

Comprehensive suicide-risk assessment in the emergency department

This guide for emergency department (ED) clinicians is based on the document *Working with the suicidal person: clinical guidelines for emergency departments and mental health services* (available at www.health.vic.gov.au/mentalhealth). All ED clinicians should review the *Clinical guidelines* carefully to become familiar with the assessment and management of persons with suicidal behaviours, and then use the quick reference guides to help remember major decision points.

Once the person is triaged and risk-to-self is identified, they should be actively managed in a safe environment while waiting for further assessment or clinical intervention. For EDs without specialist mental health staff onsite, ED staff can complete a detailed psychosocial assessment if suitably trained and supervision is available.¹

1. Engage with the person

- Be empathic – they are experiencing a crisis and stress, hopelessness and helplessness.
- Actively listen – allow expression of feelings, accept the feelings and be patient.
- Be non-judgmental – accept the person at face-value, do not debate the suicidal thoughts.
- Be direct – talk openly and matter-of-factly about suicide, your observations and concerns regarding his or her wellbeing. Asking questions about suicide helps engagement with the person and does not prompt a person to start to think about harming themselves.
- Be available – show interest, understanding and support.
- Be mindful of your own reactions, ensuring they do not interfere with the assessment or management of a suicidal person (particularly people who frequently attend or who repeatedly self-harm).

2. Assess suicide risk

- Be aware – know the risk factors and warning signs for suicide.
- At a minimum, assess intent, means, plan and presence of depression or psychosis.
- Identify the time and rapidity of the onset of the suicidal behaviour, as well as the events leading up to the presentation and past history of presentations. Useful enquiries could include:
 - the potential lethality of the method and the person's perception of lethality
 - recent drug and alcohol use
 - What are the person's feelings about living and dying? Is there an absence of hope?
 - Does or did the person feel alone and isolated? Have they discussed intent with others?
 - Have there been any preparations in anticipation of death, such as giving away possessions, making a will or saying goodbye to others?
 - Does the person have a plan?

¹ Section 2.2 in *Mental health care: framework for emergency department services*. Department of Human Services, Melbourne. Available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>

- If a suicide attempt has been made:
 - What precipitating events led to the suicidal behaviour and was it premeditated or impulsive?
 - Has the person sought help during or after the attempt?
 - What did the person understand and expect in relation to the potential lethality of their actions?
 - Did the person try to avoid discovery during the attempt or was the behaviour timed so that intervention was unlikely?
 - What is the person's own assessment of reasons for living?
- Conduct a mental-state examination. Be aware that certain at-risk mental states suggest a greater likelihood of suicide, such as expression of hopelessness, despair, agitation, shame, anger, guilt, humiliation or abandonment.

3. Obtain collateral information

- Obtain collateral information from medical records, paramedics, police, referring doctors, family or friends.
- While every effort should be made to obtain the patient's consent, if this is not possible, under HPP 1.1(f) and HPP 2.2(h), an organisation may collect, use or disclose information where it is necessary to prevent or lessen the threat to the patient's life, health, safety or welfare.
- If collateral information is not immediately available, it is always prudent to delay making a decision until all reasonable attempts have been made to obtain such collateral.
- Is the person known to an area mental health service? If so, notify the relevant area mental health service by phone and consult them regarding the person's management plan and appropriate further action.

4. Consult

- Ideally, consult with a mental health team or more-experienced colleague. This allows for another opinion, better care, and helps you articulate your course of action.

5. Document

- Document every action taken, every person you talk to. The best documentation includes an attempt to balance the risks and benefits of any decision.

6. Referral to a specialist mental health service

- Refer persons with a psychiatric history or probable mental illness.
- Consider referral to a specialist mental health service even if the acute risk appears to have subsided while the person is waiting at the ED. The fact that the person presented to an ED means that there is a risk of suicide, which will continue for some time.
- Hospitalisation may be the best option for intense assessment or more direct supervision and care of the person with high-risk.

7. Remain vigilant

- Closely monitor the person while they are waiting to be assessed and immediately after assessment while further psychiatric consultation or referral arrangements are being made.

Further information

You can download an electronic copy of this quick reference guide, the full *Clinical guidelines*, or the *Summary document* on the Department of Health website (www.health.vic.gov.au/mentalhealth). The full guidelines contain all the recommendations, details of how they were developed and discussion of the evidence they were based on.

If you would like to receive this publication in an accessible format, please email: tracy.beaton@health.vic.gov.au

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