

Suicide Risk Assessment and Management

Emergency Department



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Related documents

Framework for Suicide Risk Assessment and Management for NSW Health Staff – SHPN (MH) 040184

Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185

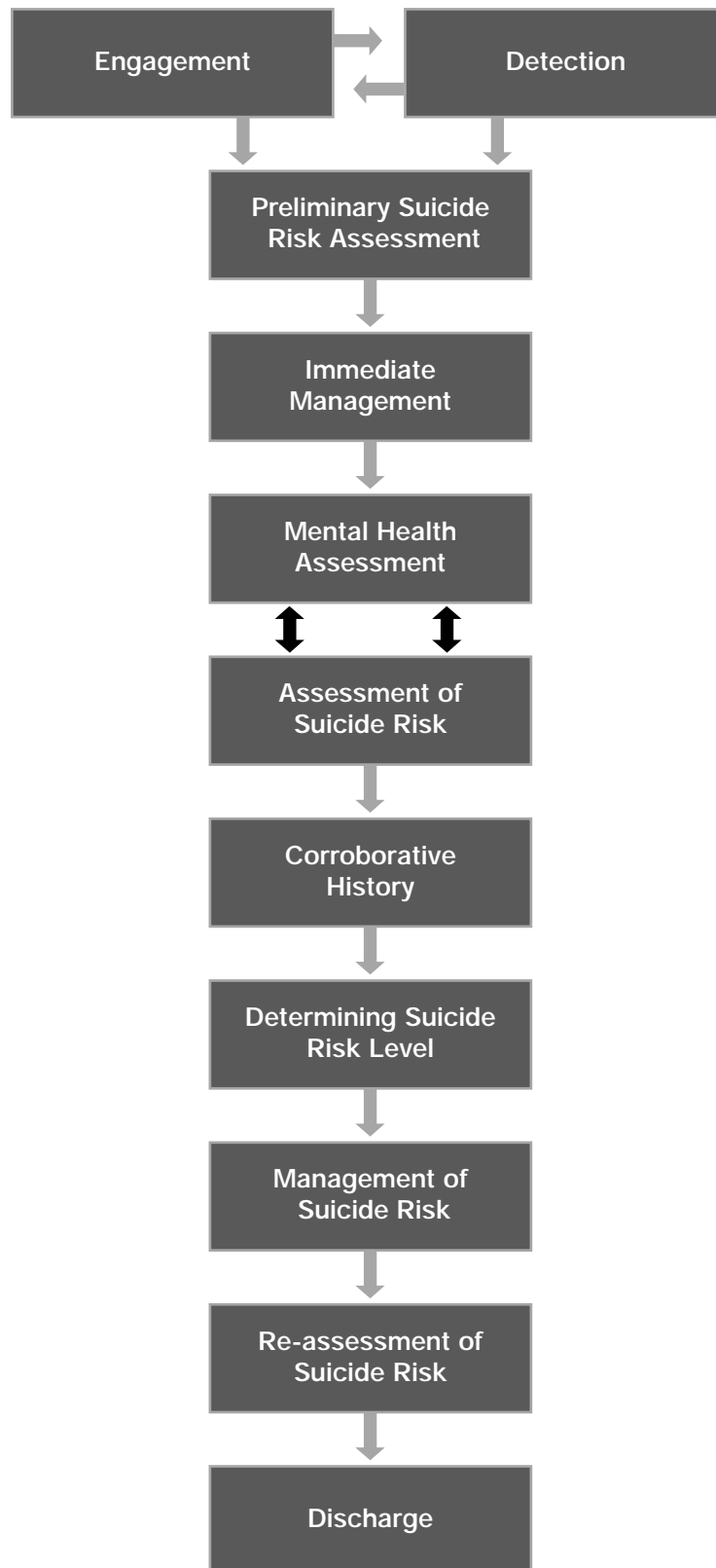
Suicide Risk Assessment and Management Protocols: General Community Health Service – SHPN (MH) 040187

Suicide Risk Assessment and Management Protocols: Community Mental Health Service – SHPN (MH) 040182

Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit – SHPN (MH) 040183

Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital – SHPN (MH) 040188

Framework for Suicide Risk Assessment and Management for NSW Health Staff



Introduction

Emergency departments are a key point of contact for people who have attempted suicide or who are at risk of suicide. Emergency departments play an important role in triage, assessment and management of people with mental health problems.

This document supports the NSW Health circular, *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities*¹ and the *Framework for Suicide Risk Assessment and Management for NSW Health Staff*.² Additional information can be found in *Mental Health for Emergency Departments: A Reference Guide*.³

Assessment of suicide risk

Detection

It has been estimated that up to ninety percent (90%) of people who die by suicide suffer from a diagnosable mental disorder.⁴ A number of demographic factors are associated with increased risk of suicide such as unemployment, alcohol and drug use, history of physical and/or sexual abuse, family discord, homelessness, incarceration and mental health problems, particularly depression.

However, the most important factors in assessing a person's **imminent suicide risk** are the **current personal risk factors**.

Examples include:

- 'at risk' mental status, eg hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes
- recent interpersonal crisis, especially rejection, humiliation
- recent suicide attempt
- recent major loss or trauma or anniversary
- alcohol intoxication
- drug withdrawal state
- chronic pain or illness
- financial difficulties, unemployment
- impending legal prosecution or child custody issues
- cultural or religious conflicts
- lack of a social support network
- unwillingness to accept help
- difficulty accessing help due to language barriers, lack of information, lack of support or negative experiences with mental health services prior to immigration.

Protective factors have also been identified that may protect a person from suicide.

These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem-solving skills
- positive values and beliefs
- ability to seek and access help.

Early warning **signs of depression** should alert the health professional to the need for further assessment of suicide risk. Early warning signs include:

- depressed mood and/or anhedonia (loss of pleasure in usual activities)
- isolated/withdrawn/reduced verbal communication
- difficulty sleeping
- refusing treatment
- reduced appetite
- complaints of pain or physical discomfort not consistent with physical health.

When suicide risk is suspected it is important for the health professional to inquire if the person is feeling suicidal. Suicide risk is not increased by a professional asking about the possibility of suicide risk.

Triage on presentation

People at risk of suicide who present to emergency departments should be triaged according to their risk category. *The Mental Health Triage Scale* developed by South Eastern Sydney Area Health Service can assist in the triage of people presenting with mental health problems. The Australasian College for Emergency Medicine has developed an Australasian Triage Scale⁵ and guidelines for implementing the scale in emergency departments⁶ which include 'behaviour/psychiatric' descriptors that may also be used to assist in triage.*

High suicide risk is suggested by:

- high intent
- definite plan
- hopelessness
- depression
- psychosis
- past attempts
- impulsivity
- intoxication
- male gender
- recent psychiatric hospitalisation
- access to means.

Initial assessment

In general, a medical assessment should be carried out before referral to a mental health service (or other specialty service). However, when a person who is known to the mental health service is showing signs of mental distress at triage, the mental health team can be contacted concurrently with the medical assessment.

The initial assessment should include a brief psychiatric assessment and an initial suicide risk assessment. The purpose of the initial suicide risk assessment is to determine:

- the severity and nature of the person's problems
- the risk of danger to self or others
- whether a more detailed risk assessment is indicated.

There are a number of factors that need to be considered prior to the suicide risk assessment.

- What are the details of the presentation, referral or the circumstances, for example, was there an incident, were they brought in by police, are they accompanied by relative or friend or is it a self-presentation?
- What collateral information is available, for example, medical records, family, accompanying person/s, police, other health providers?
- Is the person likely to leave before being assessed?
- Is the person known to a mental health service?¹

If a person is known to the emergency department and has presented before with one or more suicide attempts, the clinician should refer to the person's management plan.

Brief psychiatric assessment

- Is the person experiencing any current psychiatric symptoms (presence of depressed mood and symptoms of depression such as reduced energy, concentration, weight loss, loss of interest, psychosis, especially command hallucinations)?
- Is there a past history of psychiatric problems? (A history of a mental illness should raise the clinician's concern that the current presentation may be a recurrence or relapse.)
- Mental state assessment (GFCMA: Got Four Clients Monday Afternoon):
 - **G**eneral appearance (agitation, distress, psychomotor retardation)
 - **F**orm of thought (is the person's speech logical and making sense)
 - **C**ontent of thought (hopelessness, despair, anger, shame or guilt)
 - **M**ood and affect (depressed, low, flat or inappropriate)
 - **A**ttitude (insight, cooperation)
- Coping skills, capacity and supports:
 - Has the person been able to manage serious problems or stressful situations in the past?
 - Does the person employ maladaptive coping strategies such as substance or alcohol abuse?
 - Are there social or community supports? Can the person use them?

*The Australasian Triage Scale can be downloaded from www.acem.org.au/open/documents/triage.htm

Assessment of suicide risk

- What collateral information is available, for example, medical records, nursing reports, family, police and other health providers?
- Obtain information from family and friends to establish whether the behaviour is out of character, how long it has been evident, how they deal with crisis.

A hierarchy of screening questions that gently leads to asking about suicidal ideas is a generally accepted procedure for all health professionals (see Figure 1).

Figure 1: Assessment of suicide risk (screening questions)

- Have things been so bad lately that you have thought you would rather not be here?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- Have you ever tried to harm yourself?
- Have you made any current plans?
- Do you have access to a firearm? Access to other lethal means?

Additional aspects for assessment following an episode of self-harm or attempted suicide:

- What exactly did the person do?
For example, how many tablets were used, length of time in the car, what sort of knife was used, to what was the rope attached?
- What precipitated the self-harm?
Have the causes resolved or are they still present?
- What is the person's intention now?
For example, how does he/she feel about things now? What are their plans?
- Is the person at risk of another suicide attempt?

The person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan. If the person lives with family, the family should be contacted, in particular if the person is being discharged home.

Determination of suicide risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.^{7, 8, 9} A thorough assessment of the individual remains the only valid method of determining risk.

Assessments are based on a combination of the background conditions and the current factors in a person's life and the way in which they are interacting.

Suicide risk assessment generates a clinician rating of the risk of the person attempting suicide in the immediate period. The person's suicide risk in the immediate to short-term period can be assigned to one of the four broad risk categories: high risk, medium risk, low risk, no (foreseeable) risk.

Refer to the **Suicide Risk Assessment Guide** (p 5) to assist in estimating the current level of suicide risk. It is a guide only, however, and is not intended to replace clinical decision-making and practice.

Changeability

Risk status is changeable and requires regular re-assessment. For people identified as having highly changeable risk status, more vigilant or frequent management may be required.

Assessment confidence

Low assessment confidence may be related to:

- factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage
- factors in the social environment, such as impending court case, divorce with child custody dispute
- factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

When there is a possibility of low assessment confidence, more vigilant management may be required.

- High Changeability Flag**
- Low Assessment Confidence Flag**

Suicide Risk Assessment Guide²

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High risk	Medium risk	Low risk
'At risk' Mental State <ul style="list-style-type: none"> - depressed - psychotic - <u>hopelessness</u>, despair - guilt, shame, anger, agitation - impulsivity 	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts <ul style="list-style-type: none"> - intentionality - lethality - access to means - previous suicide attempt/s 	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder <ul style="list-style-type: none"> - current misuse of alcohol and other drugs 	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History <ul style="list-style-type: none"> - family, carers - medical records - other service providers/sources 	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) <ul style="list-style-type: none"> - expressed communication - availability of supports - willingness / capacity of support person/s - safety of person & others 	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice <ul style="list-style-type: none"> - level & quality of engagement - changeability of risk level - assessment confidence in risk level. 	Low assessment confidence or high changeability or no rapport, poor engagement.		<ul style="list-style-type: none"> - High assessment confidence / low changeability; - Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable?

Highly Changeable Yes No

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information.

Low Assessment Confidence Yes No

Management

Maximising safety

- A person assessed to be at immediate risk of suicide should never be left alone.
- The person should be located in a secure area and kept under constant observation/supervision at all times until the arrival of the mental health service.
- Medical staff may invoke the *Mental Health Act 1990* (NSW) by writing a Schedule if there is concern the person cannot be safely managed voluntarily.
- Gaining the assistance of security staff should be considered if there is concern about aggression or the person has displayed aggression that has not been resolved.
- Where the police have brought the person to the emergency department, they may be requested to stay with the person if there is concern for others' safety, until the hospital can safely manage the situation. Local protocols concerning the Memorandum of Understanding between NSW Police and NSW Health¹⁰ should be consulted.
- If possible, provide a calming support person to stay with the person at risk.
- All items that could be used for self-harm (including belts, ties, shoelaces, dangerous objects) should be removed from the person and their immediate environment.

If a person who is considered to be at significant risk **absconds from the emergency department**, the police should be immediately contacted and provided with a description of the patient and the likely areas they may be located. Local protocols concerning the Memorandum of Understanding between NSW Police and NSW Health* should be consulted. A copy of the Schedule is to be provided if relevant. The mental health service should also be contacted if it is known that the person is a client of the mental health service.

*The Memorandum of Understanding between NSW Police and NSW Health was developed and released in 1998 to provide a framework for the effective management of people with a mental illness when the services of NSW Police and NSW Health, mental health services, and the Ambulance Service of NSW are required. The document is being reviewed and revised by an inter-departmental working group overseeing its implementation.

Consultation with and referral to the mental health service

All people presenting with suicide risk to the emergency department should be referred wherever possible to the mental health service for a comprehensive mental health assessment, including a suicide risk assessment. This should occur after initial triage and assessment. At a minimum, a phone consultation with the mental health service should occur.

A **referral to the mental health service** should be made for the following presentations:

- people who present following a suicide attempt or an episode of self-harm:
 - those who report or are reported to be preparing for suicide have definite plans
- people with probable mental illness or disorder:
 - those who are depressed or have schizophrenia or other psychotic illness
- people whose presentations suggest a probable mental health problem:
 - those who report accidental overdoses, unexplained somatic complaints or who present following repeated accidents, increased risk-taking behaviour, increased impulsivity, self-harming behaviours (eg superficial wrist-cutting)
 - co-morbidity (eg with alcohol and other drugs, intellectual disability, organic brain damage)
- people recently discharged from an acute psychiatric in-patient unit, especially within the last month
- people recently discharged from an emergency department following presentation of psychiatric symptoms or repeat presentations for somatic symptoms.

Protocols must be in place for a rapid response from the mental health service in responding to a referral. There may be occasions when unavoidable delays may be experienced by the mental health service in responding due to another mental health crisis occurring simultaneously. However, it is important that the mental health service responds as rapidly as possible to referrals

from the emergency department. After contacting the mental health team the emergency department staff should advise the person and/or family of the expected waiting time to see the mental health team.

A comprehensive management plan for people who repeatedly present with suicidal behaviour should be developed between the mental health service and the emergency department to assist in managing the situation and preventing a crisis. The plan should emphasise:

- consistent treatment by the same primary clinician, wherever possible, with regular scheduled visits and communication among all care providers
- anticipation of crisis – what the person should do if they feel distressed etc.

Joint management plans with key service providers should be developed and discussed at the local mental health/emergency department liaison meeting. Memoranda of understanding between the emergency department, mental health service, police and ambulance services should be developed to ensure better linkages are established and maintained between the services.

A previous suicide attempt is an important indicator for a death by suicide and it is highly possible for an attempt of ambivalent intent and use of non-lethal means to be followed by a fatal attempt. Therefore, these procedures are to be followed on every presentation regardless of previous presentations.

Discharge or transfer from the emergency department

Transfer to an in-patient unit

Patients in acute mental health crises who are at risk of suicide need to be transferred to safe and stable environments as soon as practicable with the involvement of the mental health service.

- While awaiting transfer, there must be appropriate monitoring and observation of the patient in the emergency department.
- When the patient is being transferred from the emergency department to the mental health in-patient unit, there needs to be a clear plan for the safe escort and handover of the person to the in-patient unit.

The following information must be provided to the in-patient unit regarding presentation of the person at risk:

- a verbal report at discharge or an interim summary within one day of discharge
- a written report to follow within 3 days.

Discharge to the community

The assessment and management of suicide risk aims to assist the person through a period of immediate or imminent risk of suicide. When the person's risk can be revised down to low risk or no foreseeable risk, levels of care can be safely and appropriately reduced and the person can be assessed for discharge to the community.

The following requirements need to be met before a patient is discharged from the emergency department to the community.

- The mental health service has been consulted.
- A comprehensive suicide risk assessment has been conducted.
- A management plan has been developed including appropriate follow-up arrangements.
- The person being discharged has a means of returning home or to suitable accommodation.
- The consulting mental health staff have ensured that adequate support and follow-up arrangements have been made, including a follow-up appointment for re-assessment.
- Prior to leaving the emergency department, the person and, where appropriate, their family must be provided with information about how to access urgent help including a 24-hour contact telephone number. They must be provided with written confirmation of the follow-up appointment.
- The following information must be provided to the relevant health provider regarding presentation of the person at risk:
 - a verbal report at discharge or an interim summary within one day of discharge
 - a written report to follow within 3 days.
- If the person is under 16 years of age, contact must be made with the parents or guardian, prior to discharge.
- Significant support people must be contacted, including general practitioner, private psychiatrist, case manager, family and friends about the potential suicide risk and about follow-up arrangements that have been made.

References

- ¹ NSW Department of Health. Circular 98/31 Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities, May 1998. Note: The policy was being revised at the time of preparation of this framework.
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- ⁵ Australasian College for Emergency Medicine. Policy Document – The Australasian Triage Scale. Melbourne: Australasian College for Emergency Medicine, 1993 – updated November 2000. www.acem.org.au/open/documents/triage.htm
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