

END THE SILENCE
END SUICIDE



Department of
Health

An Roinn Sláinte

Máinnystrie O Poustie

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SHARE

**CONSENT, CONFIDENTIALITY AND INFORMATION
SHARING IN MENTAL HEALTHCARE
AND SUICIDE PREVENTION**



Zero
Suicide
Alliance

Because
ONE life lost
is **ONE** too many

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Seek consent to share information
Have regard to the law, rules and regulations
Always act in the patients' best interest
Record all discussions and activities
Ensure service user confidentiality is respected

FAMILIES VOICES FORUM

A key to improving the care and safety of any individual is to manage their safety, not as an isolated individual, but as a member of a family or friend circle who know the person and their risks and safety factors better than anyone. It is often seen as a difficult thing to do and families often feel excluded and unheard when their loved one becomes involved with specialist services.

The Forum welcomes the SHARE approach as the beginnings of a true partnership working approach between the professional, the individual at risk and the carer involved. Each have vital knowledge and experience to share which will enhance safety and promote better outcomes in the longer term. SHARE provides the guidance on how to do this with respect and care to all involved. Working this way will save lives.

Julia McKeever, Chairperson, Families Voices Forum



ZERO SUICIDE ALLIANCE

Having worked in clinical practice in a range of settings for 20 years, I am aware of the challenges facing service users, families and practitioners regarding consent, confidentiality, and capacity decisions in clinical practice. This SHARE resource and decision tool is designed to increase confidence, safety and better partnerships with all agencies in the best interest of those using healthcare services.

Dr Claire Iveson, Consultant Clinical Psychologist, Clinical and Strategic Lead – Zero Suicide Alliance and Mersey Care NHS Foundation Trust



THE CORONERS SERVICE FOR NORTHERN IRELAND

The Coroners welcome the guidance outlining best practice for mental health practitioners in gaining consent and sharing information, for the purpose of improved mental health assessment and safety planning. The issues raised in this document resonate with a, sadly, often recurring theme encountered during Coroners' investigations of suspected suicide, within the context of recent mental health assessment. The emergence of this detailed guidance gives some reassurance to Coroners that clarity and support is available to practitioners facing such challenging and complex decisions in this area.



Consent, confidentiality, and the sharing of information, both between agencies and with families and carers, is one of the most complex yet vitally important aspects of mental healthcare.

The most effective, safe and holistic mental healthcare and service user care plans will invariably involve the exchange of information within the confines of the relevant legislation and professional codes of practice. Best practice in this area will not only produce better outcomes but may also avert serious incidents and tragedy.

The Northern Ireland Protect Life 2 Strategy (2019) has a particular focus on those who have been bereaved by suicide. Families have described their distress and sense of isolation at having responsibility for looking after a suicidal relative but lacking the skills and knowledge to do so effectively. A recurrent concern raised by families is their perception that staff exclude them from the mental healthcare of their relative by excessive adherence to patient confidentiality.

While a patient's right to confidentiality is paramount, working to gain consent to share information with a person's trusted family or friends will assist in determining appropriate healthcare and safety management. There are occasions when a staff member may decide to share information in the absence of patient consent, as is described later in this document. Staff may also involve a trusted family member to obtain collateral information

to inform assessment and care planning without breaching confidentiality.

Recognising the tension between an individual's right to confidentiality and the sharing of information which may protect life and prevent harm, concern remains that practitioners may not feel adequately trained and equipped to seek consent and share information as a core, positive procedure in patient care.

As a basic principle, it is suggested that, in mental healthcare and most especially in suicide prevention, practitioners are aware of both the importance of sharing information and the legal and ethical justifications for doing so. It is important that there is a demonstrable and recorded reason with respect to whether information is shared – or not – with relevant agencies and individuals. Subject to the relevant rules and regulations, a change of culture is required.

The aim of this SHARE guide for Northern Ireland is to educate and provide guidance to support practitioners to work through the legal and clinical issues surrounding the sharing of information, to produce better outcomes and protect service users' best interests. It expands upon and enhances the DHSC 2021 Consensus Statement on information sharing, developed for use in mental health services in England (see appendix 1 for organisations involved). It draws on the format of the Zero Suicide Alliance SHARE guide. It has been approved for use within Health and Social Care services by the Department of Health (NI).



**In Northern Ireland
between 2010 to 2018,
24 percent of people
who took their own
lives were open to
mental health services
in the last year**



“Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed where possible”

The assessment of clinical risk in mental health services –
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

Family and carer involvement in risk assessment and care planning

In addition to the legal requirements, multiple professional organisations and governing bodies also recognise the importance of protecting service user confidentiality. Many organisations have prepared detailed guidance on patient confidentiality and information sharing and these can also be consulted by staff. The General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, Health and Care Professions Council, Royal College of Psychiatrists and others have all confirmed that the 2021 Consensus Statement remains consistent with their own regulatory standards and protocols.

The 2021 Consensus Statement, now augmented by this SHARE guide for Northern Ireland, does not seek to change existing guidelines and methods. Rather, these resources are designed to promote the lawful sharing of relevant information and the amplification of professional judgement within the current regulatory and best practice environment. This is under the precept that it is commonly better to seek consent to share information than not.

The Mental Capacity Act (NI) 2016, which whilst not fully implemented in Northern Ireland at the time of writing this document, is referenced in this guide as representing best practice and to future proof these guidelines.

Who this applies to

This SHARE guide applies to adults in Northern Ireland. The situation for children and young people under the age of 18 differs, although the same duties of confidentiality apply when using, sharing or disclosing information about children and young people, as about adults. Information can be shared about a child or young person for the purposes of keeping them safe.

In practice, this means that practitioners should disclose information to an appropriate person or authority if this is necessary to protect the child or young person from risk of death or serious harm. A decision can be made to share such information with the family and friends, if necessary.

More detail on sharing in respect of children and young people for safeguarding purposes can be found in [Co-operating to Safeguard Children and Young People in Northern Ireland | Department of Health \(health-ni.gov.uk\)](https://www.health-ni.gov.uk/information-and-education/children-and-young-people/co-operating-to-safeguard-children-and-young-people-in-northern-ireland)

Confidentiality, consent, and capacity

Confidentiality, consent, and capacity are all issues which have rightly received a great deal of careful attention over the years. It is clear that, where the common law duty of confidentiality applies, practitioners will usually be under a duty to respect a person's refusal to consent to disclosure of their information if the person has the relevant capacity and they do not pose a risk to anyone but themselves.





In summary, practitioners are bound by law and professional guidelines to protect confidential (personal and sensitive) information about individuals. Where this pertains to individuals aged over 18, the Consensus Statement encourages the application of clinical and professional judgement, especially when there is a clear risk to life. Where a significant risk to safety of the individual is imminent, then relevant information can and should be shared, with those people for whom consent has been given to share. Information about an individual's risk of imminent harm should be shared as necessary with relevant others, where following robust clinical judgement, the individual is assessed as having lost capacity and it is deemed in the individual's best interest to share information. Where there is a significant risk to the safety of others, including to children or the wider public, and not sharing information appears likely to result in serious harm or injury, then relevant information can and should also be shared as necessary.

The consensus statement says:

There are clearly times in dealing with a person at risk of suicide when practitioners will need to consider informing the family and friends about aspects of risk and may need to create a channel of communication for both giving and receiving information that will help keep the person safe.

In line with good practice, practitioners should routinely and frequently confirm with service users whether and how they wish their family,

friends, or carers to be involved in their care. Sharing information is a crucial consideration in situations of suicide risk.

The consensus statement says:

In order to assist practitioners to respect people's wishes, wherever possible, the person's view on who they would wish to be involved – and potentially, who they would wish not to be involved – if there is serious concern over suicide risk, should have been discussed and recorded. In cases where these discussions have not happened in advance, a practitioner may need to assess whether the person, at least at that time, lacks the capacity to consent to information about their suicide risk being shared. Assessments of mental capacity should be time and decision-specific.

Decisions about a person's lack of capacity are made on the balance of probabilities. If a person is judged to be at imminent risk of suicide and is refusing to allow information about this risk to be shared, there may well be sufficient doubts about the person's ability to use, weigh and appreciate information so as to allow the practitioner to make a reasonable decision that the person lacks capacity to make that decision at that time. The diagnostic test is satisfied if the practitioner has a reasonable belief (on the balance of probabilities), that the person has an impairment/disturbance of the brain or mind, even if temporary.

Putting this into practice

In seeking consent and sharing information, context and language are important. Practitioners should endeavour to create an approach to sharing information which is based on empathetic understanding, trust and the ability to create a care framework within which it is clear that sharing information with appropriate parties is almost always in the best interests of the service user.

Consent and confidentiality should be part of the core narrative with service users throughout the course of their treatment and support. Initial reluctance to share information can frequently be overcome as trust develops and the practitioner/service user relationship deepens and strengthens. It is helpful for practitioners to consider the kinds of conversations they would want to have with service users about involvement of others in their care, especially at first and early points of contact. It is naturally important that the language adopted is sensitive to demographic, cultural and ethnic differences. It is always preferable to establish who to involve and who not to involve in service user care as soon as possible.

Gaining consent creates a partnership between service users, practitioners and families or carers and is the bedrock of high quality, holistic mental health care. Establishing trust with clear and agreed lines of communication at the outset can often avoid difficult and tense conversations later, especially in occasions where crisis develops and risk increases.

It is imperative that all conversations relating to consent and information sharing are fully recorded.

Consent

Seeking consent is the term used to define the active seeking of permission. Within the consensus statement this refers to seeking consent to involve another person (not necessarily a family member, unless aged under 18) to share appropriate information about the service user's general care and risks. Consent should be sought as early as possible in the interaction between service user and practitioner.

It is important to recognise that information sharing is a two-way process. Those people close to service users will frequently be in possession of additional information and biographical details which will be of assistance in assessment and in developing safety plans and interventions. Practitioners should therefore regard families and carers as potentially important partners in arriving at diagnoses, assessing risk and developing care plans. A service user may be reluctant to grant consent to share their information, but this should not deter the practitioner from gathering patient related information from families, friends or carers.

Where consent is given, it must always be recorded and acted upon unless there is a demonstrable and recorded reason why this is not appropriate.

Communication and rapport should be established with identified persons and appropriate information for which consent to share is given should be shared safely and constructively.

HOW TO DISCUSS AND GAIN CONSENT FOR SHARING INFORMATION

The following statement can be useful for practitioners to adopt:

"I have a duty to respect the confidential nature of the information you share with me. However, there are some limits to this. For example, if I am worried about your immediate safety, that of someone around you or that of a child, I may need to share information and seek advice. We will of course discuss this openly and I will inform you of any actions I feel I need to take.

We need to record our meetings and discussions in documents and electronic records and these may be accessible (where relevant) to fellow professionals and those directly involved in your care. It is important that we discuss any queries or concerns you have about this."

Discussions framed in this way ensure that service users are well informed from the outset within the core parameters of transparent communication and the creation of trust. Many organisations have developed their own language and supporting record systems around the theme of consent, enabling the creation of a standard approach across the organisation within which best practice becomes second nature and an instinctive protocol.

Consent to involve an identified person should routinely be sought in all clinical interactions.

Language and overall approach is very important. In creating appropriate and positive relationships with families, friends and carers. This is especially important as not only may they be able to provide information helpful to the patient, they will also, almost invariably, want to be informed about and invested in their care. We sometimes hear concerns from families, friends and carers that they are left uninformed and without any signposting to resources and services which may assist them in looking after a service user and creating better outcomes.

Subject to appropriate consent protocols being observed within the confines of the law, families, friends and carers should generally be regarded as potential partners in the care of a service user.

The following statement can be appropriate:

“In our experience it is almost always much better to involve a third party, somebody you know and trust, in your care, treatment and recovery. This might be a family member, friend, colleague or somebody important to you. This is likely to result in a better outcome and better support for yourself.

We do not have to share everything and I will respect your wishes, but I want to do all I can to make sure you have the best possible care and support around you. Can we please discuss who else we might involve in your care?”

In this scenario, consent is clearly being sought to

work in partnership with a person of the service user's choice.

Practitioners should also explain to service users that information sharing does not have to take the form of total disclosure. There is often information in an individual's records (for example, sexuality or substance abuse) which they may wish to be kept private. It is important to establish those matters which can be shared and those which cannot. It is frequently the case that a particular characteristic and/or past action is preventing a patient from giving their consent to sharing information. Extending assurances with regard to confidentiality in respect of past actions or characteristics will deepen trust and frequently create a more positive context for the exchange of information.

When holding discussions about consent, practitioners should ensure there is clarity about what information can be shared, with whom, and for what purpose (for example, whether information can be routinely shared with an identified person, or whether it can only be shared in emergency situations). There should also be appropriate record keeping to enable this clarity.

Capacity

The consensus statement refers to circumstances in which information can be shared proportionately even if consent to share is not given. This would apply, for example, if the service user is assessed to lack capacity to consent to share information and it is considered to be in their best interests to do so.

As with consent, capacity should be a constant theme in service user engagement and safety planning.

The Mental Capacity Act (NI) 2016 states that a person must be assumed to have capacity unless it is established that they lack capacity, and that a person is not to be treated as unable to make a decision merely because they make a decision that others consider unwise.

The consensus statement says:

However if a person is at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time. In these circumstances, a professional judgement will need to be made, based on an understanding of the person and what would be in their best interest. The practitioner should take into account the person's previously expressed and current wishes and views in relation to sharing information with their family and/or friends, and, where practicable and appropriate, consult with colleagues.

The judgement may be that it is in the person's best interests to share critical information. If so, care must be taken to disclose only the minimum amount of relevant information that is necessary. If the purpose of disclosure is to protect a person who lacks the relevant capacity from serious harm, practitioners must disclose relevant confidential information, if it is considered to be in the person's best interest to do so.

When decisions are made to share information based on capacity and best interest, it is important to document clearly the decision-making process, any consultation sought and the clear rationale for the actions taken. It is important that consideration is given to the nature and type of information shared. Information shared must be kept to a minimum and limited to what is necessary.

The consensus statement says:

Data protection law does not prevent sharing personal data in an emergency situation, including to protect a person from serious harm, or to prevent the loss of human life. In an emergency, you should share data as is necessary and proportionate. In these situations, it might be more harmful not to share data than to share it.

Sharing information and public safety

The consensus statement says:

Disclosure of confidential information may also be in the public interest because of the far-reaching impact that a suicide can have on others. For example, the method of suicide could cause potential serious harm to others.

There are many instances within which information disclosure may be in the public interest. For example, suicidal plans involving public transport, public places or areas of high population are likely to raise concerns regarding public safety. Similarly, self-harm or suicidal intent which may expose children and others to trauma and harm will be of grave concern from a public safety perspective.





Safeguarding principles should always be considered in relation to consent, confidentiality and capacity.

The consensus statement says:

The practitioner will need to make a judgement about whether the benefits to an individual or society in disclosing information without consent outweigh both the individual's and the public interest in keeping it confidential. Determining where to draw the line is a matter for professional judgement in each individual case.

The consensus statement says:

The immediacy of the suicide risk will be affected by the degree of planning a person has done, the type of suicide method planned or already attempted, and circumstances such as being left alone, refusing treatment, drinking heavily or drug use.

It is always recommended that, where possible, practitioners should seek support and guidance from colleagues, more experienced clinicians and governance managers when dealing with the more complex aspects of consent and confidentiality. This is especially important where capacity is in question and confidentiality may be compromised owing to concerns over patient and/or public safety. However, seeking support for judgement should not hinder actions which clearly relate to immediate safety.

The consensus statement says:

It is also clear that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer insight into the individual's state of mind or predisposing conditions which can aid care and treatment. Good practice will also include providing families with non-person specific information in their own right, such as how to access services in a crisis, and support services for carers.

Listening to families, carers and significant others

Carers and families often have important information that can assist in diagnosis and care.

As noted, consultation with families, friends and carers enables information to be gleaned that may otherwise be missed by talking to an individual alone. They are often gravely concerned and have information that could save lives. In addition, practitioners are best placed to give general non-person specific information that can alleviate distress and ensure better care for the individual in the longer term.

Practitioners must consider the wellbeing of families, friends and carers and their potential ability to contribute to positive service user outcomes.

Carers and families can be essential in creating positive support networks

Good practice checklist

The following checklist is based on the 2017 *'Good Psychiatric Practice: Confidentiality and Information Sharing guide'* produced by Royal College of Psychiatrists.

This material is designed to assist practitioners in working closely with families, friends and carers within the boundaries of current legislation and the common law. It also assists in helping them understand their rights.

As a core principle, practitioners should note that the provision of general information (that is, not related to a specific individual) about mental health difficulties, emotional and practical support does not breach confidentiality.

In practice, and providing this does not compromise the confidentiality restrictions requested by the service user, an individual's family, friends and carers should be given general factual information, both verbal and written, relating to the following as a minimum:

- the mental health diagnosis
- what behaviour is likely to occur and how to manage it
- medication: benefits and possible side-effects
- local inpatient and community services
- guidance on service user safety
- an outline of the care and treatment pathway
- local and national support groups and resources

In following this schedule, families, friends, and carers are helped to understand (subject to any confidentiality restrictions requested by the service user):

- the present situation
- the service user's treatment plan and its aims

- any written care plan, safety plan or recovery programme
- the role of each professional involved in the service user's care
- how to access help, including out-of-hours services

Conversations and encouragement to allow this information to be shared should happen early in the consultation and treatment process. Ideally, agreements on sharing would be drawn up in partnership with the identified person or persons and the service user. Importantly, if family and/or personal dynamics are strained or likely to impact negatively on the service user then confidentiality restrictions around this information must be respected.

In all cases the service user should be encouraged to identify someone they trust with whom this information can be shared in order to optimise the support available to them.

The identified person(s) should also be given:

- the opportunity to see a professional on their own and have discussions in confidence
- encouragement to feel a valued member of the care team
- confidence to voice their views and any concerns they may have
- emotional and practical support
- an assessment of their own needs with their own written care plan, where indicated

In all cases, it is imperative that information shared is appropriate to social, cultural, and ethnic context. This is especially important in interacting with minority and hard-to-reach groups and individuals.



A failure to exchange information is too often mentioned following a tragedy

Other agencies

The 2021 consensus statement outlines the benefit of sharing information within and between agencies. Unfortunately, this can be overlooked, and tragedies can and do occur. A primary example here would include instances where someone is discharged from an A&E department or secondary care facility and their general practitioner has not been informed, advised how best to manage risk and how best to work in partnership in order to ensure service user safety. This is of the utmost importance in cases of elevated risk of suicide.

It is essential that the therapeutic alliance between the service user, professional and carer is sustained as service users' transfer between agencies and stakeholders. Transitions between and within organisations are known to create or increase suicide risk if not managed effectively. The efficient, timely and comprehensive communication of risk within and between agencies is essential.

The consensus statement says:

Sharing information within and between agencies can also help to manage suicide risk. It is therefore important for practitioners to consider discussing cases with colleagues or seeking advice from legal teams, a professional association or regulatory body if they are unsure whether information should be shared, rather than simply withholding it.

In addition to data protection obligations, practitioners must continue to adhere to any duty they may already have not to reveal a person's identity. Even when they do not have such a duty in a particular case, if possible, sharing information should be done without revealing a person's identity.

In sharing information within and between care teams, the identity of an individual will need to be revealed, as appropriate. In seeking advice from a professional or regulatory body, the identity of the service user would, however, not normally need to be revealed.

All practitioners should be informed of this process and given guidance and professional support. If information is shared this should be done securely, proportionately, safely, and sensibly. In all instances, practitioners should ensure that accurate information limited to what is necessary is given to the right people and documented accordingly.

Management support

Health and social care trusts and service commissioners have a key role to play in giving practitioners the appropriate training and confidence to navigate the sometimes complex issues associated with consent, confidentiality and information sharing. Managers are required to create a positive and informed environment which supports frontline professional judgment.

Excessive fear of transgression or breaking the rules with regard to sharing information, especially with families and carers, has all too often led to wholly avoidable tragedy.

Best practice in this field is often set within a fundamental change in culture which has previously fostered an excessive default to privacy in all instances, all too often to the detriment of the service user and those close to them.

Clinical scenarios

to aid decision making

It should be noted that, in all circumstances, recording of rationale for either sharing, or not sharing, information, alongside the risks to either decision, should take place.

We would also like to remind practitioners that, alongside this guide, you should also refer to your own professional guidance which will support you in understanding the legal powers that may be available for sharing information.

Clinical situation	Appropriate to share	Not appropriate to share
Best practice information sharing discussed and the limits to confidentiality discussed. Service user gives explicit consent to share information about all aspects of their care with a trusted member of their family.	<p>Yes – share information. As long as there are no threats to service user safety in doing so, this will include:</p> <ul style="list-style-type: none">• risks• care plans• crisis plans/safety plans• information about diagnosis• discussed risks• where to seek help.	<p>Any information that the service user has not given consent to share and which is not necessary, relevant or proportionate to share. This may include, for example, information about sexuality or previous trauma.</p> <p>It is important that, if consent to share is being relied upon, the recorded consent is clear about:</p> <p>a) who information can be shared with.</p> <p>b) what information can be shared – for example, whether this is limited to certain health issues or whether all information can be shared.</p> <p>c) for what purpose the information can be shared (for example, whether only in emergencies, or wider consent to contact nominated others to discuss general health issues).</p>

Clinical situation	Appropriate to share	Not appropriate to share
<p>Service user does not give consent to share information about their care with family but is encouraged through good practice discussion and has agreed to share information with an alternative nominated person.</p>	<p>Yes – share information as above with trusted alternative person, such as a friend or carer.</p> <p>If the service user is under 18 then information can be shared with family, if appropriate, in addition to informing other agencies (such as social services and the police) if there are risks to the safety of the child. More information can be found in DoH statutory guidance on Cooperating to Safeguard Children and Young People in Northern Ireland Department of Health (health-ni.gov.uk) and the Safeguarding Board NI procedures (www.proceduresonline.com/sbni/).</p> <p>If a family member is at risk from the service user or there are disclosed threats to their safety, information that is relevant and necessary should be shared with appropriate individuals proportionate to the risks.</p>	<p>Explain to family members the service user’s requests to keep information confidential about their care plan. However, information can be taken from family and their concerns should be listened to.</p> <p>Information can be given about where they can seek help either for themselves or a family member.</p>
<p>Service user is assessed as not having current capacity to consent to share information and is severely unwell.</p>	<p>Yes – if in the best interests of the service user, share necessary information with family member or nominated other (such as from an advance decision) and relevant professionals.</p>	<p>Only information that is necessary to share, should be shared. For example, information about sexuality or private and personal relationships or activities should only be shared if clinically necessary, relevant or impacts safety.</p>

Clinical situation	Appropriate to share	Not appropriate to share
<p>During a clinical session, the service user reports a suicide plan with intent that is likely to result in danger to the public or another person. There is evidence to suggest that they will carry out the plan. The service user may or may not give consent to share information.</p>	<p>Yes – If there is danger to the public or another individual, share necessary information with individuals at risk, public safety officials including police, and any other directly relevant professionals. Follow safeguarding policy and, if time permits, seek advice from the local safeguarding lead.</p>	<p>Only information that is necessary and proportionate to share should be shared.</p> <p>Information that is not relevant to the immediate risk of suicide should not be shared.</p>
<p>Service user has a history of withholding information about risk or your clinical professional judgement of the interaction highlights discrepancies between what the service user is saying and their non-verbal signals and history relating to suicidal thoughts, plans and intent.</p> <p>You discuss your concerns with service user and attempt to seek engagement and information about suspected risks. None is given.</p> <p>You suspect that there may be suicide risk but you are not certain. You seek consent to share information with a trusted other to support them in their safety. No permission is given. You are not clear about their capacity to make decisions about sharing or withholding information about their condition or care.</p>	<p>This is perhaps one of the most difficult clinical situations to manage. In such circumstances, you should consult your own professional guidance to assist you to make a judgement on whether to share information, and with whom.</p> <p>If possible, you should also seek guidance from another more experienced clinician, legal team or a clinical peer to support judgement. Let the service user know you are going to do this if possible.</p> <p>As in all situations, make sure rationale on whether or not to share information is documented and shared with service user where possible.</p> <p>If you fear the public is at risk, contact relevant public safety officials.</p>	<p>This would depend on the clinical judgement made, in consultation with practitioner's own professional guidance and the circumstances of individual cases.</p> <p>It would usually not be appropriate to share information if, after further discussion, it is clear that the service user is engaged, does not consent to share and has capacity.</p>

Clinical situation	Appropriate to share	Not appropriate to share
<p>Through continued engagement, you manage to gain information from the service user, which indicates suicidal thoughts but not intention to act at this stage. You discuss your concern about whether they feel able to be honest. Service user is willing to be honest, work with you and accept help from you. You are able to construct a safety plan and make follow up arrangements. The risk is not deemed to be imminent following exploration. The service user is more engaged than they have been previously.</p> <p>You are also able to explore what the service user can do if they feel their thoughts intensify or they get urges to act on them. Relevant supportive contacts and agencies are given in an emergency.</p> <p>The service user agrees to think about who they would like to involve in their care to discuss at next appointment or at a follow up contact.</p>	<p>No</p>	<p>It would usually not be appropriate to share information if it is clear that the service user is engaged, does not consent to share and has capacity.</p>

Clinical situation	Appropriate to share	Not appropriate to share
<p>You are a nursing assistant getting a coffee from the hospital café. You are approached by someone you don't know about a service user on the ward. They ask about how they are and what is wrong with them. They explain that they are a family member.</p>	<p>No</p>	<p>Explain politely that you would need to discuss with ward MDT what information, if any, can be shared. It is also not appropriate to discuss anything in a café, where confidential information could be overheard. Give them information about who to contact on the ward so they can discuss with them information that it is possible to share.</p>
<p>You are working on a ward and you are emailed by a family member asking for information about a service user on the ward.</p>	<p>You should satisfy yourself as to the person's identity and be clear about confidentiality requests from the service user before sharing information.</p>	<p>Give the person the appropriate contact details for an authorised practitioner with whom they can discuss their request. The practitioner must be clear about confidentiality requests from service user and the identity of the person calling or emailing before deciding whether to share any information.</p>

Department of Health and Social Care - information sharing and suicide prevention consensus statement

In conjunction with the Royal Colleges, the Department of Health and Social Care (England) published the Information Sharing and Suicide Prevention Consensus Statement in 2014 to encourage professionals working in health and social care to share information about someone at risk of suicide with family and/or friends.

The 2014 statement was updated and republished in 2021 to reflect the current legal position including the implementation of the UK General Data Protection Regulation (UK GDPR), tailored by the Data Protection Act 2018. The Information Commissioner's Office (ICO) has confirmed that the DHSC 2021 consensus statement is consistent with the Data Sharing Code of Practice. The DHSC 2021 Consensus Statement was produced with:

- Royal College of Psychiatrists
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Midwives
- Institute of Health Visiting
- Association of Directors of Adult Social Services (ADASS)
- The British Association of Social Workers
- The British Psychological Society
- Mental Health Network NHS Confederation

[Information sharing and suicide prevention: consensus statement - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/92222/information-sharing-and-suicide-prevention-consensus-statement-2021.pdf)

“Patients tell us they want their families to have as much involvement as possible in their assessment of clinical risk, including sharing crisis/safety plans with them.

Clinicians tell us family involvement is vital to enhancing patient safety in mental healthcare settings.”

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

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Have regard to the law, rules and regulations
Always act in the patients' best interest
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Acknowledgements

This SHARE guidance to support practitioners working in Northern Ireland and is based on the SHARE guidance developed by the Zero Suicide Alliance.

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