clinical staff to any worries or concerns. Use local organisation emergency response and escalation systems when required or instructed to. Support administrative duties within worker's area of responsibility.
Lived Experience Workforce (LEW)	<ul style="list-style-type: none"> Participate in appropriate education and training opportunities related to ligature response. Alert clinical staff to any worries or concerns. Use local organisation emergency response and escalation systems when required or instructed to. Provide and offer support to other consumers during and after a ligature event.
Medical Workforce Including: <ul style="list-style-type: none"> Medical officers Psychiatric Registrar Consultant Psychiatrist 	<ul style="list-style-type: none"> Participate in education and training opportunities related to ligature response. Use local organisation emergency response and escalation systems when required. Provide immediate medical care to the person. Ensure medical post-care and monitoring for at least 48 hours post incident.
Nursing Workforce	<ul style="list-style-type: none"> Participate in education and training opportunities related to ligature response. Communication and delegation of roles and responsibilities for staff on shift. Use local organisation emergency response and escalation systems when required. Co-ordination of the clinical response including: <ul style="list-style-type: none"> - the use of a ligature cutter tool - initial medical care and treatment including likely CPR - escalation of care. Preserve any evidence in accordance with local policies. Ensure the replacement of the ligature cutter in accordance with local policies and applicable legislations. Identify and provide any immediate support for colleagues, consumers, family and carers Associate Nurse Unit Manager (ANUM) ensures incident reports are completed.
Other Clinical Health Professionals	<ul style="list-style-type: none"> Participate in education and training opportunities related to ligature response. Provide and offer support to other consumers, families and visitors during and after a ligature event. Support administrative duties within scope of practice.

Principle 4: Consumer, visitor and workforce post incident support

Everyday support

Workforce

It is important that strategies and supports for workforce wellbeing are embedded into day-to-day practice and workplace culture. Health services should strive to support a 'just culture' in response to ligature events. This means a workplace environment that promotes open discussion, accountability, and learning from mistakes rather than assigning blame (Liukka et al., 2020).

Health services should regularly assess and enhance workplace health and safety strategies to ensure continuous support for workforce wellbeing. The review and support of healthy workplace programs will help staff maintain a healthy work-life balance.

Staff have the right to a safe and healthy workplace. They should have access to, and be encouraged to engage in, initiatives that promote team bonding, organisational trust, and service cohesion including:

- Clinical supervision
- Group reflective practice
- Group debrief (*Critical Incident Responses in Healthcare White Paper, 2023*)
- Post shift group reflection
- Wellbeing initiatives
- Education and training sessions
- Team meetings
- Service provision planning sessions
- Line management
- Leadership presence
- Individual support
- Employee Assistance Programs (EAP)

With these or similar processes in place, the workforce becomes aware of- and ideally engaged in- practices that can support more efficient team recovery.

Traditional measures, such as an open-door policy designed to encourage ad-hoc access to informal supervision, group reflective practice, and clinical supervision, are core support elements that should be available to all workforce members (Rouski, Hodge, & Tatum, 2017). The Victorian framework '*Clinical Supervision for Mental Health Nurses*' is a foundational tool designed to support services in developing clinical supervision practices. This framework encourages good quality, accessible supervision to mitigate the negative effects caused by increases in the complexities faced by the modern workforce (Victoria's clinical supervision framework for mental health nurses, 2023).

A career in mental health can be a rewarding and challenging journey. Colleagues working within mental health services generally choose this path due to the impact that their skills and care provision can have on the lives of the consumers they support. Although an exciting and rewarding career, the nature of the work, the risk of occupational

violence and aggression, psychosocial hazards and the complex nature of mental illness and drug and alcohol can lead to increased stressors, reduced motivation, and countertransference towards others.

Managers and service leaders are required to explore the options available to mitigate and minimise the effects of workplace stress on team members on an on-going basis to provide a 'buffer'. Existing initiatives and examples, such as the '*Joy in Work*' framework, can be implemented to enhance workforce wellbeing by establishing a balance in this critical area. These frameworks provide protective mechanisms to help manage ongoing exposure to occupational psychological distress and trauma.

Policies and procedures

Health services should have policies and procedures in place that support a healthy workforce by including education and training requirements (e.g., emergency procedures, ligature cutter use, open disclosure, SAPSE), wellbeing programs, supervision and reflective practice, and external support through employee assistance programs or similar initiatives.

When serious workplace incidents occur, support should be escalated to provide colleagues with individualised, active assistance, alongside processes that sensitively address the investigation of what occurred. This also ensures that, during inevitable peaks of distress arising from the complexities of healthcare provision, staff have readily accessible coping strategies and support systems they can rely on with simple prompting.

When adverse events occur in health services, there is a risk of serious impact on all of the workforce (not limited to clinicians), consumers, family members, carers and supporters (Wu et al., 2020). People experience a range of reactions when confronted with adverse events, including physical, mental, emotional and behavioural responses. The severity or strength of response can vary according to previous relevant training, available support following an incident, personal or professional stressors, natural resilience and exposure to previous traumatic events (Dept Health, Victorian State Government, 2022).

The term 'second victim' was coined to highlight the need to support all colleagues effectively through processes and programs designed to address individual needs following adverse harm, especially when the harm is deemed to be preventable (Connors et al., 2019; Wu et al., 2020). Martens et al., 2016 highlights the importance of support from colleagues immediately after an event, within four to twenty-four hours, suggesting that during this period there is a high likelihood that affected staff will be involved in another adverse event without supportive intervention. Health Services should focus on the provision of relevant information along with presence of collegial support, all of which are likely to reduce the trauma and impact associated with a serious adverse event (Kable, Kelly, & Adams, 2018). Consideration should be given to facilitating a crisis management briefing to ensure timely and effective communication and updates.

Education and training

Velmans, J et al., 2023 suggests improving workforce understanding and management of serious adverse improves the workforce response to incidents. The importance of embedding education and training cannot be overstated. Colleagues who undertake simulation training for the discovery of a person who has used a ligature to self-harm will respond better than a team who have not undertaken simulation training.

It is important that formalised staff supervision education and training is undertaken by senior staff and those staff have an ongoing role in supervision of the workforce. Supervision provides an opportunity for reflective discussions, allowing individuals to explore issues arising from a clinical incident with a trusted colleague.

Managers and senior leaders require education and training to support the use of open disclosure with families and supporters, as well as the use of SAPSE processes, well before a serious adverse event occurs.

A phased approach of providing support with clear allocated roles for managers, senior leaders and executives has shown significant improvement in their confidence to respond to traumatic incident (Lewis et al., 2014).

A serious adverse event provides an opportunity for individual and organisational learning. Organisations and senior leaders must provide the workforce, consumers and other stakeholders with guidance, information training and support to maintain a safe and healthy work environment (Dept Health, Victorian State Government, Guide for health service staff, 2018).

The *'Occupational Violence and Aggression post incident support'* guide provides clear responsibilities for Managers, senior leaders and staff including the immediate provision of emotional and practical support to the workforce and all others who have experienced or been exposed to a serious adverse event, including patients and visitors (Victorian State Government, Guide for health service staff, 2018). This guide recommends Psychological First Aid (PFA) as the preferred approach for providing support. It clearly advises that psychological debriefing should not be offered, as it may be counterproductive to the person's recovery.

Reporting

Serious adverse events are often required to be reported externally to statutory authorities such as WorkSafe, Victoria Police, Office of the Chief Psychiatrist, Safer Care Victoria and the State Coroner of Victoria. Health services should ensure that senior leaders responsible for responding to serious adverse events, such as deliberate self-harm, are aware of the internal and external reporting requirements and who to consult for advice to ensure all reporting obligations are met.

Media interest and enquiries may be received by health services following a serious adverse event. Colleagues should be aware of where to obtain organisational support if required.

Post incident support

The workforce impacts

Managers and leaders are in an ideal position to respond to individual and collective staff needs where following a serious adverse event as they understand the culture of the unit and have a trusted relationship with the staff.

Clinical and non-clinical colleagues- such as security, lived experience staff, domestic services, the code blue team, as well as consumers, carers, families, and supporters present during the incident- must be given the opportunity to access and engage with supportive practices. This includes the initial diffuse session and longer-term supports, such as Psychological First Aid and general practitioner follow-up, where required.

The principles of Psychological First Aid consist of a sense of safety, calming, self-efficacy, connectedness, and hope should guide the development of these supportive interventions (Victorian State Government, Psychological first aid for post-incident support, 2018). Psychological First Aid is practical and helpful, rather than a therapeutic or clinical intervention, and so can be successfully delivered by people who are already known to those exposed to trauma (Wang et al.,2024).

While there is no set formula for providing Psychological First Aid to a person or group of staff following a very stressful or traumatic experience, the focus should be on supporting each person to utilise strategies and resources that best suit their needs, promoting self-healing and drawing on existing support networks. This includes, but it not

limited to, providing information to keep the consumer cohort on the unit informed, while carefully balancing the privacy and dignity of the individual involved.

The provision of open disclosure and Statutory Duty of Candour in cases of a SAPSE should be conducted by senior colleagues who have the education, training, and experience required to effectively communicate these messages to families and supporters. Next steps should be clearly communicated to staff, ensuring they understand the statutory investigations and the plans for recovery following a serious adverse event on the unit.

Recommended processes to have in place where there is a likelihood of a traumatic event occurring include: Employee Assistance Programs; peer support programs; reporting systems that prompt managers or leaders to check in with the impacted person; role rotations to reduce exposure to trauma; file-flagging processes to prevent inadvertent exposure to distress; and guidelines for post-event follow-up, ensuring adequate recovery time (WorkSafe Victoria, 2021).

WorkSafe Victoria “*A guide for employers – Preventing and managing work related stress*” recommends that managers receive training in appropriate responses to trauma. It also advises organisations to be transparent from the recruitment stage by indicating in the position description that the role may involve exposure to traumatic events.

Recommended responses and preventative measures include:

- Practical support
- Counselling and professional support
- Communication and transparency of information/ follow-up
- Ongoing monitoring of impacted employee's wellbeing
- Redesign of the work to minimise risk
- Considering additional risk controls, such as increased breaks and recovery time, for those who have experienced or who are at risk of experiencing repeated exposure to stressful events.

The impact on managers and senior leaders

Managers and leaders are often in roles where they have a responsibility to respond. Where a manager is required to investigate, review and deliver post incident supports, there is an ongoing risk to their own tolerance of distress. Activities such as reading incident details or reports, reviewing CCTV footage, or trying to understand how incidents could have been avoided especially when examining policies or processes they themselves developed- can lead to heightened stress, feelings of guilt, failure and blame, as well as vicarious trauma.

Managers and leaders care about their workforce and consumers, and incidents can affect them both personally and professionally. It is essential for organisations to establish clear processes and support networks for managers and senior leaders, regularly reviewing the impact of such work on them. This ensures a similar "buffer" is in place to prevent the cumulative build-up of distress and exposure to these challenging events.

When a leader responsible for supporting their workforce experiences burnout, the impact on the entire team can escalate significantly. Leaders and managers should have access to resources and support for their own wellbeing, enabling them to effectively fulfill their ‘responsibility to respond’.

Manager and senior leaders support steps include:

- Self-check in
- Seek support to follow up
- Breakdown of incident – who was impacted
- Summarise what support is available and already exists
- With support, reach out to all impacted and outline what is available
- Review individual needs and communicate relevant resources
- Keep people in the loop
- Seek opportunity to reflect

Managers and senior leaders who are repeatedly exposed to incidents and adverse events face a cumulative risk of experiencing vicarious trauma and psychological distress, which can impair their ability to support their teams. It is essential for executive members to monitor the well-being of managers and provide necessary support to this group.

Consumers

Consumers involved in a serious incident in the inpatient setting will require additional care, support and information. This support should also extend to other consumers residing in the unit at the time, who may not have been directly involved but are aware of the incident. The types of support needed may vary, but interventions can be broadly defined under the headings of defuse, debrief, and targeted, individualised support, and guided by the principles of Psychological First Aid (Victorian State Government, Psychological first aid for post-incident support, 2018).

In the initial phase following a serious incident, careful assessment is essential to determine the level of harm or impact on consumers involved, either directly or indirectly. This assessment should guide the implementation of interventions aimed at reducing harm and suffering and ensuring that appropriate recovery-oriented support is organised for emotional, psychological, and physical safety.

In addition to this, open disclosure, expressions of compassion, reflective communication, and offering an apology are important components in helping both consumers and staff heal and in restoring trusting relationships.

Visitors

Visitors, including family, carers, and supporters present in the unit at the time of the critical incident can also be impacted by the experience (Satchell et al., 2023). This can involve exposure to psychosocial hazards that may affect their physical state, thoughts, emotions and behaviours. In most instances, these reactions are short-term and subside relatively quickly, often within a few days or weeks. Most people recover fully and do not develop clinical disorders such as depression or Post Traumatic Stress Disorder (PTSD) that would require specialist treatment. However, a small percentage may be more vulnerable to experiencing strong trauma reactions post-incident. Contributing factors include prior experiences of trauma, thinking style, personality traits, limited support, or current major stressors. Best practice is to offer information and simple advice, practical and emotional support, and encourage the use of helpful coping strategies and social/professional supports. These actions also allow natural recovery processes and assist with psychological wellbeing (Petit & Stephen.,2015). It is also important to note that visitors to the unit fall under the remit of the local organisations' occupational health and safety responsibilities.

Appendix 1: Glossary of terms

Glossary of terms

Ligature: “is anything, like a cord or other material, that could be used for the purpose of hanging or strangulation” (Care Quality Commission, 2023, p. 5).

Ligature anchor point: “is anything that could be used to attach a ligature” (Care Quality Commission, 2023, p. 5).

NOTE: Ligatures do not necessarily need to be attached to a ligature anchor point.

Suspended: where a person has a ligature around the neck, which is attached to an anchor point.

Unsuspected: ligature is tied around part of the body to restrict breathing and/or blood flow.

Appendix 2: Acknowledgments

SCV wishes to acknowledge and thank the following people for their time, commitment and expertise who have helped develop this clinical guidance document “**Improving safety for consumers at risk of harm of ligature**”.

Table 2: Project Governance and Expert Working Group Membership

Name	Role	Organisation
Project Governance		
Anna Love	Executive Sponsor; Chief Mental Health Nurse and Executive Director, Clinical and Professional Leadership Unit	Safer Care Victoria
A/Professor Janine Davies	Clinical Lead; Senior Mental Health Nurse Advisor	Safer Care Victoria
Sonalee Ghosal	Project Management; Senior Project Officer, Clinical Leadership and Response	Safer Care Victoria
Expert Working Group		
A/Professor Janine Davies	Chair	Safer Care Victoria
Anna Sowden	Lived Experience Discipline Lead	Barwon Health
Annetta Clark	Senior Psychiatric Nurse	Grampians Health
Belinda Scott	Executive Director, Mental Health	Northern Health
Courtney Neill	Program Manager Adult Acute, Mental Health and Wellbeing Service	Peninsula Health
Donna Hansen-Vella	Director of Nursing, Mental Health	Barwon Health
Harry Singh	Senior Psychiatric Nurse	Eastern Health
Rachel Tolan	Senior Psychiatric Nurse	Royal Children’s Hospital
Thomas Wilson	Senior Psychiatric Nurse	St. Vincents Health

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