

Suicide Risk Assessment and Management Protocols

General Hospital Ward



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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: Emergency Department – SHPN (MH) 040186

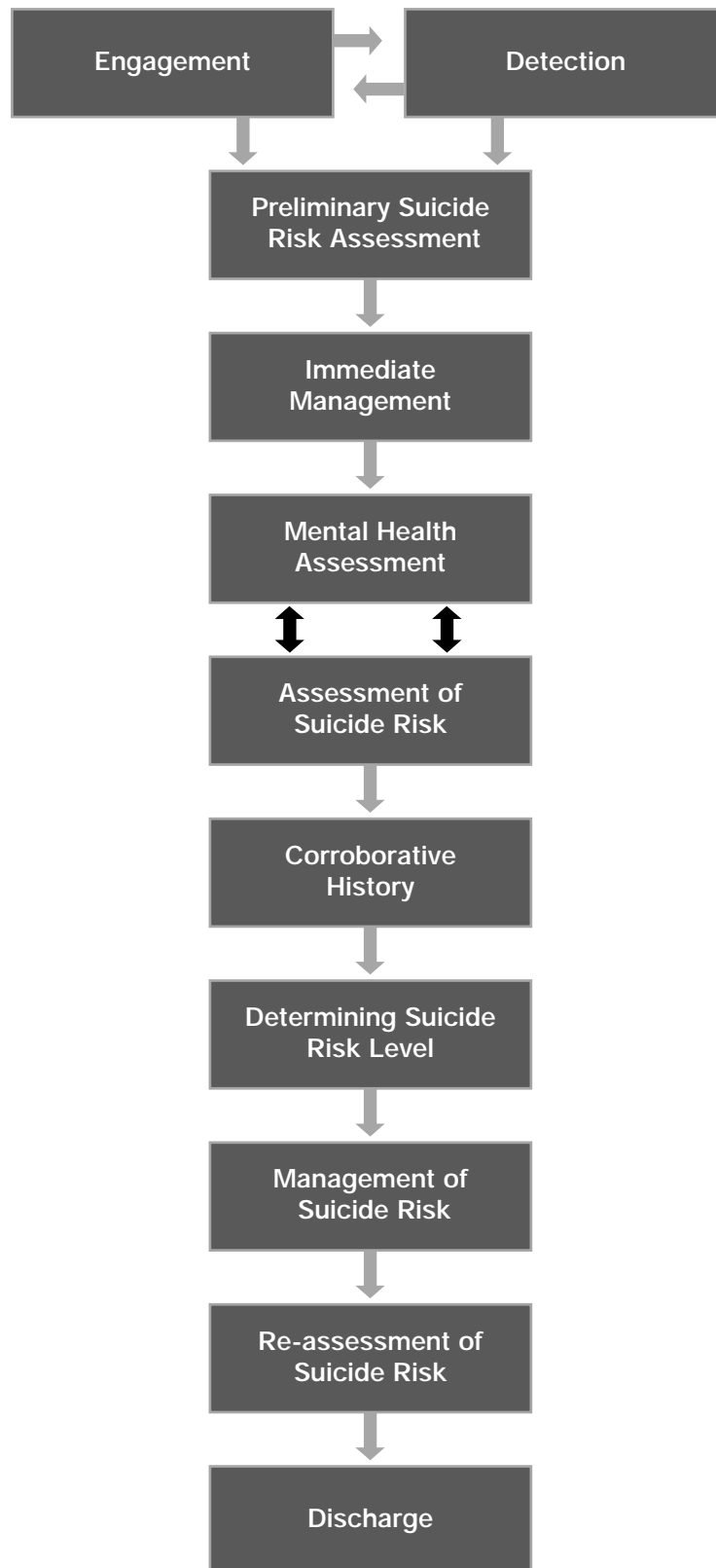
Suicide Risk Assessment and Management Protocols: General Community Health Service – SHPN (MH) 040187

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

Suicide is a major cause of death in NSW. Self-harm and attempted suicide are a significant cause of morbidity. Health care professionals are in a vital position for identifying people at risk of suicide and preventing suicide. Management of a person at risk of suicide requires assessment of risk, an estimation of the level of risk and appropriate interventions to minimise the risk.

All persons with possible suicidal behaviour in contact with general health services must receive a preliminary screening for suicide risk and be referred to specialised mental health services or, at a minimum, consultation on the assessment and management of suicide risk should occur.

Competent management when a person is suicidal will have a significant influence on both morbidity and mortality outcomes.

These suicide risk assessment and management protocols are to be read in conjunction with 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

Assessment of suicide risk

Detection

It has been estimated that up to ninety percent (90%) of people who die by suicide have a diagnosable mental disorder.³ 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.

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, 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)
- feelings of hopelessness
- 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.

Intoxication precludes a valid immediate assessment. If suicide risk has been identified in an intoxicated person they should be detained in an appropriate and safe setting until a full assessment is conducted. Enduring risk cannot be judged until the person is sober.

Preliminary suicide risk assessment

When a patient in the general hospital ward has been detected to be at risk of suicide, a preliminary assessment is to be conducted by the appropriate health professional prior to being referred to specialised mental health services or other professionals (eg general practitioner) where appropriate.

The purpose of this assessment is to determine:

- the nature and severity 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 or referral or the circumstance (for example, an incident) that has brought the issue of suicide risk to the attention of staff?
- A brief chronological account of the presenting problem (why the person has come to the health service) should be elicited.
- Is the person medically well enough to participate in the interview? Do they require medical assessment?
- Access any collateral information available, eg medical records, nursing reports, family, other health providers.
- Given individual circumstances and if appropriate, it is highly desirable to contact a family member or carer of the person and involve them in the assessment.
- **If the person is under 16 years**, the carer must be actively involved in the management plan whenever possible and should be contacted prior to discharge from a service. If no carer is available, a suitable advocate for the young person should be contacted.
- Discuss with family and friends whether the person's behaviour is out of character, how long it has been evident, how they deal with the crisis.
- Is the person known to a mental health service?

Essential aspects for preliminary screening of suicidal risk include:

- current predicament, stressors, social situation

- current thoughts of suicide
- previous suicide attempts or threats
- drug or alcohol use
- impulsiveness.

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?

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, or 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).

Assessment of suicide risk

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

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

- What exactly did the person do? For example, how many tablets 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 they 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?⁴

The person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan.

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.^{5, 6, 7} 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

Changeability of risk status, especially in the immediate period, should be assessed and high changeability should be identified.

While risk status is by nature dynamic and requires re-assessment, highly changeable risk status is worth identifying as it will guide clinicians as to the safe interval between risk assessments.

High Changeability: The clinician recognises the need for careful re-assessment and gives consideration as to when the re-assessment should occur, eg within 24 hours. A more vigilant management is adopted with respect to the safety of the person in the light of the identified risk of high changeability.

Assessment confidence

The clinician should consider the confidence he/she has in this risk assessment. A number of factors may indicate low assessment confidence. These include:

- 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.

Low Assessment Confidence: The clinician recognises the need for careful re-assessment to occur, eg within 24 hours. A more vigilant management is adopted with respect to the safety of the person in the light of the gaps in information or rapport.

- 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 a safe environment

Staff should be aware that individuals with a depressive illness and/or suicidal risk are at particular risk of suicide at certain times in a hospital ward setting.

The risk periods for increased incidence of suicide are:

- between 10:00pm and 6:30am
- around change of shift time
- over the weekend period.

These times are periods of decreased observation and interaction with staff members.

- The safety of both the person being assessed and the clinician is the primary concern at all times throughout the assessment process.
- The level of observation/supervision needs to be considered during the time that the person is waiting to be assessed and after the assessment while consultation or referral arrangements are being made. The level of observation required by a person will depend on the risk and the physical environment. Wherever possible, a person at risk of suicide should never be left alone.
- Where the risk is assessed as high or medium, the person should be moved to a ground floor room, or if this is not possible, the person should be cared for in a room that is easily observable and from which exit can be monitored.
- 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.
- The use of the *Mental Health Act 1990* (NSW) may be necessary in the following instances to enable the continued observation and safety of the person:
 - if suicidal thoughts or verbal intentions are persistent and intense, or
 - the self-harming is serious in nature, or
 - there is evidence of serious mental disorder or illness.

- If a person who is considered to be at risk absconds from the ward, the police should be immediately contacted and provided with a description of the person, the likely areas they may be located and a copy of the Schedule, 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 person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan.

Consultation and referral to specialist mental health service

- General hospital wards should have access to the hospital consultation-liaison psychiatry (C-LP) service (where this service is available) or the mental health service or other appropriate specialised professions. The service must be accessible and provide a response commensurate with the estimated risk. A protocol must be in place that outlines how and when the C-LP service, mental health service or other appropriate specialist professions will be contacted once the person is medically stable and a preliminary suicide risk assessment has been conducted.
- People assessed to be at risk of suicide while resident in a general hospital ward must have a comprehensive suicide risk assessment by the consultation-liaison psychiatry team (where this service is available), the mental health service or other appropriate specialist professionals.
- A referral to the C-LP team, mental health service or where appropriate, other specialist service for a comprehensive suicide risk assessment should be made immediately 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 who have recently been discharged from an acute psychiatric in-patient unit, especially within the previous month
 - people who have recently been discharged from a mental health in-patient unit, especially within the previous month.
- In some circumstances, referral to a mental health service is not always possible or practical, for example, in rural and remote areas. At a minimum, a phone consultation with the mental health service or other specialist service should occur.
 - The attending Medical Officer and relevant members of the treating team should be notified of the preliminary suicide risk assessment and management plan.
 - The attending Medical Officer should contact the mental health service if possible.

Management options

The management options for a person assessed to be at risk of suicide include:

- Continue to treat the person within the general ward, which will include ongoing risk assessment and appropriate treatment.
- Admit the person to a psychiatric in-patient unit or transfer the person to the appropriate area when their medical status allows.
- Make a decision to discharge the person. This will require arrangements to be in place for follow-up by the mental health service.

Management plan

- People at risk of suicide who are to be managed in the general hospital ward must have a management plan developed, in consultation with the patient and the mental health service whenever possible.
- The plan should be documented in the medical record and include the following:
 - the level of assessed risk to the patient
 - the steps to be taken to ensure their safety, for example
 - the frequency of observations
 - the requirement for a 'special' nurse
 - the frequency of re-assessment and documentation of each suicide risk assessment, including a reviewed rating as high, medium or low.

HIGH RISK:	conduct re-assessment at least twice daily
MEDIUM RISK:	conduct re-assessment at least daily
LOW RISK:	conduct re-assessment at least weekly

- There should be consideration of sleep, hygiene and where appropriate, night sedation to assist the patient's rest and sleep.
- Depending on level of risk and availability of specialist service, the use of a 'special' nurse or maintaining constant observation may need to be considered.
- The management plan should include information regarding triggers, stressors, precursors, methods/plans and the individual importance of various factors to the patient, including anticipation of likely circumstances that may escalate the patient's risk.
- It should include information regarding family and friends and details of significant relationships.
- There should be active C-LP team and/or specialist mental health service or other specialist service involvement during hospitalisation and on discharge.

Managing a suicide attempt

- Do not leave the patient. Obtain assistance from other staff.
- Remove the patient from danger without placing staff or other patients and visitors at risk. If there is a risk to others, obtain assistance from security staff.
- Ensure immediate emergency medical care.
- Assess the patient's current suicide risk. An attempted suicide usually indicates the person is at high risk in the immediate and short-term period.
- Provide support to other people present who may be acutely distressed, including other patients, staff and visitors.
- Follow all related procedures in regard to incident reporting, management and review.⁸

Managing a suicide death

Refer to NSW Health *Postvention guidelines surrounding a suicide death for NSW Health staff and staff in private hospital facilities.*⁹

Discharge and follow-up

Where the decision has been made to discharge a person at risk in the community, discharge from the general hospital ward should only occur if adequate support and follow-up arrangements have been made.

Requirements prior to discharge from a general hospital ward

- The mental health service has been consulted.
- 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.
- If the discharge from the general hospital ward is to the psychiatric ward, there is a plan for the person's safe escort and handover to the in-patient unit.
- Prior to leaving the ward, 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.
- **A follow-up appointment for re-assessment must be provided.**
- **If the person is under 16 years** of age, contact must be made with the parents or guardian prior to discharge.
- There must be a plan to contact significant support people about the potential suicide risk and about follow-up arrangements that have been made. This includes the general practitioner, private psychiatrist, care coordinator, case manager, family and friends.
- Information must be provided to relevant health care providers regarding presentation of the person at risk.
- There must be a verbal report at discharge or an interim summary on the day of discharge.
- A written report must follow within three days.

People assessed to be at **high risk** of suicide must have a **follow-up** appointment with the relevant health provider (for example, acute care team, community care coordinator/case manager, general practitioner, private psychiatrist) **within 24 hours of discharge** and contingency plans must be in place.

People assessed to be at **medium risk** of suicide must have a **follow-up** appointment with the relevant health provider **within one week of discharge and contingency plans** must be in place.

People assessed to be at **low risk** of suicide must have a **follow-up** appointment with the relevant health provider **within one month of discharge** and accessibility to the appropriate health service if required prior to appointment.

Missed appointment

- Where a suicide attempt has been made or there is ongoing risk and the person does not attend an initial follow-up appointment, the relevant health care provider with whom the appointment has been made must immediately contact the person and assess his/her suicidal behaviour. All reasonable attempts to contact the person are to be undertaken.
- 'Reasonable' attempts include:
 - telephone calls
 - contacting family, other identified carer, general practitioner (all subject to privacy provisions)
 - visits to the person's residence, if practicable
 - follow-up letter.
- All attempts at contact must be documented in the medical file.

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 these protocols.
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