Department of Health

health

Working with the suicidal person

A summary guide for emergency departments and mental health services

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A Victorian Government initiative

Working with the suicidal person

A summary guide for emergency departments and mental health services

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About this summary

This summary has been developed to assist health care professionals working in Victorian emergency mental health services in providing optimal evidence-based care for people at risk of suicide, and support for their families. It provides an overview of the key risk factors to consider when assessing and treating people who have attempted suicide or who have suicidal thoughts, and includes practical recommendations for improving their assessment and management.

The guidelines on which this summary is based were developed by an interdisciplinary group comprising mental health care professionals, emergency department staff, consumer and carer representatives and allied organisations. For a description of the guideline development process, see the complete document *Working with the suicidal person: clinical guidelines for emergency departments and mental health services*. The complete guidelines, this summary, and the quick reference guides can be downloaded from the Department of Health website: www.health.vic.gov/mentalhealth/

Clinicians and management should review the complete guidelines carefully to become familiar with the assessment and management of people at risk of suicide, and then use the summary and quick reference guides to help remember major decision points.

Disclaimer

The information provided in this summary guide is intended as general information and not as legal advice. If health service staff using the guidelines have queries about individual consumers or their obligations under the *Mental Health Act 1986*, or under their common law duty of care, service providers should obtain independent legal advice. Services need to ensure that local policies and procedures are developed to enable staff to respond in an appropriate manner to persons whom they believe may be suicidal or have recently attempted suicide, or engaged in self-harming behaviours.

Endorsed by:

the Australian College of Mental Health Nurses Inc.

The Royal Australian & New Zealand College of Psychiatrists

CENA
College of Emergency Nursing Australasia Ltd

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Contents

Risk factors for suicide

- Risk factors can alert the clinician to take particular care in the assessment of an individual with suicidal behaviour.
- In the acute-care setting, assessment of acute suicide risk is a subjective clinical judgement based on a review of the known risk factors (both aggravating and protective), current intent and planning, prior history of suicidal thought or behaviour, and current emotional state.
- Risk factors are also an important component in any management decision and it is advisable to take into account fluctuations in the level of risk as circumstances change.

Individual risk factors for suicide	
Co-morbidity	People with mental illness often present with more than one psychiatric disorder or may have a substance use problem.
Deliberate self-harm	The risk of the person committing suicide in the first year after an episode of self-harm is up to 100 times greater than the general population risk. The more serious the level of suicidal intent at the time of self-harm, the greater the risk of subsequent suicide.
Hopelessness	A sense of hopelessness, desperation, demoralisation or emotional pain has been identified as a strong precipitant of eventual suicide.
Mental illness	Biological vulnerability to depression probably plays the greatest role in suicide attempts related to stressful situations. In many cases, it is underlying depression rather than a stressful life event that precipitates a suicidal act. In addition to depression, suicide and suicidal behaviours are strongly associated with substance use disorders, bipolar disorder, schizophrenia and anxiety disorders, and chronic post-traumatic stress disorder.
Pain and physical illness	Pain associated with physical illness, especially in the elderly, is associated with increased suicide risk. Helplessness and hopelessness about pain, the desire for escape from pain and problem-solving deficits are psychological processes that contribute to suicidality in people with chronic pain.
People recently discharged from acute psychiatric care	Suicide risk in the first four weeks after discharge is 100 to 200 times greater than normal, and the risk remains for at least five to 10 years after last discharge. Those with a history of suicide attempts, self-harm and mood disorders are at particular risk of post-hospitalisation suicidal behaviour.
Postpartum suicide risk	Women with a psychiatric disorder, substance use disorder or both, have a significantly increased risk of a postpartum suicide attempt, particularly in the first year after giving birth.
Isolation or remoteness	Factors associated with rural living, isolation and remoteness contribute to higher rates of suicide.
Previous suicide attempts	Previous suicide attempts greatly increases risk of further suicidal behaviour. But it is important to note that an estimated 60 to 70 per cent of those who complete suicide do so on the first known attempt.
Stressful life events	Certain recent life events such as conflict in, or the loss of, a close relationship, job termination, rejection, failure, humiliation, poor health, retirement and financial stressors can precipitate suicidal behaviour, especially in combination with existing vulnerabilities.

Family risk factors	
Childhood physical or sexual abuse	Adolescents and young adults with a history of childhood abuse are three times more likely to become depressed or suicidal than those without such a history.
Family factors	Family factors, including high levels of conflict, parental mental illness and a family history of suicidal behaviour can elevate the risk for suicide.
Relatives and peers of people who have died by suicide	A recent suicide or suicide attempt by a relative or peer is also associated with a higher suicide risk (up to five times greater).

At-risk groups

- The unique characteristics of special populations such as Aboriginal and CALD groups, the young, the elderly and people with a dual diagnosis deserve particular attention (see the complete guidelines for details), as these characteristics may elevate risk for suicidality and influence prevention and management considerations.

Risk factors in adolescents

- past or present mental illness (for example, mood and anxiety disorders, substance use disorders or both concurrently)
- previous suicide attempts
- male gender
- previous self-harm
- social skills deficits
- hostility, aggression and impulsivity
- homosexuality or bisexuality
- current suicidal thoughts
- interpersonal conflict or loss
- ongoing physical or sexual abuse, or emotional stress (for example, bullying)
- parent–child discord
- recent commencement of antidepressant therapy
- feeling of isolation
- availability of firearms or lethal means
- close friends who have died by suicide.

Risk factors in the elderly

- depression
- co-occurring depression and anxiety
- limited social interaction
- previous suicide attempts
- recent discharge from psychiatric hospitalisation (within three months)
- male gender
- bereavement (especially for men)
- chronic relationship problems
- concerns about being a burden to others
- tension with caregivers
- recent visit to primary care physician (in the last month)
- physical illness (pain, chronic disability)
- vulnerable personality traits (hopeless or helpless, rigid, unable to sustain close relationships)
- recent change in accommodation.

Protective factors

- Protective factors include personal and family supports and experiences that appear to reduce risks for suicide, and are equally important in the assessment of risk.
- Reinforcing reasons for living and positive thoughts that the person may have about themselves or their significant others may help to buffer the individual from further suicidal thoughts and behaviour.

Protective factors

- family warmth, support and acceptance
- community support and a strong cultural identity
- pregnancy (self or partner) or having young children
- a strong sense of belonging and connection
- support from ongoing medical and mental health care relationships
- skills in coping and problem solving, conflict resolution, and non-violent ways of handling disputes
- cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- experiences with success and feelings of effectiveness
- interpersonal competence.

General principles of assessment and management

- Regardless of whether the point of access is an emergency department or a mental health service, there are several main principles for staff to consider in the assessment and management of people at risk of suicide.

Engagement

- Good communication is vital.
- Communicating with people who are emotionally distraught or behaviourally disturbed can be challenging, but the key to engagement is listening. Validate the person's feelings and persevere with questioning in an empathic way.
- The communication needs of adolescents, the elderly, those who chronically self-harm and Aboriginal Australians require particular consideration.
- Use an interpreter where needed – the use of family or friends for this purpose is contraindicated to protect the person's confidentiality. Engaging a professional interpreter ensures that family dynamics do not sway the interpretation.

Information-gathering

- Information-gathering is crucial.
- Making direct enquiries about suicide does not prompt a person to start to think about harming themselves. Questioning about suicide both facilitates and develops engagement.
- Ascertain the person's level of distress, their feelings about, and reasons for, living and dying, and whether they have a sense of hope. It is important to reinforce any positive thoughts and reasons for living the person has identified. Certain mental states (for example, despair, guilt, anger, abandonment) are indicative of a higher likelihood of suicide, as is the presence of mental illness.
- Ascertain if the person has made any preparations in anticipation of death, such as giving possessions away or saying goodbye to loved ones. Have they talked to others about wanting to die? Do they have a plan to commit suicide? What is the lethality of the plan?
- If a suicide attempt has been made, ask about any precipitating events, whether it was impulsive or premeditated, if the person understood the potential lethality of their actions, whether they tried to avoid discovery during the attempt, whether they sought help beforehand and so on.
- Find out if there is a history of mental illness, previous suicide attempts and recent medication history. Is the person a client of a mental health service?
- It is very important to gain information, not only from presenting individuals, but also from other informants such as friends or family, case notes and other professionals. The perceived level of risk should guide the breadth of this information-gathering. Sometimes, requesting information about a person from other sources can be time consuming and cause an extended wait in the emergency department. However, it is more important that the correct clinical decision about care is made and this can take time. The use of short-stay beds, where available, may assist in managing emergency department targets.
- Particular care should be taken to transfer pertinent information from one attending clinician to all others to ensure a consistent and holistic approach and to prevent adverse outcomes for the patient.
- If a person is subject to an order under the *Mental Health Act 1986* or the making of an order in relation to the person is an appropriate clinical decision, there is a legal basis for involuntary detention. This may be an appropriate and reasonable response in the circumstances, in order to provide ongoing care and treatment to a person who is at risk of suicide.
- A person cannot be detained against their will where the clinician determines that, although they are at risk of suicide, they are not mentally ill within the meaning of the *Mental Health Act 1986*. In cases of this type, however, the clinician should document the clinical basis for this diagnosis together with the nature of the treatment and care offered to the person, including the strategies used to stabilise the person. The clinician should contact family and friends so that they can provide informed ongoing support.
- The collection, use and disclosure of patient information are subject to the Health Privacy Principles. 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.

Thorough assessment

- Investment in a thorough assessment is essential.
- Use the collateral information and history gathered to inform the decision-making process regarding the person's management. Assess current level of risk on the basis of the available information to ensure that acute risk has been alleviated.
- Ascertain if the person is safe to wait, and consider ways in which they can be supported while they wait (for example, physical comforts that convey caring, a quiet room, an accompanying person to wait with them). This can reduce the person's agitation and the potential necessity for more-restrictive interventions.
- Any interventions that restrict a person's liberty should be commensurate with the level of risk to self and others. They must be kept to an absolute minimum, with a level of supervision at least consistent with the *Mental Health Act 1986*.
- Intoxication can increase impulsiveness and the risk of self-injury in the short term.
- Alcohol and drug intoxication does not preclude early assessment for suicide risk, although initial assessment may indicate the need for more comprehensive assessment when the person is no longer intoxicated.
- In cases of chronic suicidality, a sudden deterioration in a person's baseline level of functioning may indicate that one or more of their reasons for living have recently changed, and this requires investigation and documentation.
- Although risk-factor checklists are not a not substitute for an assessment, they are useful when formulating a management plan. Particular attention should be given to the needs of identified at-risk groups.
- Health services are responsible for ensuring that emergency department clinicians are appropriately skilled and trained in making psychosocial assessments and know when and how to seek help from specialist services.
- Following initial consultation, giving feedback to the referrer (for example, the police officer who brought the individual to the emergency department) may elicit more information from them than was forthcoming at triage. The newly developed police transfer form will help facilitate this exchange.

Secondary consultation, debriefing, and supervision

- When a person presents in the emergency department with suicidal ideation or self-harm risk, the treating clinician should always consider referral for mental health assessment, or at least seek to discuss the situation with an experienced mental health clinician.
- When treating those from high-risk groups, such as the chronically suicidal, the elderly, adolescents and Aboriginal Australians, consultation and debriefing can be particularly beneficial.

Management plan

- The treatment plan for an individual should be appropriate to the level of assessed risk. Careful consideration will need to be given to the degree of support available to the person, as well as their legal status under the *Mental Health Act*. High suicide risk is generally managed better in a contained environment.
- The person, their family and social supports should be involved in the development of a home-based treatment plan, with consideration of the person's home environment and potential stressors.
- The treatment plan should include written information regarding available community resources (help lines, triage numbers), dates of review appointments, who to contact in a crisis and so on.
- Family members should be given a copy of the plan, **advised** to remove potentially lethal means of self-harm and **asked** to monitor the person's whereabouts and any sudden behaviour change.
- Suicide risk is by nature dynamic. Lack of suicidal thoughts while in the hospital or mental health service does not mean lower outpatient risk. Consider referral to a specialist mental health service even if the acute risk appears to have subsided.
- 'No-suicide contracts' are unreliable and are not recommended.

Documentation

- After an assessment has taken place and a treatment plan is in order, documentation includes the following:
  - risk–benefit analysis of proposed treatment or options
  - basis for clinical judgment and decision-making
  - medications
  - tests ordered
  - consultations requested
  - referrals
  - any precautions
  - plan for follow-up and reassessment of suicidality.

Discharge planning and follow-up

- The first week after admission or discharge from inpatient units is one particular time when suicide risk is greatest, and the risk is believed to remain for at least five to 10 years after last discharge.
- Active clinical contact after discharge encourages the person to participate in post-discharge care.
- While face-to-face follow up is preferable, a phone call may be the only tool available for follow up in rural areas.
- No more than one week of medication should be provided at discharge from a short-stay unit for people with a history of self-harm in the last few months, to prevent self-injury and to encourage follow up with community management teams.

Reassessment

- Reassessment of risk of suicide by a mental health clinician is most effective when it is conducted face-to-face and the clinician is cognisant of the level of risk initially assigned.
- It allows for review of current risk and protective factors and how they may have changed, review of treatment effectiveness, re-evaluation of previously detected at-risk mental states, and collection of collateral information from family, friends and relevant service providers.
- Any variance from previously assessed risks needs to be clearly documented by the mental health clinician or, where applicable, the GP.
- Aim to reassess suicide risk within:
  - 24 hours for the person at **high risk**
  - seven days for the person at **moderate risk**
  - one month for the person with **mild but current risk.**
- Reassessment of risk by mental health clinicians entails:
  - reviewing current environment, risk and protective factors and how they may have changed
  - reviewing treatment effectiveness and engagement with service providers
  - re-evaluating previously detected at-risk mental states
  - collecting collateral information from family, friends and relevant service providers.

Language barriers

- Qualified interpreters are available through the **Translating and Interpreting Service** (TIS; www.immi.gov.au/tis/) run by the Department of Immigration and Citizenship (DIAC). TIS National is available 24 hours a day (telephone 131 450), seven days a week for any person or organisation in Australia requiring interpreting services.
- Alternatively, **VITS Language Link** (www.vits.com.au/) can provide telephone (24 hours a day, seven days a week) and face-to-face interpretation services in Victoria. For general enquiries, phone 03 9280 1941.
- The online manual ***Working with interpreters: guidelines for mental health professionals*** is available at www.vtpu.org.au/docs/interpreter_guidelines.pdf
- A directory of **bilingual mental health professionals is** available online at www.vtpu.org.au/resources/bilingualdirectory.html

Chronically suicidal

- Suicidal ideation is often a chronic state in some people, including those with borderline personality disorder (BPD), and it does not always represent sincere life-threatening intent.
- Yet at least three-quarters of people with BPD will eventually attempt suicide and approximately 10 per cent will complete suicide, so threats of suicide by those diagnosed with BPD must always be taken seriously.
- For detailed guidance on the appropriate assessment and management of people who self-harm, refer to joint guidelines published by the Royal Australian and New Zealand College of Psychiatrists and the Australian College of Emergency Medicine.
- Recognise the distress associated with deliberate self-harm and treat the person with respect.
- Be mindful of your own reactions to ensure that they do not interfere with the assessment or management of a person who repeatedly self-harms.
- At each presentation, it is important to enquire about any recent changes in the person's situation or relationships.
- Avoid hospitalisation of people for repeated self-harm where possible, as it is considered counter-therapeutic. Otherwise, keep it brief and symptom-focused when risk clearly warrants it. If possible, consult with other professionals before making the decision to hospitalise a person.
- People who present frequently with self-harm require a comprehensive, individualised management plan developed with the person and in collaboration with the mental health clinicians involved in their care.
- Area mental health services can refer case-managed clients with underlying personality disorder to professionals with expertise in the area of personality disorder treatment (for example **Spectrum, 03 9871 3900**)

The elderly

- Attempted suicide in the elderly is a very serious matter.
- Remain vigilant to the presence of suicide risk factors in older people who present to emergency departments, as older people are more likely to have few social supports and are frailer in general, so self-injurious acts are more likely to have lethal consequences.
- Refer all older adults presenting with self-harm or attempted suicide for a specialist psychogeriatric assessment by a suitably trained medical practitioner.
- Consider all such aged people for admission to an aged-psychiatry inpatient unit.
- Conduct a thorough and systematic assessment of suicide risk factors for each older adult. In particular, screen for depression with or without concurrent anxiety, lack of social supports, and previous suicide attempts.
- Strengthen the assessment with good history-taking from the person and also from as many collateral sources as possible, particularly when cognitive impairment is suspected.
- Enhance health status and function by initiating treatment or improving management of underlying conditions, such as chronic pain or depression.
- Contemplate discharge only if a comprehensive psychosocial assessment and aftercare plan can be arranged before discharge.
- Regularly follow up with active clinical contact, particularly in the immediate post-discharge period (the first month).
- Reassess older people at risk of suicide after the appropriate length of time indicated by the level of assessed risk.

Referral of people of CALD background

- When making referrals to specialist mental health services or general practitioners for people from CALD backgrounds who require follow-up, select bilingual mental health professionals and ethno-specific services where possible. A directory of **bilingual mental health professionals** is available at www.vtpu.org.au/resources/bilingualdirectory.html
- Negotiate a management strategy that is meaningful and acceptable to the person, family and clinician.

Indigenous Australians

- It is not always possible for the clinician to have had experience interacting with Aboriginal people or to have general knowledge of Aboriginal language and culture. Therefore, whenever possible, engage the services of an Aboriginal Health Liaison Officer, Koori Mental Health Liaison Officer or interpreter to ensure that meanings and experiences are properly conveyed.
- When assessing suicide risk, it is important for mental health workers to understand that the risks of self-harm for Aboriginal people extend beyond an expression of mental or alcohol-related disorder.
- Social and cultural risk factors such as social cohesion, spirituality, sexual abuse, family violence, trauma, culture, racism, removal policies, unemployment, exclusion from education, and lack of connection to country (birthplace, Dreaming) must always be considered.
- Building rapport is especially relevant when interviewing Aboriginal people for whom personal relationships and respect among others in their own community is highly valued.
- Conduct the interview at a relaxed pace where silence is tolerated. Silence is an important and positively valued part of Aboriginal conversations. It may be appropriate for Aboriginal people to pause before giving answers. Interviewers who do not understand this may misinterpret the silence as an indication of a lack of knowledge or language difficulty.
- Adopt an open-ended questioning style. Open-ended questions such as 'Can you tell me what happened…?' allow the interviewee to tell their story with minimal interruption and contamination of information by the interviewer. Use more-direct questions only when open-ended questions are not generating adequate information from the interviewee.
- Listen carefully to the interviewee and acknowledge that you have understood them. This earns trust and respect, and shows a willingness to be guided by the client. Aboriginal people may be guarded and reticent in a clinical setting. Avoid giving reflective feedback as it may be considered to be rude.
- Respect the narrative. When meeting with an Aboriginal person, it is important to allow time to hear their story. Although there is a great deal of pressure to complete assessments in a limited amount of time, let Aboriginal people unfold the details of their story at their own pace.
- Direct eye contact can be very intimidating. Whereas it is polite and expected for non-Aboriginal people to make eye contact when talking to a person, the same does not always apply for Aboriginal people. On the contrary, this behaviour may be considered disrespectful and a reluctance to maintain eye contact should not be misconstrued.
- Adopt a more holistic approach. Look beyond drug and alcohol use as the source of the problem and instead recognise that they are symptoms of more complex issues.
- Consider involving family members, close friends of the person or community elders in the discussion about treatment (after first seeking approval of the person), and accommodate their views of the treatment, as they may be essential to treatment compliance.
- Design appropriate and culturally sensitive interventions that work within the most accessible levels of the person's social system. Consider the traditional treatment system as a viable alternative to mainstream services.
- When making referrals to specialist mental health services or general practitioners for people who require follow-up, select Aboriginal mental health professionals and services where possible, or ensure cultural safety through the use of an Aboriginal health worker.

Dealing with aggression

- Early identification of agitation and consideration or use of de-escalation techniques should occur before more restrictive means of containment are considered.
- Every effort should be made to respect the dignity and autonomy of the person, particularly when restrictive practices are deemed necessary.
- Mechanical restraint or rapid sedation may be required when attempts to de-escalate a potentially violent situation with less restrictive interventions have been ineffective.
- All forms of restraint must follow formal policies and be carried out by those who are specifically trained and competent in their implementation.
- The risks and benefits of sedation need to be balanced against the need for a careful assessment of mental status.
- Consideration is given to the use of involuntary patient status under the *Mental Health Act*, which provides clear safeguards of the person's rights.
- Environmental variables that can be modified in the emergency department to reduce the potential for escalation of violence in the agitated person include:
  - having a quiet room available to decrease external stimuli; maintain adequate supervision
  - offering the person physical comforts, such as a chair, stretcher or blanket, to convey caring and respect
  - avoiding body language that can be perceived as confrontational by the agitated person, such as crossed arms or hands behind the back
  - always explaining the reason for the restraint to the person being restrained and seek their consent if possible[1]
  - attending potentially violent people promptly to prevent a minor incident becoming more serious. Obtaining collateral information is often helpful in this regard.

1 The use of restraint is a significant infringement of a person's right to free movement, privacy, liberty and freedom from medical treatment without full, free and informed consent. Restraint should only be used as last resort after other options have been considered and excluded, and for the purpose of protecting the person from an immediate, imminent and significant risk to their health or safety. Health services have a responsibility to promote a restraint-free environment and a duty of care to ensure persons are protected from the risk of injury associated with the use of restraint. Each service is responsible for ensuring that the use of restraint is supported by staff education and protocols which clearly articulate the associated legal, ethical and management processes and responsibilities.

People who do not wait to be seen

- Each service has a clearly articulated local policy regarding notifications and actions required in the event that a patient does not wait to be seen.
- The first health care professional to come into contact with the person records a description of their clothes.
- If a person at risk does not wait to be seen, make every effort to contact the person (and their next of kin) and ask them to return for a proper evaluation.
- Where applicable, notify hospital security staff as well as police.
- Alert the person's GP or psychiatrist about the person's departure.
- Alert the local CAT team so that they may follow up with the person within 24–48 hours.

Bereavement strategies

- Each hospital and area mental health service should be aware of what local bereavement support services are available and make appropriate referrals.
- The SANE Mental Illness and Bereavement Project has developed *Best practice bereavement guidelines*, information for consumers, a helpline for bereavement support training, and the *Mental illness and bereavement training package* DVD to assist health services to respond to bereaved family and friends of people with mental illness. For more information on accessing these resources, visit www.sane.org or call: 1800 18 SANE (7263)
- For more information, contact:
  - Australian Centre for Grief and Bereavement: www.grief.org.au
  - Compassionate Friends Victoria: www.compassionatefriendsvictoria.org.au
  - Lifeline: www.lifeline.org.au
  - National Missing Persons Coordination Centre: www.missingpersons.gov.au
  - SANE Australia: www.sane.org
  - Ministerial Council for Suicide Prevention, Indigenous Suicide: www.mcsp.org.au/suicide/aboriginal
  - Hope Bereavement Centre: www.bereavement.org.au
  - National Association for Loss and Grief: www.nalagvic.org.au/fh-wheretofindhelp.htm
  - Dunne, E. & Wilbur, M.M. (1999). *Survivors of suicide: coping with the suicide of a loved one.* Lifeline Melbourne and The Victorian State Coroner's Office
- Where to call for help:
  - Life Line 24-hour crisis telephone counselling: **13 11 14**
  - 24-hour suicide help line: **1300 651 251**
  - Mensline: **1300 789 978**
  - The Compassionate Friends 24-hour telephone support line: **1800 641 091**
  - National Missing Persons Coordination Centre: **1800 000 634**
  - National Association for Loss and Grief: **03 9331 3555**
  - Australian Centre for Grief and Bereavement: **1300 664 786**
  - Salvation Army Hope Line: **1300 467 354**
  - SANE Helpline: **1800 18 SANE (7263)** or helpline@sane.org