Suicide and Non-suicidal Self-injury in Children and Adolescents: Evidence-based Clinical Practice Guideline

DRAFT Version 1.2

The following document is a DRAFT intended solely for public consultation, running from 14 October to 14 November 2025. Further design enhancements and comprehensive reviews will be undertaken before the guideline's final publication. By providing us feedback during this consultation phase, you are assisting us in refining the content and ensuring its applicability before the guideline's official release. We appreciate your help and participation in this process.

To submit your feedback, please complete the following form:
https://redcap.link/CMHSCPGpublicconsultation

Developed by Melbourne Children's Campus Mental Health Strategy in partnership with The Royal Children's Hospital, Murdoch Children's Research Institute, and The University of Melbourne, Department of Paediatrics.

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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 non-suicidal self-injury (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.

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 families experiencing suicidal ideation, suicide attempts, and NSSI within their scope of practice. Some recommendations are intended for professionals with specialised training; these are indicated within the recommendation(s) or section.

This includes:

Non-health professionals: individuals who may interact with or support children and adolescents in community or educational settings, such as educators and youth workers. These professionals may use this guideline to inform support and response within their role and capacity.

Healthcare professionals: medically trained professionals who provide direct healthcare and clinical management, such as nurses, paediatricians, emergency department clinicians, and allied health professionals. This can include GPs and mental health professionals.

General practitioners (GPs): healthcare professionals who provide primary care and play a key role in early identification, initial assessment, management, and referral.

Mental health professionals: healthcare professionals with specialised training and credentials in mental health, such as psychiatrists, clinical psychologists, mental health nurses, and specialist social workers.

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

Considerations for reviewing 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. For a summary of methods, see *how the recommendations were developed* on page 31.

There are two types of recommendations in this guideline:

Evidence-based recommendations (EBR): Recommendations formulated from Guideline Development Group (GDG) discussion of the research evidence, where a systematic search and evidence review was conducted, and evidence was identified and analysed.

Consensus-based recommendations (CBR): 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.

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 or 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

This guideline aims 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 system. 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 aligned with the preferences of those they are supporting.

There are many terms 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.

A glossary of terms used in this guideline is available on page 29.

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1. Principles of care

#	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, suicide attempts, and NSSI.
1.2	CBR	Organisations that provide services to children and adolescents should have clearly defined policies and procedures, and supports available, as appropriate to their setting, for staff working with children and adolescents who experience suicidal ideation, attempts, and NSSI. Examples of these may include: • social workers/counsellors • specialists (eg child and adolescent psychiatrists) • legal advisors • translators • 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 always involve the child/adolescent and their support system, acknowledging that there are situations where the involvement of some support people is not appropriate.
1.4	CBR	Questions and conversations about suicidal ideation, attempts, or NSSI should be specific and unambiguous.
1.5	CBR	Professionals working with children and adolescents who experience suicidal ideation, attempts, and NSSI should: • be aware of policies and procedures for identifying and accessing supports, including organisational and legal frameworks relevant to their field • know how to implement the policies and procedures within their role and responsibilities • know who to go to for support and supervision
1.6	CBR	Healthcare professionals working with children and adolescents who experience suicidal ideation, attempts, and NSSI should be: • appropriately qualified, with current registration with the standard registration body for their profession (such as the Australian Health Practitioner Regulation Agency) • appropriately trained in child and adolescent mental health, including in developmentally nuanced, trauma-informed, intersectionality sensitive approaches and undergoing supervision with a clinician experienced in this field

		• appropriately trained and supervised in the therapy they are offering, if applicable • aware of relevant legal frameworks or regulations
1.7	EBR	Information and support for children and adolescents who experience suicidal ideation, attempts, or NSSI should be provided. Topics to discuss may include: • what suicidal ideation, suicidal attempts, or NSSI encompasses • why people might experience suicidal ideation, attempts, or NSSI and, where possible, the specific circumstances of the child/adolescent • available treatment options • available supports, including lived experience workers, community supports, and peer groups • self-care • how to manage wounds and care for their injuries • how to manage scars • care plans and safety plans, and what they involve, including protective measures • stigma and common misunderstandings around suicide and NSSI, and how they might react to this • what to do if they have any concerns • what to do in an emergency, including when to seek help
1.8	CBR	Where appropriate, information and support for the support system of children and adolescents who experience suicidal ideation, attempts, or NSSI should be provided. Topics to discuss may include: • the emotional impact on the child/adolescent and their support system • what to do if the child/adolescent engages in NSSI or a suicide attempt again • what to do if the child/adolescent discloses an experience of suicidal ideation • how to seek help for the physical harm that may occur • how to assist and support the child/adolescent to prevent perpetuation of stigma or blame • how to recognise signs that the child/adolescent might be at risk for further harm • steps to reduce the likelihood of suicidal ideation, attempts, or NSSI in the future • 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) • What to do in an emergency, including when to seek help
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:

		• whether this is a first known presentation or a repeat event • the nature and type of self-harm (suicidal ideation, attempts, or NSSI) • if the child/adolescent has any co-occurring health or mental health conditions • the child/adolescent's preferred method of receiving support or information (eg digital, written, visual, audio etc) • 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, people who are neurodivergent, people with a learning or intellectual disability, Aboriginal and/or Torres Strait Islander peoples, culturally and racially marginalised persons, refugees, and people who are LGBTQIA+ to avoid discrimination.
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: • consider the reasons why a 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) • 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) • work collaboratively to establish and document preferred methods of communication throughout care • provide appropriate access to translations
1.12	CBR	Healthcare professionals working with 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: • Confidentiality: what information will be kept private, what might be shared, with whom, and under what circumstances. • Mandatory reporting obligations: a clinician's legal duty to report concerns about abuse, neglect, or serious risk of harm. • Consent: what the adolescent or legal guardian is being asked to consent to (eg treatment), and that their preferences will be respected where it is safe to do so.
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	Restrictive interventions should only be used where clinically indicated and in accordance with local regulation.

The recommendations in this section are informed by evidence reviews and clinical discussions by the GDG, where no evidence was identified.

The GDG discussed that this guideline must reflect a whole-of-society and whole-of-community responsibility for supporting children and adolescents experiencing suicidal ideation, attempts, and NSSI. The GDG felt strongly that the responsibility for care should not rest solely with individual healthcare providers, but instead be shared across health systems, schools, families, communities, and broader services to ensure sustainable and holistic support. It was also noted that each person involved in supporting a child/adolescent must act within the scope of their training, role, and responsibility. Collaboration across disciplines and settings is encouraged and should be led by clear role definitions, with the child/adolescent as the focus. The group also highlighted the need for care to be individualised and culturally sensitive, recognising that each child and adolescent has unique experiences, needs, and contexts.

This summary was drafted for public consultation. Detailed evidence and discussion points will be included in the final publication of the guideline.

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2. Identification and risk assessment

#	Type	Recommendation
2.1	EBR	The experience of suicidal ideation, attempts, or NSSI is often impacted by socioeconomic and environmental factors and experiences. Healthcare professionals working with children and adolescents should consider the possible risk of suicidal ideation, attempts, or NSSI associated with the following high-risk factors: • previous suicide attempt(s) • personal history of mental illness • neurodiversity • taking medications with known adverse effects of suicidal ideation or self-harm • obesity • family history of mental illness, or death by suicide • peer suicide attempt or death by suicide • experiences of maltreatment or abuse • parental incarceration • contact with child protection services or out-of-home care • experience of bullying or cyberbullying • female gender
2.2	CBR	Healthcare professionals working with children and adolescents could consider the risk of suicidal ideation, attempt or NSSI in those with any of the following high-risk factors/conditions: • LGBTQIA+ • gender diversity • disability • increased social media use • social isolation • experience of financial stress • family history of legal difficulties • chronic illness within the support system • death of a loved one • experience of community or family violence • experience of discrimination • common co-occurring conditions (see recommendation 2.12)
2.3	CBR	Healthcare professionals concerned about the risk of suicidal ideation, attempt, or NSSI in a child/adolescent should engage in clear, unambiguous clinical discussion to identify risk. Consider: • conducting clinical discussion in a quiet, comfortable space • establishing a connection/rapport with the child/adolescent

		• supporting the child/adolescent through a non-judgemental, active supporting role
2.4	CBR	Screening should be followed by appropriate clinical discussion to consider the child/adolescent's individual context, needs, and risks, and to inform next steps in assessment or care planning.
2.5	CBR	Population-level screening for suicidal ideation, attempts, or NSSI should not be routinely implemented when working with children and adolescents. Screening decisions should be guided by individual clinical judgment on a case-by-case basis rather than applied universally.
2.6	CBR	Risk assessment tools and scales should **not** be used to predict future suicide or repetition of suicidal ideation, attempts, or NSSI.
2.7	CBR	Risk assessment tools and scales should **not** be used to determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI.
2.8	CBR	Global risk stratification (eg low, medium, or high risk) should **not** be used to predict future suicide or repetition of suicidal ideation, attempts, or NSSI.
2.9	CBR	Global risk stratification (eg low, medium, or high risk) should **not** be used to determine treatment, triage, or discharge of children and adolescents at risk of, or experiencing suicidal ideation, attempts, or NSSI.
2.10	CBR	Mental health professionals should undertake a risk formulation as part of every biopsychosocial assessment. Risk formulation should be collaborative and focus on the child/adolescent's needs, wants, and how to support their immediate and long-term psychological and physical safety.
2.11	CBR	Mental Health professionals should create a risk formulation that considers the risk caused or exacerbated by any co-occurring conditions that can inform interventions and support for the child/adolescent. The risk formulation should explore risk, protective factors, and potential triggers for risk escalation.
2.12	CBR	Suicidal ideation, attempt, or NSSI commonly co-occur with (or are 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: • ADHD, autism spectrum disorder, and specific learning disorders • anxiety disorders • asthma • bipolar and related disorders • borderline personality disorder

		• depressive disorders or depressive factors, such as feeling hopeless or worthless • dissociative disorders • epilepsy • feeding and eating disorders • intellectual disabilities • obsessive-compulsive disorder and body dysmorphic disorder • oppositional defiant disorder and conduct disorder • physical disabilities and chronic conditions (eg chronic pain) • post-traumatic stress disorder (PTSD) and complex PTSD • schizophrenia spectrum disorders (including psychosis) • substance-related and addictive disorders For socioeconomic and environmental factors associated with increased risk, see recommendations 2.1 and 2.2.
2.13	CBR	Healthcare professionals working with children and adolescents who experience suicidal ideation, attempts, or NSSI and a co-occurring condition should consider: • early warning signs, symptoms, prognosis, and best practice treatment, and support options associated with these co-occurring conditions • how co-occurring conditions may present in children and adolescents of different ages, genders, and cultural backgrounds • precipitating factors, and functions, associated with suicidal ideation, attempts, or NSSI that may co-occur with other conditions • subclinical psychological symptoms and traits that may be associated with suicidal ideation, attempts, or NSSI (eg impulsivity, lower self-esteem, emotional dysregulation) and a co-occurring condition, even if a person does not meet criteria for a diagnosis • appropriate, affordable, accessible, and timely assessment and referral pathways for children and adolescents who may be experiencing these co-occurring conditions • the child/adolescent's preferences regarding the use of diagnostic labels, person-first language, gender affirming, and neuro-affirming language

The recommendations in this section are informed by evidence reviews and clinical discussions by the GDG, where no evidence was identified.

The GDG felt it was important to consider risk factors and co-occurring conditions when identifying and assessing risk of suicidal ideation, attempts or NSSI and consider these factors when planning next steps. To limit potential misinterpretation, incorrect use, and unintended harm, the GDG recommends against using screening and risk assessment tools and scales as a sole indicator of risk or triage. The use of risk formulation is recommended as an alternative to traditional risk assessment tools. Instead, tools can be used to inform or

lead a risk formulation discussion by a mental health professional trained to tailor responses appropriately.

This summary was drafted for public consultation. Detailed evidence and discussion points will be included in the final publication of the guideline.

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3. Care in non-specialist settings

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

#	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: • the severity of any physical injury and if urgent medical treatment is needed • the child/adolescent's emotional and mental state, and level of distress • whether there is immediate concern about the child/adolescent's safety • whether the child/adolescent has a care plan and/or an established relationship with a mental health service or GP
3.2	CBR	The child/adolescent should be referred to appropriate healthcare professionals for physical injury and mental healthcare as soon as possible.
3.3	CBR	When supporting a child/adolescent who experiences suicidal ideation, attempts, or NSSI, non-health professionals should: • discuss with the child/adolescent the best way to help in their role/capacity • follow the child/adolescent's care plan and safety plan if available • seek advice from healthcare professionals where necessary • communicate, where appropriate, with relevant people involved in ongoing care, including support person(s) or healthcare professionals • 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 or social care services for a biopsychosocial assessment or informing their existing mental health team, with consent from the child/adolescent and their support system. Make referring to mental health professionals a priority when: • the child/adolescent's levels of concern or distress are rising, high, or sustained • the frequency or degree of suicidal ideation, attempts, or NSSI is increasing • the child/adolescent or their support system asks for further support from mental health services

		• levels of distress in their support system are rising, high or sustained, despite attempts to help
3.5	CBR	When communicating with relevant healthcare professionals or referring to specialised mental health care services, collect and document relevant information about the child/adolescent's: • home environment • social and family support network • community involvement (eg school, sport, religion) • history of NSSI or suicide attempts • current emotional and mental state, and level of distress • 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: • regular appointments for review of symptoms and their impact • a medicines review (see recommendations 9.1-9.4 for considerations about prescribing medications) • information about available supports, including lived experience workers, community supports, or peer groups • care for any co-occurring conditions • established positive community and social supports • information about safety planning, including harm minimisation or healthy coping strategies, if appropriate
3.7	CBR	Healthcare professionals caring for a child/adolescent after an episode of NSSI or suicide attempt should: • establish the means of self-harm and, if accessible to the child/adolescent, discuss removing with therapeutic collaboration or negotiation, to keep them safe • gather information to understand the full context and function of the behaviour • seek consent to liaise with support person(s), as appropriate • discuss with the child/adolescent and their support system, about care plans, safety plan(s) or healthy coping strategies

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The recommendations in this section were informed by clinical discussion.

The GDG felt it was important to provide guidance for non-mental health professionals, such as GPs or school counsellors, who are often the first healthcare professional to encounter a child/adolescent experiencing mental health difficulties and identify risk of suicidal ideation, attempts or NSSI. Healthcare professionals in these settings play a crucial role in identifying, providing an initial response, and facilitating appropriate physical and mental health services. These professionals also play a large role in building rapport and trust with the child/adolescent and may remain involved throughout their care journey.

This summary was drafted for public consultation. Detailed discussion points will be included in the final publication of the guideline.

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4. Care in emergency or urgent care settings

#	Type	Recommendation
4.1	CBR	Healthcare professionals in an emergency department (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: • information included in recommendation 3.7 • the child/adolescent's willingness to accept medical treatment and mental healthcare • the appropriate observation level
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 for consultation-liaison psychiatry services (or an equivalent specialist mental health service, or suitably skilled mental health professional) as soon as possible after arrival, for a biopsychosocial assessment, support, and assistance concurrent with physical healthcare.
4.3	CBR	A consultation-liaison psychiatry professional or suitably skilled mental health professional should see and speak to the child/adolescent and their support system at every ED attendance after an episode of suicidal ideation, attempt, or NSSI. If a mental health professional is not available to consult with the child/adolescent directly, the treating team should liaise with a suitably skilled mental health professional for advice in the interim.
4.4	CBR	EDs or urgent care clinics should have: • a quiet, designated area for biopsychosocial assessments to take place, where it is possible to speak in confidence without being overheard • waiting area(s) close 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. This can include: • access to electronic document systems for both mental health services and medical treatment at the point of care • agreed referral pathways for concurrent physical and mental healthcare • jointly agreed approaches to initial assessment and triage • shared understanding of relevant organisation and legal frameworks • jointly agreed observation policies • referral pathways to appropriate community services

4.6	CBR	Restrictive interventions in EDs should only be used as a last resort, where clinically indicated, and in accordance with local regulations.
4.7	CBR	Short-term extended stay in an ED could be considered when: • there are concerns about the safety of the child/adolescent (eg risk of violence, abuse, or exploitation) • the child/adolescent is unable to engage in a biopsychosocial assessment (eg because they are too distressed or do not have capacity) • the child/adolescent requires support while being referred to specialist mental health supports or transferred to a mental health inpatient unit

The recommendations in this section are informed by clinical discussion.

The GDG agreed that EDs and urgent care clinics are a critical point of care for children and adolescents presenting with suicidal ideation or after an attempt or NSSI. EDs or urgent care clinics are often the first point of acute care and carry the responsibility of ensuring both immediate physical safety and timely access to specialist mental health services. The GDG agreed it was important for these settings to have policies and procedures in place to provide psychological and physical care concurrently, and that they be equipped to respond to these presentations appropriately.

This summary was drafted for public consultation. Detailed discussion points will be included in the final publication of the guideline.

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5. Care in specialist settings

#	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: • build rapport and develop a collaborative therapeutic relationship with the child/adolescent • begin to develop a shared understanding of why the child/adolescent is at risk of, or experiencing suicidal ideation, attempts, or NSSI • 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 the biopsychosocial assessment should ask about the child/adolescent's: • social, peer group, education, and home situation • caring responsibilities, if any • use of social media and the internet to connect with others and the effects of these on mental health and wellbeing • any issues or concerns regarding their safety • historic factors or past experiences • changeable and current factors, including current symptoms or substance use • future factors, including specific upcoming events or circumstances • protective or mitigating factors
5.6	CBR	Mental health professionals conducting the biopsychosocial assessment should explore the function, motivation, or purpose of the suicide attempts, or NSSI for the child/adolescent. Consider: • their values, wishes, what matters to them and their support system • the need for psychological interventions, social care and support, or occupational rehabilitation • any learning disability, neurodevelopmental conditions, or mental health concerns

		• their treatment preferences • that each episode of self-harm should be treated in its own right, and their reasons for self-harm may vary from episode to episode, individual to individual • whether it is appropriate to involve their support system or trusted person(s) • existing care or safety plans
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: • making appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition the person may have • providing the option to have a professional of a similar demographic background (eg gender) to carry out the biopsychosocial assessment when requested and available
5.8	CBR	If the child/adolescent is not able to or does not want to participate in the biopsychosocial assessment, mental health professionals should assess their safety, ensure that they have regular reviews, and complete the assessment when possible.

The recommendations in this section are informed by evidence reviews and clinical discussion by the GDG, where no evidence was identified.

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. In particular, the assessment should consider the function of the behaviour for the individual, recognising that it may serve to regulate emotion, communicate distress, or manage overwhelming experiences. During assessment, the mental health professional can create a trusting therapeutic relationship with the child/adolescent, which is an important factor in effective management.

This summary was drafted for public consultation. Detailed evidence and discussion points will be included in the final publication of the guideline.

6. Aftercare and safety planning

#	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. These decisions should be documented in the child/adolescent's care plan. 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	CBR	Together with the child/adolescent and their support system, the mental health professional should develop or update the care plan using the key areas of need and safety considerations identified in the biopsychosocial assessment and follow as closely as possible.
6.4	CBR	Mental health professionals should give the child/adolescent a copy of their care plan. Document this in the child/adolescent's medical record (including MyHealthRecord, if available) and, as soon as possible, share the plan with all professionals involved in their care.
6.5	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. Safety plans should be used to document ways to keep the child/adolescent safe in times of distress or crisis, including: • establish means of self-harm • identify triggers and warning signs of increased distress, or further episodes of suicidal ideation, attempts, or NSSI • identify healthy coping strategies, including problem-solving and any factors that may act as a barrier to these • identify people in the support system who can provide support and/or help resolve a crisis • contact details for healthcare services, including existing links to mental health professionals and emergency contact details • making their environment psychologically and physically safe, including managing access to means of self-harm

6.6	EBR	The safety plan should be: • developed in collaboration with the child/adolescent and their support system • in a format that is accessible and understandable to the child/adolescent (eg digital, visual) • developed using a problem-solving approach • held by the child/adolescent or their support system, where appropriate • shared with relevant professionals involved in their care, with consent from the child/adolescent • accessible to the child/adolescent, their support system, and professionals involved in their care at times of crisis or distress
6.7	CBR	The use of digital care plans or phone safety apps could be used to increase access for the child/adolescent and their support system.

Recommendations in this section are informed by evidence and clinical discussion where no evidence was identified.

Care and safety planning is an important component in the management of suicidal ideation, attempts, and NSSI risk for children and adolescents. The GDG highlighted that care and safety plans are most effective when developed jointly with the child/adolescent and their support system. Because safety plans can be used in or applied to multiple settings across a child/adolescent's life, professionals from these settings, including school and primary care, should contribute to or be aware of the plan.

This summary was drafted for public consultation. Detailed evidence and discussion points will be included in the final publication of the guideline.

7. Treatment

#	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 can be used after a biopsychosocial assessment and should be: • discussed in collaboration with the child/adolescent, their support system, and other relevant professionals involved in their care • draw on the child/adolescent's strengths, healthy coping strategies, and what matters to them • focus on positive outcomes • be part of an ongoing care and management • be reviewed as part of ongoing care
7.7	CBR	Harm minimisation strategies may not be appropriate for all children and adolescents who experience suicidal ideation, attempts, or NSSI, and should be considered based on the child/adolescent's care and support needs.
7.8	CBR	If a child/adolescent is engaged in ongoing care and treatment for a suicide attempts or NSSI but is not yet in a position to resist the urge to harm themselves, harm minimisation strategies can be considered: • in the spirit of hope and optimism, and to reduce the severity and/or recurrence of injury • as part of an overall approach to the child/adolescent's ongoing recovery-focused care and support, and not as a standalone intervention

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		• after being discussed and agreed in a collaborative way with the child/adolescent, their support system, and the wider multidisciplinary care team
7.9	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, for example: • alternate distraction techniques or coping strategies • approaches to self-care • wound hygiene and aftercare • providing factual information on the potential complications of injury • discussing the impact of alcohol and recreational drugs on the urge to harm oneself • information about available supports, including lived experience workers, community supports, or peer groups
7.10	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 may need to be involved, to agree on a joint plan and approach. This may involve: • identifying an appropriately trained professional who the child/adolescent trusts, to coordinate their care and act as a point of contact • reviewing existing care and support, and arranging referral to any necessary services • developing or updating the care plan • developing or updating the safety plan, which should be written with and agreed upon by the child/adolescent
7.11	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. See recommendation 2.12 for common co-occurring conditions. See recommendations 9.1-9.4 for considerations on prescribing medication for co-occurring conditions.

Recommendations in this section are informed by evidence and clinical discussion where no evidence was identified.

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, and treatment should be tailored to the underlying drivers of their distress and behaviours.

The GDG also highlighted the importance of harm minimisation strategies in keeping the child/adolescent safe when they are not in a position to stop self-harming completely. Recognising the child/adolescent's dignity of risk with therapeutic risk-taking also plays a role in supporting them to make choices and develop autonomy within a therapeutic environment.

This summary was drafted for public consultation. Detailed evidence and discussion points will be included in the final publication of the guideline.

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8. Admission to hospital

#	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 admission to hospital, considering: • specific goals for the child/adolescent at that point in time • the home and social environment that will be supporting the child/adolescent • existing links to mental health and community outpatient supports • existing care and safety plans
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: • access to specialist mental health services or consultation-liaison psychiatry 24 hours a day • a joint daily review by both the paediatric team and the mental health team • daily access to support person(s), ideally 24 hours a day • 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: • a biopsychosocial assessment has taken place • a plan for further management has been decided, including a care plan and a safety plan • a discharge planning meeting with the care team has taken place, including physical healthcare professionals if necessary • arrangements for aftercare have been specified, including clear documentation and written communication with the relevant care or primary care team

The recommendations in this section are informed by clinical discussion.

The GDG agreed that admission to hospital should be carefully considered by the treating healthcare professional, weighing the potential benefits and harms. Hospital admission can provide safety, stabilisation, and access to multidisciplinary care, however, it can also be a

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distressing and disruptive experience for children and adolescents, particularly if not developmentally appropriate or if separation from their usual supports occurs. When admission is required, the specific needs of children and adolescents must be prioritised, including access to a support person(s), maintaining routines where possible, and an environment that feels safe, therapeutic, and age appropriate.

This summary was drafted for public consultation. Detailed discussion points will be included in the final publication of the guideline.

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9. Safer prescribing

The following recommendations 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.

#	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: • potential adverse effects and risk of increased suicidal ideation, attempts, and NSSI • the toxicity of the prescribed medicines for people at risk of overdose (eg opiate-containing painkillers, tricyclic antidepressants, and propranolol) • recreational drug and alcohol consumption, the risk of misuse, adverse events, and possible interaction with prescribed medicines • the need for effective communication where multiple prescribers are involved
9.2	CBR	Discuss with the child/adolescent and their support system elements of safe prescribing, including: • symptom diary to track adverse effects • education on how to manage medications, including medication adherence, and warning signs/symptoms of stockpiling medications • safe medication storage, including who is responsible for and has access to medications • limiting the quantity of medicines supplied (eg staged supply arrangements or weekly prescriptions) • safe disposal of unwanted medications • the child/adolescent's wider access to medicines prescribed for themselves or others
9.3	CBR	Healthcare professionals prescribing medication should consider carrying out a medicines review after an episode of suicidal ideation, attempts, or NSSI. Consider: • medications where suicidal ideation/attempts are known adverse effects (eg Isotretinoin) • the pharmacokinetic properties of medicines (eg half-life) • risk of toxicity • 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. For example: • asking about thoughts of self-harm or suicidal ideation • access to substances that might be taken in overdose (including prescribed, over-the-counter medicines, herbal remedies, and recreational drugs)

The recommendations in this section are informed by clinical discussion.

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. The GDG also agreed that medications used to treat co-occurring conditions should be carefully monitored, noting known adverse effects of specific medications and the potential for toxicity or overdose.

This summary was drafted for public consultation. Detailed discussion points will be included in the final publication of the guideline.

Glossary

Biopsychosocial assessment	A comprehensive assessment, including an evaluation of the person's needs, safety considerations, strengths and vulnerabilities, that is designed to identify biological, psychological, and social factors that might 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 in which 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. The legal guardian might not always be the most trusted support person in a child/adolescent's life.

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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.
Non-suicidal self-injury (NSSI)	An action or behaviour where an individual 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 physical, mechanical, or chemical restraints.
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. This is often referred to as suicidal thoughts, of thoughts of suicide in a non-clinical environment.
Suicide attempts	An action or behaviour where an individual causes harm to themselves with the intent to die and survives.
Support system or support person(s)	An individual 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. There are instances where the involvement of specific persons may not be safe or appropriate.
Therapeutic risk-taking	The allowance of 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. This concept can also be called dignity of risk.

How the recommendations were developed

Guideline Development Group (GDG)

A multidisciplinary Guideline Development Group was convened by the chair and supported by the evidence team. The group comprised members with lived and living experience, including those caring for 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 self-harm in children and adolescents was conducted. 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).

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.

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, we adopted the methods used by NICE and updated the NICE 2022 evidence reviews.

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).

Evidence review questions

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. The methodological quality of included studies was evaluated using criteria developed a priori according to study design to assess risk of bias.

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.

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Drafting of recommendations

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.

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