Working with the suicidal person

health

Quick reference guide

Rapid suicide-risk assessment at emergency department triage

This guide for emergency department (ED) triage staff is based on the document *Working with the suicidal person: clinical guidelines for emergency departments and mental health services*. All emergency department triage 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.

At first face-to-face contact with a person with suicidal behaviour:

1. Assess and ensure safety

- Is the person safe to wait?
- Is the person in obvious severe distress?
- Is the person likely to wait until seen by an ED clinician or mental health specialist?
- Is the person able to, or likely to, ask for assistance if circumstances change?
- Is the person affected by drugs or alcohol?
- Is the person a current patient of a mental health service?
- Is there a risk of danger to self or others?

2. Establish rapport

- Engage with the person; be non-judgmental, respectful and professionally empathic.
- Use open body language; for example, use varied eye contact, lean forward and lower your voice.

3. Collect collateral information and document it

- Obtain collateral information from medical records, paramedics, police, caregivers or referring doctors.
- Document and pass this information on to the next attending clinician.
- Ask accompanying friends or family members to remain available to ensure collateral information.
- Record a description of what the person is wearing to aid identification if the person leaves the ED.

4. Assess suicide risk

- Apply the Victorian Emergency Department Mental Health Triage Tool.
- For an initial, rapid suicide-risk assessment (see box below), enquire about:
  - duration of the suicidal thoughts
  - any history of previous suicide attempts
  - recent help-seeking behaviours
  - the existence of a suicide plan
  - access to means to complete the plan.

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Examples of rapid suicide-risk assessment questions for triage:*

Duration, intent and history of suicidal ideation

- Has something very stressful happened to you recently?
- Have you ever thought about harming yourself?
- Are you able to wait for further assessment and treatment?
- Have you sought medical or social advice in the last six months?
- Have you had thoughts about ending your life recently?
- Have you ever considered ending your life in the past?
- Do you intend to hurt yourself?
- Have you ever attempted suicide?
  - *The patient who has acute thoughts of completing suicide, has attempted suicide in the past, or expresses a specific intent to end life is at* ***higher risk.***

Specificity of plan

- Do you have a plan as to how you would harm yourself or end your life?
- Have you been drinking or using any substances when you have these thoughts?
- Do you have a method to harm yourself, and access to that method?
  - *The patient who has a detailed, carefully thought-out plan or access to lethal means is at* ***higher risk****.*

*Note that not all of these questions will apply in all cases.

5. Take action

- Provide continuous or one-to-one supervision and urgent assessment (within 10 minutes) for acutely suicidal persons (code 1 or 2).
- Remove lethal means of self-harm such as pills, ropes, firearms, and alcohol or other drugs.
- If the person has agreed to wait for further assessment without supervision, encourage them to talk to an allocated clinician or triage should they begin to feel agitated and not want to wait.

6. People who do not wait to be seen

- 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.

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). The full guidelines contain all the recommendations, details of how they were developed and discussion of the evidence they were based on.

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