

## Immediate management of suicide risk 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*. 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.

The expectation in developing a management plan for a person at risk of suicide is that a specialist mental health service will be consulted, either on- or offsite. A clear evaluation, treatment and follow-up plan is necessary before discharge from the ED. Outpatient management is feasible for people with suicidal ideation assessed as being at either mild or moderate suicide risk.

### 1. Developing an outpatient management plan

- No patient with suicidal ideation or self-harm risk should be discharged from the ED prior to discussion with an experienced mental health clinician or referral for mental health assessment. For EDs without specialist mental health clinicians on site, area mental health service triage is available 24 hours a day to provide telephone advice.
- Community management by an area mental health service is not appropriate if the risk of suicide is assessed to be high (high lethality and intent), or if there is a lack of social support. Exceptions to this are cases of chronic suicidality or borderline personality disorder, where high-risk cases may be better managed in the community.
- When developing a treatment plan, first conduct an environmental assessment:
  - Enquire about social supports (individuals, organisations and activities).
  - Identify potential stressors as well as gaps in support or resources.
  - Evaluate the person's ability to access his or her support system.
- Actively involve and gain agreement from the person and their family in developing the community-based treatment strategy.
- Provide person at risk, family or significant others with written information regarding available community support resources (for example, help lines, area mental health service triage numbers).
- Arrange treatment for underlying psychiatric illness.
- Take appropriate steps to address psychosocial precipitating factors.
- Consider and address the broader psychosocial needs of the person, such as housing, food, employment and social networks.
- Educate the person and their family about strategies for dealing with symptoms and distress (problem-solving and coping skills).
- The treating clinician or treatment team can develop a written crisis plan with the person and their family when appropriate, which specifies what the person should do if they experience an acute suicidal episode, including methods of accessing emergency care and alternative ways of coping.

- Provide instructions to the family on how to manage a person with suicidal behaviour (knowing the person's whereabouts, the company they keep, how and who to contact in the clinical team if there is a sudden change in behaviour or a crisis).
- Include dates of face-to-face review appointments (as determined by the level of risk at the previous assessment) in treatment plan.
- Be sure to talk to family members about the importance of removing potentially lethal means of self-harm (for example, firearms, medications, knives, or razor blades) from the person and their home environment, particularly if the person has mentioned specific means in the process of assessment. Do this in collaboration with the person, if possible.

## 2. Documentation

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

## 3. Follow-up

- A person remains at risk of suicide after a suicidal crisis is over; appropriate and systematic follow-up reduces this risk; this is particularly true for inpatients, as suicide risk is greatest in the first week after discharge.
- Active clinical contact after discharge from the ED encourages the person to participate in post-discharge care.

### 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/mentalhealth](http://www.health.vic.gov/mentalhealth)). The full guidelines contain all the recommendations, details of how they were developed and discussion of the evidence they were based on.