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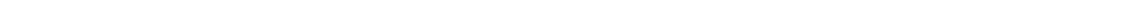
health

Working with the suicidal person

Clinical practice guidelines for emergency
departments and mental health services

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Foreword

Suicide has an overwhelming impact on those close to the person who died, often with enduring emotional consequences. It also affects the wider community, at a human level and in terms of its vitality and wellbeing. Suicide is often, but not always, associated with mental ill health. Effective treatment requires a willingness to recognise and remove barriers to effective care in order to reduce the risk of suicide. These barriers to effective care include the stigmatisation of those with mental illness and their families, and public ignorance about mental health issues.

People experiencing suicidal ideation may find it difficult to access appropriate services. Those services need to work effectively with other community organisations and individuals to provide a range of interventions and supports that continue for long enough to reduce the suicide risk and improve the person's coping strategies in the longer term.

These guidelines are a resource for clinical staff in emergency departments and mental health clinicians when assessing and working with people who have made a suicide attempt or are at risk of taking their own lives. They are a guide to clinical practice, both for individuals and for the health services in which they work. The guidelines are based on explicit evidence where possible and are supplemented by considered and consensus expert opinion.

In many ways, the development of a guideline is the easy part of the task of improving practice. Achieving a commitment to changes in practice and systems of care requires effective implementation at health service level, backed by quality educational measures that are maintained over time and supported by adequate regular supervision, clinical audit and quality improvement processes.

All of the parties involved in the development of these guidelines are committed to optimal care for the suicidal person in order to reduce the rate of both suicide and suicide attempts. Health services are urged to implement these guidelines as a fundamental step towards achieving these goals.



Dr Karleen Edwards
Executive Director
Mental Health, Drugs and Regions

The Victorian Department of Health gratefully acknowledges the endorsement of this document by the following organisations:

Australian College of Mental Health Nurses

Australian College of Emergency Medicine, Victorian Faculty

College of Emergency Nursing Australasia

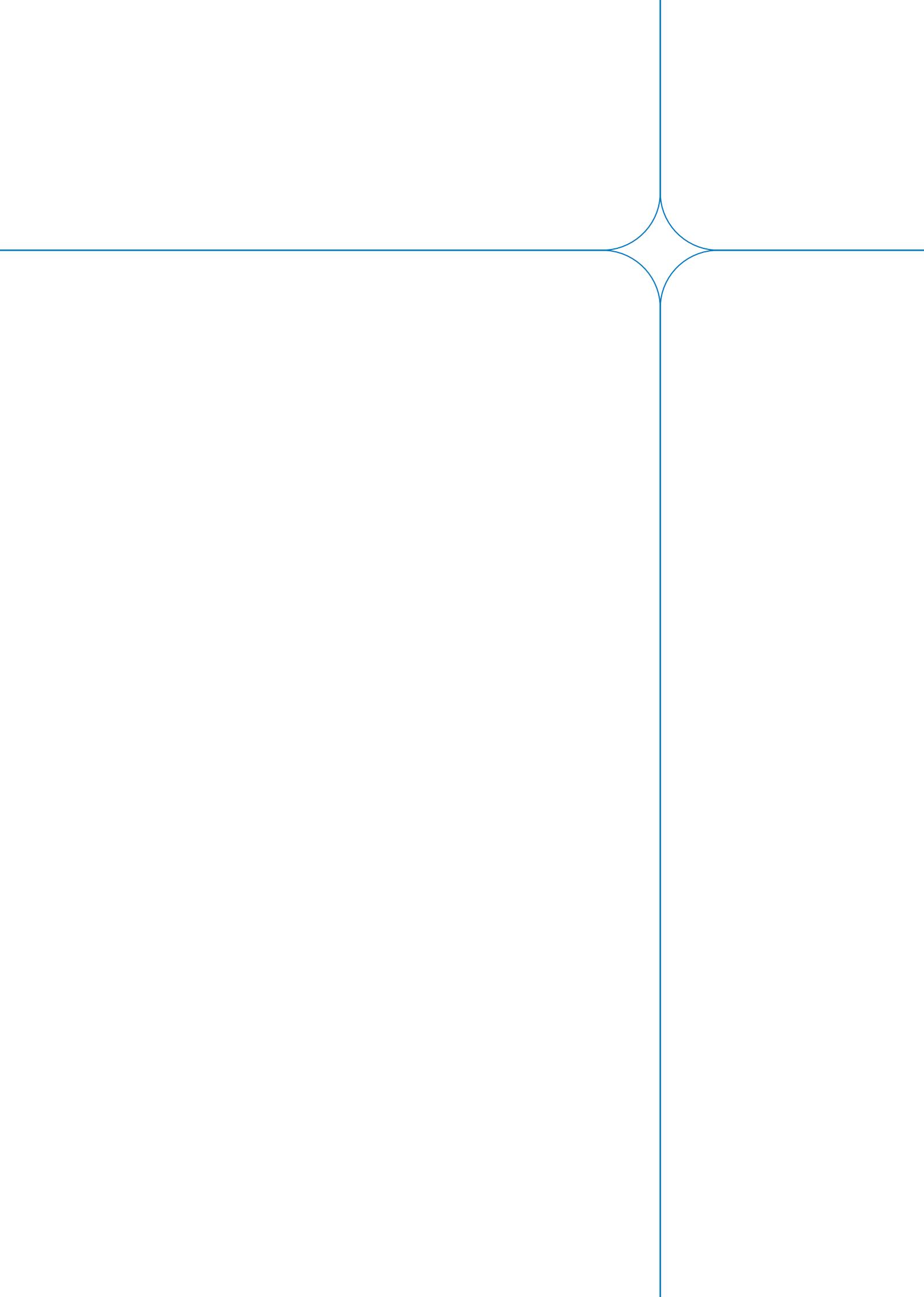
Royal Australian and New Zealand College of Psychiatrists

Royal College of Nursing, Australia



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Purpose

The *Working with the suicidal person: Clinical guidelines for emergency departments and mental health services* are designed to provide guidance to healthcare professionals working in Victorian emergency mental health services on how to improve the assessment and management of people with suicidal behaviours. The guidelines are principally intended for:

- emergency departments
- area mental health triage services
- crisis assessment and treatment teams

Community-based services may also find the guidelines helpful.

Not all components of a mental health service are readily available to every emergency department (ED). For this reason, and as outlined in *Mental health care: Framework for emergency department services*¹, the response to people with mental health problems presenting to Victorian EDs is not the exclusive responsibility of mental health practitioners. ED clinicians require skills in the assessment and management of the various mental health problems they are likely to encounter, and the ability to provide support, information and appropriate referral for mental health clients, their families and carers.

These clinical best practice guidelines are intended to serve as an information and planning tool, to support and complement clinical training and to improve the quality of care a person receives *before* a mental health worker is assigned to them, regardless of their point of access.

The guidelines include recommendations based on the most current empirical evidence (from controlled clinical trials and observational studies) and strong clinical consensus. While they are expected to apply most of the time and should always be considered by clinicians, there are exceptions to their application. The guidelines do not represent a prescribed standard of care and so do not stipulate a single correct approach for all clinical situations. The ultimate judgement regarding the assessment or management of a person at risk of suicide must be made by the healthcare professional based on their experience, the clinical presentation, and the assessment and management options available at a particular health service. Decisions regarding particular procedures for specific individuals remain the responsibility of the attending professionals and health service.

These guidelines supplement Victoria's *Mental health care: Framework for emergency department services*², which provides a set of overarching principles and guidelines relating to service delivery and clinical care.

¹ Sections 1.1.1 and 2.2 in *Mental health care: Framework for emergency department services*. Victorian Government Department of Human Services. Available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>

² Available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>

Guide to using these best practice guidelines

This document aims to be readable and practical. It is recognised that a ‘one size fits all’ guideline approach does not work in the Victorian health service context. While taking into consideration the diversity of EDs and area mental health services (AMHS), their capacities, capabilities and resources, the guidelines do not attempt to cover all service alternatives, but rather provide general principles to guide assessment and management processes.

It is recommended that readers thoroughly acquaint themselves with the guidelines, although clinicians clearly also need quick access to specific content areas and key recommendations for their day-to-day decision-making processes. As a practical resource for healthcare professionals, the accompanying *Quick Reference Guides* will contain a summary of the guidelines’ recommendations in a concise, easy-to-use format for everyday practice.

It is the responsibility of every mental health service and hospital ED to ensure that appropriate protocols, training programs and audit processes are in place and used in conjunction with the guidelines. **Each service will need to identify and make clear to staff how and when they will apply these guidelines.** Clinicians who are interested in further training are encouraged to pursue continuing education activities.

Disclaimer

The information provided in these guidelines 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 who they believe may be suicidal or have recently attempted suicide, or engaged in self-harming behaviours.

Development process

These guidelines have been developed with the involvement and cooperation of a broad spectrum of mental health practitioners and ED staff, some involved in research and other academic endeavours (see Appendix A). Carers, consumers and other representatives of the mental health sector were also consulted. Drafts of the guidelines have been reviewed by both departmental and sector reference groups, a technical advisory group, other experts and allied organisations.

Key features of the development process include:

1. a comprehensive, systematic literature review
2. development of evidence tables and grading of the evidence
3. a report of the results of the literature review that was critically reviewed by a committee of technical advisers which included psychiatrists and psychologists with clinical and research expertise in suicide and suicidality
4. extensive consultation with the health sector, carers and consumers
5. production of multiple revised drafts with widespread review and input
6. approval by the Executive Director, Mental Health, Drugs and Regions Division, Department of Health.

A more-detailed description of the literature review process can be found in the literature review report, which illustrates the strength of the evidence base behind the guidelines' recommendations. Taking into account that available evidence, the technical experts reached a clinical consensus regarding clinical decisions represented in the guidelines.

Where clear recommendations for action are made, they are accompanied by statements about the strength of the supporting evidence that they are based on. Individual studies were first assigned a level of evidence from 1 to 4 (refer to Appendix B for details). Once the Technical Expert Reference Group considered the whole body of evidence, each recommendation in the guidelines was given a grade based on all of the individual studies. The grades A to D described below, and the good practice point, give an indication of the strength of the evidence underpinning each recommendation. They do not give an indication, however, of the relative importance of each recommendation.

Grades of recommendations

- A** At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.
- B** A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results; **or** extrapolated evidence from studies rated as 1++ or 1+.
- C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
- D** Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

Good practice point

- ✓** Recommended best practice based on the clinical experience of the Technical Expert Advisory Group and substantiated by a wide peer review process. This document represents a synthesis of current scientific knowledge and rational clinical practice on the assessment and management of people with suicidal behaviours. It is intended that these guidelines will be reviewed every five years.

Acknowledgments

Many individuals and organisations gave their time and expertise in the development of the guidelines. The generous assistance of psychiatrists, emergency physicians, and psychiatric nurses who assisted with this project is gratefully acknowledged. Particular thanks go to Dr Peter Burnett, Mr Anthony A (Tony) Catanese, Dr Angelo De Gioannis, Professor James Ogloff and Professor Bruce Singh, who contributed as members of the Technical Expert Reference Group through the necessary review and critique of the many drafts.

The Victorian Mental Illness Awareness Council and Carers Victoria facilitated the involvement of a number of consumers and carers who shared their personal stories and experiences to assist our understanding of the very human aspects and impacts of suicide and suicide prevention.

Thanks are also due to Assoc. Prof Steve Ellen, as Chairperson, and all members of the Mental Health Sector Consultative Group and their representative organisations; Associate Professor Steve Elsom (Chair) and members of the CATT/ECATT Consultative Group and the health services they represented; Dr Erminia Colucci for her input on mental health issues facing culturally and linguistically diverse communities; and members of the departmental consultative group, especially project sponsor Ms Tracy Beaton, Senior Mental Health Nurse Adviser, Dr Ruth Vine, Chief Psychiatrist and Dr Lesley McKarney, researcher and project manager.

Our appreciation is also due to New South Wales Health and the New Zealand Ministry of Health who helped us inestimably with their earlier efforts in producing similar guidelines.

Summary of recommendations

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

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.

Information gathering is crucial

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, any previous suicide attempts and recent medication history. Is the person a client of a mental health service?

Use an interpreter where needed – the use of family or friends for this purpose is contraindicated.

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 take time and cause an extended wait in the ED. 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 ED targets.

Particular care should be taken to ensure that pertinent information is transferred 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; they are legal where it is necessary to prevent or lessen the threat to the patient's life, health, safety or welfare.

Investment in a thorough assessment is essential

Use the information 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 should not preclude early assessment of a person's suicide risk, particularly as it can increase impulsiveness and the risk of self-injury in the short term.

Although risk factor checklists do 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.

Secondary consultation/debriefing/supervision

When a person presents in ED 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.

Decision-making

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.

1. Background

1.1 Definitions

Suicidal behaviour is complex and may exhibit different forms and levels of severity ranging from suicidal ideation, suicide gestures, suicide threats, suicide plans and suicide attempts, to death by suicide. While there is a large number of people who think about suicide, very few make actual attempts and of those who make attempts, only a small subset complete the act. Moreover, not everyone who dies by suicide has a history of attempting it.

It is important to distinguish between deliberate self-harm (DSH) and DSH with the intent to die. Some people with self-induced injuries, who present to EDs or AMHS, may not have intended to die and so are not deemed to be suicidal.

In these guidelines, the following terms will be used [1]:

Suicide	Self-inflicted death with evidence (explicit or implicit) that the act was intentional
Suicide attempt	Self-injurious behaviour with a non-fatal outcome accompanied by evidence (explicit or implicit) that the person attempted to die
Suicidal intent	Subjective expectation and a desire for a self-destructive act that would end in death
Suicidal ideation or thoughts	Thoughts of serving as an agent of one's own death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and degree of suicidal intent
Deliberate self-harm	Wilful self-inflicting of, at times, painful, destructive or injurious acts without intent to die

1.2 Epidemiology of suicide

1.2.1 Overall trends of suicide

Suicide is a relatively rare event, but its impact on families, friends and society in general is enormous. Suicide remains a major public health problem and one of the leading causes of death in Australia [2]. Reports from the World Health Organisation (WHO) estimate that 10.4 per cent of the population seriously consider suicide at some point in their lifetime, while 4.2 per cent of people attempt suicide [3]. Suicide rates are usually expressed in terms of deaths per 100,000 people. In Australia, suicide is four times more common in men than women, with approximately 21 suicide deaths per 100,000 men and 5 suicide deaths per 100,000 women [4].

It is important to note that the number of suicides in any given year is likely to be underestimated. For deaths with limited findings, such as hanging or carbon monoxide poisoning, WHO guidelines specify that the Australian Bureau of Statistics (ABS) must code these as accidental until the coroner can decide if the death was due to suicide, homicide or intent undetermined³. Intent is not always obvious and some coroners are under pressure to emphasise 'accidental death' where there is doubt [4]. The ABS has a cut-off date for any deaths that are delayed in the Coroner's court, and after this date, defaults all outstanding suspected cases of suicide to 'accidental death', underestimating actual suicide numbers and rendering comparisons between states meaningless due to differences in coronial inquest load and resources between jurisdictions. Nonetheless, data from the National Coroners Information System shows that between January 2006 and December 2007, there were 927 closed cases involving suicide of residents living in Victoria — 703 or 72 per cent of them were male.

1.2.2 Pattern of suicide by age and gender

According to the ABS, there were 2,191 deaths from suicide registered in 2008, of which a large proportion (almost 80 per cent) was male⁴. The median age at death for suicide in that year was 42 years for males and 44 years for females. Middle age appears to be a critical time, as 10 to 16 per cent of all deaths in males aged between 40 and 49 were due to suicide. The highest age-specific suicide death rate for males was observed in the 40 to 44 year age group (26.4 per 100,000 population). The age-specific suicide death rate among males peaks again in the very elderly (85+ years), at 26.2 per 100,000. However, as a proportion of total deaths in this age group, the number of suicides was relatively low (0.2 per cent).

The highest age-specific suicide death rate in females in 2008 also occurs around middle age, with 8.6 deaths per 100,000 recorded in the 50 to 54 year age group. Advancing age appears to be a protective factor in females, with the 80 to 84 year age group recording the lowest age-specific death rate (2.0 per 100,000).

Suicide also accounts for a much-greater proportion of deaths from all causes in younger men and women. For instance, in 2008 20 per cent of all deaths of males aged 15 to 24 were from suicide (age-specific rate of 9.4 per 100,000 population).

The pattern of suicide also varies between ethnic groups, and this is discussed in more detail in Section 4.4 of the guidelines.

1.2.3 Attempted suicides

While the rate of completed suicide is much lower in females than males, females attempt suicide more often. In the general population, it is estimated that for each completed suicide, there may be up to 50 male and 300 female attempted suicides [5], and this trend has been reported for both Indigenous and non-Indigenous Australians [5,7]. Some have suggested that this gender difference in suicide completions versus attempts is partly due to the fact that males tend to use more immediate and violent methods than females, to an extent accounting for their higher rate of completion [5,6].

3 Australian Institute of Health and Welfare: National Mortality Database Documentations 2007. Population Health Unit Technical Paper, Number 1. Available at http://www.aihw.gov.au/mortality/mortality_database.cfm

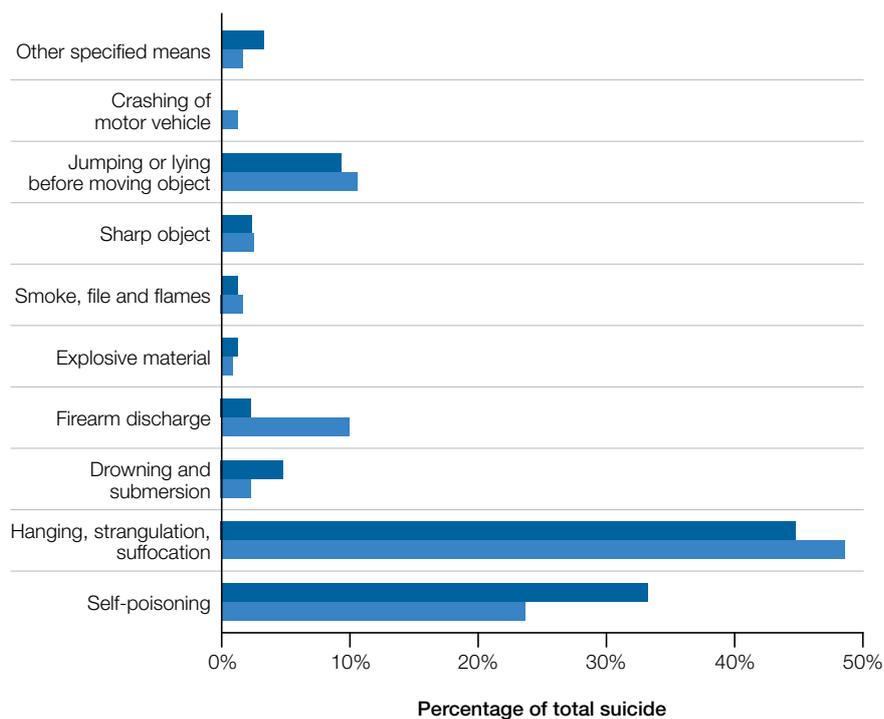
4 Australian Bureau of Statistics. Causes of Death, Australia, 2008. Available at <http://www.abs.gov.au/>. Last accessed 14 April, 2010.

Self-report surveys of young Australians reveal that many suicide attempts or episodes of deliberate self-harm never come to medical attention, meaning that suicidal behaviour is likely to be far more common than official data suggests [4]. Victorian data shows that the number of Aboriginal persons presenting to EDs following intentional self-harm is significantly higher than the non-Aboriginal rate in all age groups⁵. The reasons behind the increases in youth suicide and deliberate self-harm overall are unclear; however, the increased rates of suicidal behaviour in young people may, at least in part, be related to increased rates of substance abuse [7].

1.2.4 Trends in methods of suicide

According to ABS statistics, death by hanging, strangulation or suffocation is the most common method of suicide in both men and women, followed by self-poisoning (Figure 2).

Figure 2: Methods of suicides registered in Victoria in 2006
(source: Australian Bureau of Statistics)



The decision around method of suicide is likely to reflect availability, familiarity with the method, technical skills and the level of planning required [5]. For example, higher firearm suicide rates have been found in rural areas, for both genders, whereas carbon monoxide poisoning, drugs and poisons are more frequently used in metropolitan areas [5,10]. Since the mid 1980s, the overall firearm suicide rate for Australian males has declined, falling more rapidly in urban areas and coinciding with tighter firearms legislation around the country. However, the hanging rate increased over the same period, particularly among young Australian males, and this may represent a shift in social and cultural attitudes [11,12].

⁵ Department of Human Services: Victorian Admitted Episodes Dataset, 18th edition. Available at <http://www.health.vic.gov.au/hdss/vaed/index.htm>

In addition to socio-cultural factors and access to means, there has also been some suggestion that the mental state of persons who attempt suicide may influence the method of violent self-harm they choose. Of people who commit suicide by jumping from heights, a greater proportion tend to be suffering from psychosis at the time than for other methods of suicide [8]. They are often single and unemployed. Those who use firearms, on the other hand, are more likely to be male, have alcohol use problems and may have an antisocial or borderline personality disorder.

1.2.5 Urban-rural differences

On a per population basis, rural and remote areas have consistently demonstrated greater suicide rates than urban areas, despite similar rates of reported psychiatric disorders [5,14–17]. Factors associated with rural living, such as rural socioeconomic decline, health service availability and accessibility, culture, community and individual attitudes to mental health and help seeking, and access to firearms, have been identified as contributing to higher rates of suicide [4,9–14]. Males aged 15 to 24 years, who reside in small rural communities, are at much greater risk of committing suicide than other age groups or females.

1.2.6 Ethnicity

There is believed to be substantial variation in suicide rates among various ethnic groups in Australia, though there is a paucity of reliable data related to this, and what exists is outdated. Suicide rates in specific groups may more closely mirror those of their countries of origin. People who come from countries with traditionally high rates of suicide have higher rates than the general Australian population, and those from countries with low rates of suicide repeat similar incidence levels [21–23]. This indicates that cultural, religious, social and other value or lifestyle systems and patterns of behaviours are likely to play important roles in either protecting or increasing risk factors associated with self-harm [15]. *The National Survey of Mental Health and Wellbeing (2007)* revealed that more than 60 per cent of the community with mental disorders fail to receive appropriate support. The problem of access to services may be more severe in ethnic minority groups.

Migration and pre-migration experiences can have profound effects on mental health. In people of culturally and linguistically diverse (CALD) backgrounds, a number of factors may be crucial to the mental health of individuals or ethnic communities. These include:

- pre-migration life and experiences (for example, in refugees who are torture and trauma survivors, a diagnosis of post-traumatic stress disorder (PTSD) is also linked with suicidal behaviour [16])
- the process of resettlement
- response to the stressors of the dominant culture
- reduced access to mental health services due to the language barrier, lack of information and the stigma attached to mental illness [17,18].

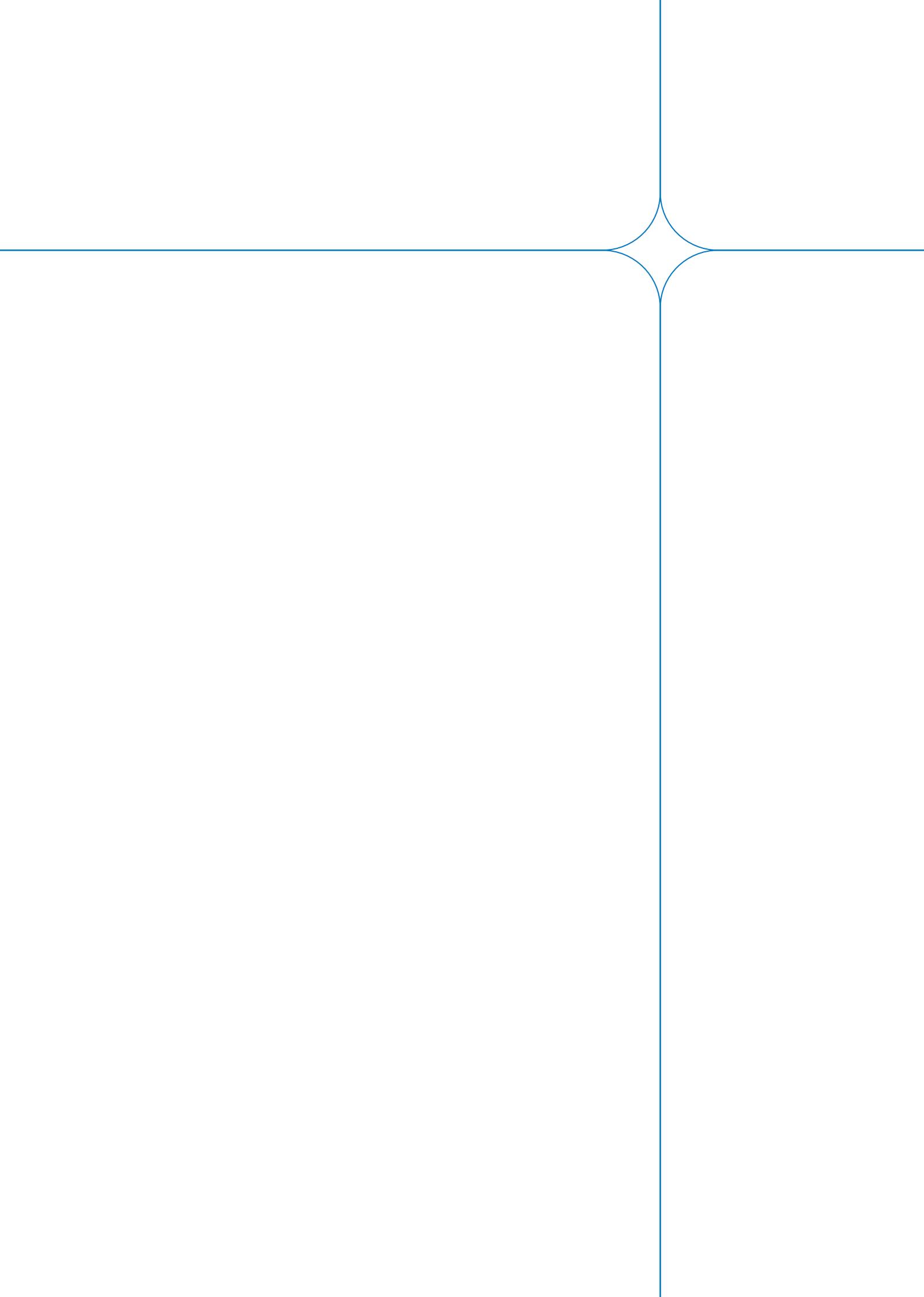
A marked increase in the relative rate of female suicides has been observed with immigrants [19].

In Indigenous communities, the incidence rate of suicide has increased since the 1970s and is estimated to be 40 per cent higher than in the general Australian community, a trend that has also been observed for Indigenous people of other countries [4,20,21]. Suicides predominantly occur among Indigenous males under 35 years of age and are much less common among Indigenous females. Suicide rates also vary substantially across Indigenous communities [7].

The problem of suicide by hanging is growing at a much higher rate in remote areas of Australia compared with other areas, and is a particular burden in the Indigenous population where the use of hanging by young Indigenous men accounts for more than 50 per cent of deaths [22,23].

1.2.7 The need for a clinical best practice guideline

Fortunately, many suicidal individuals appear to give some indication of their intention and so present opportunities for intervention, assessment and management. Studies have shown that in the days and weeks prior to the act of suicide, a number of people have commonly sought help from an array of service providers [24–27]. Consequently, telephone crisis services, EDs, inpatient and outpatient AMHS and primary care settings all hold the potential of reducing the suicide toll by improving internal practices and inter-agency collaboration [28–30]. For this to happen, staff must be trained to recognise individuals who are at imminent risk of suicide, and to deliver treatments that have been shown to reduce both attempted and completed suicides [31–35]. These evidence-based assessments and management must be combined with more-comprehensive risk management strategies.



2. Assessment of suicide risk

‘If mental health staff are to give up the culture of inevitability [of suicide], it is up to commentators outside clinical practice to give up the culture of blame’⁶.

2.1 Overview

Suicide is almost impossible to predict with any certainty, and because of the low base rate of suicide, there is no ‘test’ that is both sensitive enough to identify most people who will go on to kill themselves, and so accurate that it will not falsely predict suicide for many others. It is therefore unrealistic to expect services to prevent all suicides. At the same time, assessing the level of risk of suicide in an individual does not signify that the individual’s death is inevitable; this is a dangerous view that could prevent staff from making every effort to promote an individual’s safety.

Despite the high proportion of people with a psychiatric disorder among suicides (about 90 per cent), it is important to remember that suicidality is a fluctuating state that can be influenced by alcohol and drug use; personal events such as experiences of loss, separation and abandonment; and situational factors such as unemployment [7]. Such transient factors can complicate prediction of long-term risk of suicide. Risk factors may identify a group or population at risk of suicide, but it is important to note that, in isolation, they do not enable identification of suicidal individuals. What risk factors can do, however, is alert the clinician to take particular care in the assessment of an individual. 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/behaviour and current emotional state.

A person presenting to an ED may be completely unknown to the service, so greater effort and investment in a thorough assessment are required to ensure care is optimal.

2.2 Identifying those at risk

2.2.1 Evidence-based risk factors

In the realm of suicide research and clinical practice, there has been an increasing recognition of the factors that elevate suicide risk, which can be categorised as psychiatric (for example, major mental disorders), psychosocial (for example, adverse life situations) and sociodemographic (for example, male gender) risk factors [7]. Risk factors are not only important for identifying a person’s immediate risk of suicide, but are a particularly important consideration in any management decision; for example, in cases of domestic abuse, the suicide risk will not be mitigated by sending the consumer back to that environment without appropriate family intervention.

Major risk factors for suicidal behaviour are identified in **Table 1**.

⁶ Quote from *Avoidable deaths: five-year report of the national confidential inquiry into suicide and homicide by people with mental illness*. December 2006. The University of Manchester.

Table 1: Major risk factors for suicidal behaviour (listed in alphabetical order)

Individual risk factors for suicide	
Co-morbidity	People with mental illness often present with more than one psychiatric disorder [36–38]. For example, a person with bipolar disorder may have borderline personality disorder or may have a substance use problem [36]. Co morbid substance use disorders are common in persons with schizophrenia and increase suicidality in this cohort [39]. People with co morbidities are at significantly high risk for suicide.
Deliberate self-harm	DSH includes intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act. While it is accurate to say that not all persons who are hospitalised due to self-harm have attempted suicide, 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 [40–42]. Moreover, within five to 10 years, up to 7 per cent of self-harmers will die by suicide [43,44]. The more serious the level of suicidal intent at the time of self-harm, the greater the risk of subsequent suicide [45].
Hopelessness	A sense of hopelessness, desperation, demoralisation or emotional pain has been identified as a strong precipitant of eventual suicide [42,46].
Mental illness	Biological vulnerability to depression probably plays the greatest role in suicide attempts related to stressful situations [47]. Depression should not be ignored or discounted just because it appears that a suicidal act is a 'reaction' to unfortunate but commonplace life events. 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 certain mental health conditions such as substance use disorders, bipolar disorder, schizophrenia and anxiety disorders [3,37,38,40–42,46–52]. There is also a strong connection between suicidality and the experience of trauma. Suicide risk is elevated in those suffering from chronic PTSD [53,54].
Pain and physical illness	Pain associated with physical illness, especially in the elderly, is associated with increased suicide risk [55–57]. 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 [57].
People recently discharged from acute psychiatric care	Where people have been discharged from a psychiatric facility, the suicide risk in the first four weeks after discharge increases to 100 to 200 times greater than normal [24,58], and the risk remains for at least five to 10 years after last discharge [2]. Those with a history of suicide attempts and those with mood disorders are at particular risk of post-hospitalisation suicidal behaviour [59]. Particular care is advisable with persons admitted for self-harm, as this group has been shown to be a high risk of suicide both within hospital and within one year of discharge [60].
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 [61–63].

Individual risk factors for suicide	
Isolation/remoteness	Rurality, isolation and remoteness, and their associated factors such as socioeconomic decline, health service availability and accessibility, culture, community attitudes to mental health and help seeking, and access to firearms, have also been identified as contributing to higher rates of suicide [4,9–12]. Suicide rates of 15 to 24-year-old males living in remote Australia are close to twice those of males living in capital cities.
Previous suicide attempts	People who have made previous suicide attempts are significantly more at risk of further suicidal behaviour [42,46,48,64,65]. However, the absence of a history of suicide attempts should not be taken as diminishing risk. An estimated 60 to 70 per cent of those who complete suicide, do so on the first known attempt [66].
Stressful life events	Certain recent life events can precipitate suicidal behaviour, especially in combination with existing vulnerabilities. Stressful life events could include conflict in, or the loss of, a close relationship, job termination, rejection, failure, humiliation, poor health, retirement and financial stressors [3,40,49,67].
Family risk factors	
Childhood physical/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 [68,69].
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 [3].
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 5-fold) [3].

Adolescence

Adolescence is the most vulnerable period for those youths who make repeated suicide attempts. One survey found that 14 per cent of Australian children aged 4 to 17 years have mental health problems, and a high proportion of children and adolescents experience suicidal thinking and behaviour [70,71]. Suicidal thinking in adolescents should always be taken very seriously, as those who have a history of suicidal behaviour and ideation are at much greater risk of future death by suicide than their peers (Table 2)[70–73]. Approximately one-fifth of young people presenting to EDs with self-harm have self-harmed in the past, and a history of self-harm is a significant risk factor for suicide in this cohort [74]. Childhood sexual abuse is a common cause of depression and suicidality during adolescence and young adulthood [69]. There is also sufficient evidence to support potentially increased risk of emergent suicidal thoughts or behaviours with antidepressant use in youth, particularly during the first few months after commencing treatment [75–78].

Tip

Rather than dismiss intoxication in an adolescent as normal teen behaviour, place the emphasis of assessment on why the teenager is intoxicated and evaluation of any underlying depression or substance abuse, both well-established risk factors for suicide.

When treating suicidal behaviour in children or adolescents, clinicians should be mindful of their options and responsibilities under the *Children, Youth and Families Act 2005* to ensure the safety of the young person⁷.

Table 2: Risk factors for adolescent suicide

- Past or present mental illness (for example, mood and anxiety disorders, substance use disorders or both concurrently)
- Previous suicide attempt(s)
- Male gender
- Previous self-harm
- Social skills deficits
- Hostility, aggression and impulsivity
- Homosexuality/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

⁷ Under section 182 of the *Children, Youth and Families Act 2005*, registered medical practitioners and registered nurses must make a report to Child Protection if they believe on reasonable grounds that a child is in need of protection from physical injury or sexual abuse. Other health professionals should always make a report to Child Protection if they have reasonable grounds to believe that a child is in need of protection from physical injury or sexual abuse.

The elderly

In most industrialised nations, suicide rates in males aged over 75 are among the highest of any demographic, and suicidal behaviour in this cohort is undertaken with greater intent and lethality than in younger age groups [79]. Attempted suicide in the elderly is a very serious matter. Older people are more likely to live alone, so it is less likely that someone will be around to help them after a suicide attempt [80]. They are also frailer in general, so self-injurious acts are more likely to have lethal consequences.

Depression is highly prevalent in older Australians and often poorly recognised in elderly people presenting to EDs (Table 3), [81,82]. It is also the most significant risk factor for late-life suicide and suicide attempts [55,83,84]. Depression in late life often occurs in the context of physical impairment and medical illness, particularly cancer. These factors can erode the will to live. However, older adults have a tendency to minimise or underreport depressive or suicidal symptoms [85]. Instead, they are more likely to complain of somatic symptoms of depression, such as insomnia, weight loss, guilt feelings and pain.

- Lack of social supports is a significant factor in elderly suicide attempts and is to be investigated at each presentation [55]. Helpful questions that focus on social supports are listed below.
- In the past two weeks, has someone provided you with help, either by giving you a ride somewhere or helping you around the house?
- In the past two weeks, have others let you know they care about you?
- Do you have someone special you could call if you need help? Who?
- In general, how many people do you have that you feel close to and have contact with at least once a month?

Table 3: Risk factors for suicide in the elderly

- Depression
- Co-occurring depression and anxiety
- Limited social interaction
- Previous suicide attempt(s)
- Recent discharge from psychiatric hospitalisation (within 3 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/helpless, rigid, unable to sustain close relationships)
- Recent change in accommodation

2.2.2 Protective factors

Consideration of an individual's protective factors is as equally important as evaluating risk factors for suicide. Protective factors refer to personal and family supports and experiences that appear to reduce risks for suicide [42, 86]. During an interview with a person, it can be useful for the clinician to investigate some of the personal factors (see below) that may serve to protect a person against future suicide attempts [87,88].

Protective factors

- Family warmth, support and acceptance
- Community support and a strong cultural identity
- Pregnancy (self/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

In particular, reasons for living include anything that the person believes prevents them from attempting suicide, such as responsibility toward family, fear of social disapproval, moral objections to suicide, coping and survival skills, fear of suicide and so on [87,88].

↘ Recommendation

In addition to examining the person's reasons for wanting to die, examine reasons for living as part of the assessment of persons at risk for suicide. 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.

C

2.2.3 How to use risk factors

A suicide risk management plan must take into account fluctuations in the level of risk as circumstances change. Rather than relying solely on specific tools for risk assessment, the aim is to combine the evidence base for risk factors (as highlighted in Table 1) with individual assessment to form a structured clinical judgement [89].

It is useful to consider three *categories* of risk factors when forming your clinical judgement [89]:

1. **Static risk factors**, which are fixed and historical in nature, including:
 - history of self-harm
 - seriousness of previous suicide attempts
 - previous psychiatric hospitalisation
 - history of mental disorder
 - history of substance use disorder
 - personality disorder/traits (for example, introversion)
 - childhood physical or sexual abuse
 - family history of suicide
 - age, gender, marital status.
2. **Dynamic risk factors**, which fluctuate in duration and intensity, and are present for an unknown length of time, including:
 - suicidal ideation, communication and intent
 - hopelessness
 - active psychological symptoms
 - treatment adherence
 - substance use
 - psychiatric admission and discharge
 - psychosocial stress
 - problem-solving deficits
 - access to support and services
 - physical pain
3. **Future risk factors**, which can be anticipated to a certain degree, including:
 - access to preferred method of suicide
 - compliance with treatment
 - future service contact
 - future response to drug treatment
 - future response to psychosocial intervention
 - future stress.

By structuring a comprehensive risk assessment around static, dynamic and future risk factors, one can better develop a management plan.

↳ Tips

- Structured clinical judgement:
 - is based on the clinician's interview, mental state examination and collateral history
 - is informed by the clinician's intuition
 - takes into account fluctuations in the person's circumstances
 - accounts for static, dynamic and future risk factors
 - increases transparency in the decision-making process.
- Static risk factors may render a person at high risk of suicide throughout life
- Dynamic risk factors may change in response to treatment or may change suddenly, leading to unpredictable suicide
- Review management of people at risk of suicide in light of changing dynamic and future risk factors.

2.3 Triage of the suicidal person

2.3.1 Establish rapport

First contact with suicidal persons is particularly important, but often occurs in less than ideal circumstances such as a busy, pressured ED. Establishing rapport with a suicidal person can require considerable expertise and patience, as they readily perceive rejection [90]. They may also find the ED environment frightening, thus adding to their feeling of agitation, which may or may not be readily observable [29,91]. Interpersonal interaction creates a sense of caring for those who are suicidal, thereby enhancing a sense of connectedness to others. Taking into consideration the lack of privacy in the ED, triage staff can adjust their communication style to facilitate engagement, such as using open body language (for example, maintained but varied eye contact, leaning forward and lowering one's voice) [92].

It can be helpful for triage staff to indicate a wish to understand what is happening to that person and that time be afforded for them to do so [93]. If the person believes they can talk about suicide with relative privacy and without judgement, they may feel relieved and be more able to discuss what is happening to them.

Tip

Communicating with emotionally distraught people can be very challenging. Nevertheless, it is clinically important for triage staff and clinicians to be professionally empathic and to persevere with their questions.

Some suicidal persons may not verbalise a desire to commit suicide during the triage process, but may instead complain of feelings of hopelessness, depression, insomnia, loss of appetite or the desire for medication changes [35,40]. Triage staff must therefore be alert to signs that may indicate those most at risk for suicide.

It is also important to note that some persons at risk of suicide will require triage for both medical and mental health management. A clinical judgement will need to be made about the relative priorities for treatment and the need for concurrent or sequential management of the patient's needs. It is important to be alert to the underlying mental health needs of persons presenting with injuries or ailments indicative of suicidal ideation, such as recurrent physical complaints with no apparent origin or clinical pathology.

2.3.2 Collateral information and documentation

It is very important that all steps during the triage and observation of a suicidal person be accurately recorded. Information that is necessary for further comprehensive suicide risk assessment can be collected during triage. Documentation of both the person's behaviour and staff interventions is most effective if it is clear, concise, chronological, contains only objective information and ideally uses standardised forms for universal staff utilisation [35].

Collateral information, (information obtained from others), can be obtained from medical records, paramedics, police, caregivers or referring doctors, then documented and utilised by triage staff to determine the severity of the physical or mental condition. This information must then be passed on to the next attending clinician.

Ask friends or family members who accompany a person to the ED or mental health service to remain available to the assessing clinician as a source of collateral information pertinent to the assessment and the development of a management plan [34].

2.3.3 Initial risk assessment

As part of the triage of people with a suspected or actual suicide risk, an initial risk assessment is extremely important, as a significant number of all suicides occur following hospital attendances as a result of DSH [94].

Persons presenting to EDs in Victoria after a suicide attempt are commonly assessed by:

- the Australasian Triage Scale (ATS) with mental health descriptors⁸, and
- the Victorian Emergency Department Mental Health Triage Tool (VEDMHTT)⁹.

In addition, *Mental health care: Framework for emergency department services*¹⁰ provides a set of overarching guidelines encompassing the areas of service delivery and clinical care. The *Victorian Emergency Department Mental Health Triage Project Training Manual* provides assistance to guide nurses in the triaging of mental health presentations to the ED with descriptors of observed and reported behaviours to assist in allocating an appropriate triage scale. It is designed to be used in conjunction with the ATS.¹¹

Within community mental health settings, mental health triage is provided for all consumers and potential consumers at the first point of contact with AMHS. A state-wide Mental Health Triage Scale for use in community mental health services has been developed and is being implemented across all AMHS in 2010. The scale (not to be confused with the VEDMHTT discussed above) will promote a more-consistent and clinically appropriate response to consumers, carers and referrers seeking access to AMHS.

An initial, rapid suicide risk assessment conducted by triage staff at either EDs or AMHS includes [88]:

- duration of the suicidal ideation
- any history of previous suicide attempts
- recent help-seeking behaviours
- the existence of a suicide plan
- access to means to complete the plan.

8 Australian College of Emergency Medicine (2000). Guidelines for implementation of the Australasian Triage Scale in Emergency Departments. Available at http://www.acem.org.au/media/policies_and_guidelines/G24_Implementation__ATS.pdf

9 Available at <http://www.health.vic.gov.au/emergency/mental.htm>

10 Available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>

11 Available at <http://health.vic.gov.au/emergency/mental/htm>

Recommendations

Regardless of the process or scale used by triage staff for initial risk assessment, it is important to be able to answer these immediate questions:

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



Examples of interview questions that triage staff can ask when preparing a rapid suicide risk assessment are shown in the box below. The idea is to gradually lead the person through a series of questions that uncover information about past, current and future suicidal thoughts.

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**.*

* Adapted from *Working with the client who is suicidal: a tool for adult mental health and addiction services*. British Columbia Ministry of Health, 2007.

† Not all of these questions will apply in all cases.

All persons presenting to an ED are triaged as soon as possible and assigned a triage code, which determines maximum time to treatment. When a person is assessed at triage as being suicidal or self-injurious, time to treatment should be limited to within 10 minutes [95]. This means that they should be given a triage code of either one or two according to the Victorian ED mental health triage tool.

Following risk assessment, a triage clinician will place the person on a corresponding level of safety observation while waiting for a more-detailed psychosocial or comprehensive assessment from an ED clinician, consultant, psychiatry registrar or mental health clinician. An acutely suicidal person requires one-to-one supervision and urgent assessment. When the person has agreed to wait for further assessment without supervision, in the interests of their safety they should be encouraged to talk to an allocated clinician, should they begin to feel agitated and not want to wait, rather than leaving without notice.

Where a mental health triage assessment indicates that specialist mental health services are required (or may be required), a more comprehensive assessment is provided through the mental health service intake assessment. This assessment may result in referral to another organisation or treatment within the specialist mental health service.

2.4 Comprehensive suicide risk assessment

In some hospitals and EDs, specialist mental health service staff or the on-duty consultation-liaison psychiatrist or psychiatry registrar are available to undertake a comprehensive mental health and suicide risk assessment of the person identified as being at-risk of suicide. Where a crisis assessment and treatment (CAT) team is available locally, a referral can be made.

However, not all Victorian EDs have local access to mental health specialists. For EDs without specialist mental health clinicians on site, AMHS-based triage is available 24 hours a day to provide telephone advice and referral. Nevertheless, ED staff can carry out a detailed psychosocial assessment if they are suitably trained and supervision is available¹² [93]. ED clinicians should be aware of their own level of expertise and limitations in this area and seek the assistance of colleagues with appropriate referral as necessary [93].

↘ Recommendation

Health services are responsible for ensuring that ED clinicians are appropriately skilled and trained in making psychosocial assessments and know when and how to seek help from specialist services.



Key elements of the detailed suicide risk assessment are detailed below.

2.4.1 Assessment environment

Once the person has been triaged and a risk to self is identified, it is recommended they be actively managed in a safe environment while waiting for further assessment and/or clinical intervention. Ideally, the person will be taken to a room where observation can occur and where external stimuli are lessened. It is preferable to relocate the person to a quiet area with observation or supervision appropriate to the level of risk. The restriction of a person's liberty requires consideration of and respect for their human rights. The provisions of the Mental Health Act may be considered, but any action to restrict a person's liberty must be commensurate with the level of assessed risk. The least restrictive option must be utilised.

The setting should not allow access to means or objects which may be used by the person to harm themselves or others, for example, sharp objects, cords, plastic bags, glass items, string or other items that can be easily broken, thrown or transformed into items of destruction [35]. The person's access to any personal medications or implements with which to hurt themselves should be reviewed and rectified. Depending on the assessed level of risk, changing into a hospital gown, or the removal of items such as belts or shoelaces, should be negotiated with the person.

If the person is believed to be at imminent risk prior to assessment, **they should not be left alone**. Rather than relying on remote monitoring devices, the presence of a calming support person in the room will help to establish a sense of connectedness for the person at risk and reduce feelings of isolation. Local policies will provide useful guidelines for managing the safety of a person or staff.

¹² Section 2.2 in *Mental health care: Framework for emergency department services*. Victorian Government Department of Human Services. Available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>

2.4.2 History

Sufficient history needs to be obtained in order to establish the need for and urgency of referral to specialist mental health services. It is important to build up as comprehensive a picture as possible of the individual, including significant personal and family relationships, social history and other environmental issues relevant to the person. The goal is to identify the time and rapidity of the onset of the suicidal behaviour, as well as the events leading up to the presentation. By asking 'why now?' the clinician can gain an understanding of the crisis that overwhelmed the person's usual coping mechanisms and resulted in presentation at the ED or AMHS.

Information about the risk factors associated with a particular suicide attempt, such as past suicidality, current or prior alcohol and drug use, and family history of suicide, must be sought so that longitudinal management and follow up can be implemented. This makes a subsequent attempt less likely.

Useful enquiries could include:

- the circumstances in which previous attempts occurred
- whether the person sought help before an attempt
- the potential lethality of the method and the person's perception of lethality.

If the triage nurse has not already obtained collateral information, the clinician is advised to obtain records of previous management and medication, if applicable. Specifically, ask questions about current or recent prescription or non-prescription medications, as medication additions, subtractions, or changes in dosing frequently cause or contribute to mental state.

The primary obstacle to collecting reliable and valid information via the clinical interview is low engagement of the person in the assessment process. Evidence shows that a calm, objective and empathic approach by the interviewer encourages engagement [96,97].

↘ Recommendation

Engagement of the person is crucial:
Proven tools that can help the clinician develop a therapeutic relationship are:

- active listening
- validation of emotions.

D

2.4.3 Suicide risk assessment scales

For any given individual, risk factors can assist in the assessment, but are not predictive in themselves. While suicide risk assessment scales are no substitute for clinical judgement based on the history of the person, they may provide a structure for systematic enquiry about risk factors for repeated suicide attempts [88]. The risk factors outlined in **Table 1** should be taken into consideration. The unique characteristics of special populations such as Aboriginal and CALD groups, the young, the elderly and people with a dual diagnosis (see **Chapter 4**) deserve particular attention, as these characteristics may elevate risk for suicidality and influence prevention and management considerations.

↘ Recommendation

Risk factor checklists are not complete assessments in themselves but can help inform a management plan.

D

Some risk factors may fluctuate markedly in duration and intensity (for example, with acute anxiety symptoms), which means that the person needs to be assessed and evaluated each time they present.

Many services have developed their own risk assessment scales or proformas. It is essential that risk assessment scales are always used in the broader context of suicide risk assessment.

2.4.4 Assessing the reasons for the current attempt or ideation

Suicide does not have a simple cause. When trying to uncover which pragmatic reasons the person had for the suicide attempt, it is preferable to avoid challenging or direct questions that could be interpreted as critical. A person who is thinking about suicide is in crisis, and one way to reduce the anxiety that is causing this ideation is to acknowledge their feelings and encourage their expression [96,98]. Some clinicians might be concerned that asking about suicide will precipitate suicidal thoughts and acts; however, there is no evidence to support this concern. In fact, it has been suggested that suicidal individuals benefit from an opportunity to discuss their self-destructive ideas and feelings [99]. Furthermore, consultations with consumers who have either sought help after a suicide attempt or been taken to an ED by a third party, have revealed that they expect to be questioned about their suicidal thoughts and behaviours, and feel dissatisfied and disregarded when it does not occur.

'Even on my couple of attempts, when I went in [to the ED], no one talked about the fact that I had tried to commit suicide...Nobody discussed that I had attempted it.'

(Consumer A)

'Either the person that you're seeing as your mental health professional or people in the community...it's all hush, hush. It happens, and then no one says a word and you just sit there [in the ED]. It's almost surreal that you've just tried to commit suicide and no one talks about it.'

(Consumer B)

↳ Tip

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.

Empathic opening comments such as, 'Things seem to have got on top of you.' or 'You must have been pretty upset.' are often sufficient to allow a person to talk about their difficulties [93]. Alternatively, open-ended questions such as 'Can you tell me more about it?' may help build rapport and indicate a willingness to listen. More specific, closed-ended questions such as 'How long have you had these thoughts? Do you have a specific plan?' can follow later. Give special attention to feelings of hopelessness, helplessness, and excessive and seemingly misplaced guilt.

Reasons for living are also to be explored. A person's reasons for not having attempted suicide may provide valuable information in formulating a management plan. The American Psychiatric Association has published questions that may be helpful for the clinician making specific enquiries about aspects of suicidal behaviour¹³.

↳ Tip

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.

While it can be challenging for a clinician to listen to the despair of a suicidal person without interjecting and trying to prematurely resolve the problem, it is essential that the interviewer doesn't cut short the individual's expression of feelings. By doing so, there is a risk of the person feeling misunderstood or only half heard, and for vital information to subsequently be lost [96,98]. Active listening in this context is the ED clinician's tool to establish engagement and can be therapeutic in itself.

13 Available at <http://www.psychiatryonline.com/popup.aspx?alID=56178> Last accessed 26 July 2010.

↳ Recommendations

The following issues are important for the clinician to consider and evaluate when assessing suicidal ideation.

- What are the person's feelings about living and dying? Is there an absence of hope?
- Does/did the person feel alone and isolated?
- Have there been any preparations in anticipation of death, such as giving away possessions, making a will or saying goodbye to others?
- Has the person discussed their suicidal intent with others?
- Does the person have a plan?

If a suicide attempt has been made:

- What precipitating events led to the suicidal behaviour?
- Was the suicidal behaviour premeditated or impulsive?
- Has the person sought help during or after the attempt?
- What was the understanding and expectation of the person about the potential lethality of their actions?
- Did the person try to avoid discovery during the attempt?
- Was the behaviour timed so that intervention was unlikely?
- What is the person's own assessment of reasons for living?

D

↳ Tip

Lack of suicidal thoughts while in the hospital or mental health service does not mean lower outpatient risk. Regardless of what the person says or does during a presentation, a clinician may have a 'gut feeling' that the person is going to commit suicide. Such feelings should not be ignored, as they are part of intuitive clinical judgement and an integral part of suicide assessment and management.

2.4.5 Assessing intoxicated persons

The risk of a suicide attempt should not be dismissed because a person is intoxicated. Many impulsive suicidal acts or acts of deliberate self-harm occur in association with alcohol or drug consumption, since both impair judgement and foster impulsivity and aggression, or indirectly worsen symptoms of a coexisting mental illness [100,101]. Intoxication can result in a lack of inhibition or have a depressant effect on the central nervous system, and may increase the risk of harm to self and others and exacerbate the risk of suicide. Suicide attempts that involve alcohol are more likely to be impulsive; however, alcohol or drug intoxication may also be a component of a more-serious suicide plan.

Co-occurrence of substance use disorder (be it alcohol, tobacco or other drugs) and mental illness, often referred to as a **dual diagnosis**, is much more widespread than is commonly understood. It is estimated that up to three-quarters of people with a mental illness will also have a substance use problem, and vice versa [39,102–106]. Many people who abuse drugs and alcohol may have an underlying mental health condition such as depression, post-traumatic stress disorder or schizophrenia, and may present with anxiety or panic attacks [107,108]. Overall, having a mental illness appears to quadruple the chance of being diagnosed with a substance use disorder [103].

Not surprisingly, individuals who have a dual diagnosis of psychiatric disorder (particularly mood disorders such as depression and bipolar disorder) and substance abuse are at particularly high risk for suicide [105,109–112]. People with a dual diagnosis often experience deprived social support and personal losses, and have access to lethal means of self-harm.

Coronial findings have emphasised the importance of mental state assessment in the presence of alcohol or drug intoxication. While acute alcohol intoxication may impair the ability to conduct a valid psychiatric assessment of an individual, there is no evidence-based data to support a specific blood alcohol concentration at which the individual will regain adequate decision-making capabilities [113]. Furthermore, there is no evidence to support delaying the initiation of the suicide risk assessment or mental health evaluation until the person is more alert. If a mental health assessment is postponed because the person is intoxicated, this can result in long delays from referral to review by mental health services, or even a failure to assess the person [3,114–116]. This also leaves the person at risk of further attempts.

Waiting to do the assessment until the person is less intoxicated or sober may also result in valuable clinical information being lost. For example, while questions about depression are standard practice, in most people, the criteria for major depressive disorder are not met if the person is interviewed when he or she is less intoxicated and psychiatric symptoms have diminished [113]. Given the prevalence of dual diagnoses, it is important to systematically rule out the presence of a comorbid depressive disorder and not simply assume that depressive symptoms result from alcohol use.

↳ Tips

- The disinhibition resulting from intoxication can facilitate suicidal ideas and impulsive suicidal actions. A person may be quite suicidal while drinking and less so when sober.
- It is worth assessing the degree of substance use, as it may be important in suicides among individuals with no previous history of mental illness [112].
- Mental illness may be covered up or masked by drug use, or alternatively, drug use or withdrawal from drugs can mimic or give the appearance of some psychiatric illnesses, thus complicating the diagnostic process [117, 118].
- Misuse of prescription drugs can produce symptoms of intoxication [39].

The Chief Psychiatrist's guideline for the *Assessment of Intoxicated Persons*¹⁴ states that 'When a request for assessment is received, it is not appropriate to insist that the person be free from the effects of alcohol and/or drugs. This includes requests by police for assessment of persons held in police cells when there is a concern that mental illness or risk of suicide is present in a person who is also intoxicated. The coexistence of intoxication does not prevent assessment by CAT services. This is emphasised in the Key Service Requirements for Enhanced (CAT) Services and applies to the assessment of suicide risk and general mental state assessment.' (Department of Human Services, 1999).

Tip

Following initial consultation, giving feedback to the referrer (for example, the police officer who brought the individual to the ED) may elicit more information from them than was forthcoming at triage. The newly developed police transfer form will help facilitate this exchange.

Recommendations

- Alcohol and/or drug intoxication does not preclude early assessment for suicide risk, although it may indicate the need for more comprehensive assessment when the person is no longer intoxicated. D
- Clinicians should commence their assessments based on the person's cognitive abilities, rather than a specific blood alcohol level. D
- The person's safety is paramount in cases of threatened suicide, as intoxication significantly increases risk of self-injury in the short term. Provision of a safe detoxification area is necessary until a proper assessment of suicide potential can be conducted. C
- Given the high prevalence of dual diagnosis, try to assess all consumers for substance use (how often, how much and how recently), previous psychiatric history and medications. C
- Be aware that people tend to under-report their substance use, and wherever possible, obtain collateral history from a family member, partner or friend. C
- Psychiatric and substance use disorders are regarded as primary disorders when they coexist, each requiring thorough and immediate assessment and diagnosis.

¹⁴ *Assessment of Intoxicated Persons* is available at <http://www.health.vic.gov.au/mentalhealth/cpg/intoxicated.htm>

2.4.6 The calm before the storm

'Sometimes people will plan a suicide attempt, and they think, "Oh, look, in a couple of days' time I'm going to do it" and between then and the time you sort of go into a lull...'

(Consumer C)

'And that's why people often aren't identified that they're going to do it. They've sort of programmed themselves, "I'm going to do it then and in the meantime I'm gonna just lay back and feel okay".'

(Consumer D)

Sometimes a person may deny their suicidality while waiting in the ED for an assessment. They may suddenly appear much calmer. The inherent risk in this situation is that the person may have decided to carry out a suicide plan and wants to avoid detection [34]. In this case, it is important to look at the seriousness of the suicidal behaviour; if it was of moderate intent and with some degree of planning, it is best to assume the suicidal crisis is not over, despite the apparent resolution of distress. The fact that the person presented to an ED means that there is a risk of suicide, which continues for some time [40].

📌 Recommendation

Suicide risk is by nature dynamic. Consider referral to a specialist mental health service even if the acute risk appears to have subsided.



2.4.7 Involving family and friends in the assessment

Other people may be able to provide vital information regarding the person's pattern of behaviour. Information obtained from individuals who are suicidal and in chaotic circumstances may be unreliable, and their insight and judgement can be compromised. This can impede risk assessment and heighten the need to seek information from other sources, known as collateral information.

Whether they have accompanied the person to the ED or are available by telephone, family or friends may be able to offer crucial information about the person's history, present condition, circumstances relevant to the attempt or their baseline functioning [66].

Families and carers play vital roles in safeguarding and improving the health and wellbeing of the people they care for. In assessing a person's risk of suicide, the perspectives of family and friends can be crucial to reaching a decision about current risk status.

The canvassing of collateral information and the disclosure of health information are quite different matters. Generally speaking, it is important to the engagement of the person concerned that they agree to the involvement of family and friends before their perspectives in relation to risk of suicide are canvassed. However, it is important to acknowledge that this information is being sought for the purpose of providing appropriate treatment and care to that person and ensuring their safety. The pursuit of appropriate collateral information is a legitimate part of a clinical assessment.

In the case of suicidal behaviour, the seriousness of the risk indicates broader enquiry into the person's living and family circumstances than might otherwise be appropriate. Collection of information from the person's family or other service providers is governed by the *Health Records Act 2001*, and the Health Privacy Principles (HPP) apply, specifically HPP1, which relates to consent, and the need to collect information to prevent or lessen a serious and imminent threat to the life of any individual. It also covers the relevant confidentiality aspects. *Confidentiality under the Mental Health Act 1986* is a program management circular detailing consideration of this and related matters¹⁵.

Informed consent should always be sought for the disclosure of a person's health information. Where a person has refused to provide consent, discussion should take place to determine whether there is someone else the person would prefer the treating clinician to contact.

On the other hand, the disclosure of a person's health information to a third party (for example, that the person is in the ED following a suicide attempt) requires the person's consent wherever reasonable and practical, and this is governed by Section 120A of the *Mental Health Act 1986*. Generally speaking, the disclosure of personal information should be in the best interests of the consumer, and the treating clinician must balance the need for disclosure with the right to privacy in the best interests of the consumer.

↳ Tip

The collection, use and disclosure of personal information about a patient is treated as health information for the purposes of the Health Privacy Principles (HPP) contained in Schedule 1 to the Health Records Act 2001. 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.

15 Available at <http://www.health.vic.gov.au/mentalhealth/pmc/confidentiality.htm>

2.4.8 Language barriers and use of interpreters

Language can be a major barrier to assessment and intervention. Assessment and management processes cannot occur without meaningful communication. The unique cultural challenges associated with suicide cannot be adequately addressed unless they are well understood. Language relates to much more than words, so any interpretations provided of the person's perspective must include the cultural concepts and ideas associated with suicide in a way that captures the person's view of the world.

Where a person has a limited grasp of English, a trained interpreter can be used to ensure a meaning-oriented translation and to avoid errors of omission. An interpreter may help ensure clarity of speech and thoughtfulness about use of language. In addition, an interpreter can provide the clinician with important cultural, social and contextual information that is pivotal to the psychological issue being discussed [119]. Given that individuals from different cultures may have different views of mental illness, their views of treating mental illness and suicidality may also vary from mainstream culture [120–122]. To protect the person's confidentiality and avoid causing the person any shame or embarrassment associated with an attempted suicide, the use of family or friends as interpreters is contraindicated [119].

Working with interpreters can be challenging and time consuming for those unfamiliar with the process. The Victorian Transcultural Psychiatry Unit (VTPU) has published an online manual *Working with Interpreters: Guidelines for Mental Health Professionals* to assist mental health professionals in working with persons from CALD backgrounds. Moreover, Tribe and Lane (2009) [119] have written a useful practice guideline that can be adapted by mental health services to improve clinical service provision when using interpreters.

↘ Recommendation

To protect the person's confidentiality, the use of family or friends as interpreters is contraindicated. Engaging a professional interpreter ensures that family dynamics do not influence the interpretation.

D

↘ Tips

- 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** (<http://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 http://www.vtpu.org.au/docs/interpreter_guidelines.pdf
- A directory of *Bilingual Mental Health Professionals* is available online at <http://www.vtpu.org.au/resources/bilingualdirectory.html>

2.4.9 Mental state examination

A mental state examination (MSE) is an integral part of the suicide risk assessment conducted by mental health clinicians, and is to be conducted concurrently with the detailed assessment interview [34,123]. An MSE collates information about the person's **physical, emotional** and **cognitive state**. An MSE interview will note the onset or recurrence of symptoms suggestive of a psychiatric disorder, particularly major depression and substance abuse.

In Victoria, several MSE tools are in use and there is no agreed or mandated MSE template for the state.

The main areas of enquiry in the MSE are listed in **Table 4**, with reference to mental states relevant to suicidal behaviour. Note that a full MSE should be conducted according to each service's protocol.

Table 4: Mental state examination (MSE): factors to consider when assessing suicide risk*

Physical	
Appearance and general behaviour	This provides a summary of the person's presentation that may suggest their mood, illness and ability to take care of themselves. What is the person doing and wearing, what is their general hygiene and posture, and how does the person look? How is the person behaving and how do they appear? Is the person obviously distressed, markedly anxious or highly aroused? Look for grooming that might be suggestive of a mood state or disorganisation (dishevelled, unkempt, or inappropriately dressed).
Motor activity	This describes both the quality and the types of internally driven behaviours observed, such as overall level of movement (psychomotor retardation or agitation), slowed movement (bradykinesia), decreased movement (hypokinesia), absence of movement (akinesia), or tremor. A person who is suicidal may be agitated, or exhibit slowing of movements, speech and thoughts.
Emotional	
Attitude/demeanour	Identifiers may be whether the person is closed, guarded or suspicious, the degree of cooperation and attentiveness, level of eye contact and tone of voice. A person who is suicidal may be distrusting or disengaged, and unwilling to disclose painful material.
Mood and affect	<p>Mood is a sustained emotion that the person is experiencing over several days or weeks. It requires the clinician to depend upon the person's introspections and their subjective experience. Descriptors, which may be observable or articulated, include depressed or euphoric mood, agitation, irritability, suspiciousness, and fear. Stability of mood can also be noted, with alternation between extreme emotional states being referred to as emotional lability.</p> <p>A person's affect is the predominant emotion observed during the course of an interview. The range, intensity and variability of affect can be described using the following terms: exaggerated (fully animated or overly strong emotional reaction), euthymic (normal), restricted (limited emotional range and intensity), blunted (minimal variation) or flat (absence of emotional expression).</p>

Cognitive	
Speech and language	<p>Speech can be described in terms of volume, rate, idiosyncratic symbols or other odd speech and tone (include any accent or stuttering).</p> <p>Language includes naming objects, repeating phrases and performance of commands, as well as reading, writing and comprehension.</p>
Disorders of perception	<p>A clinician needs to ask about hallucinations, including whether there are command-type hallucinations. The enquiry needs to be expanded to include what the person will do in response to these command hallucinations, particularly those linked with dying or delusional beliefs. Does the person feel controlled or influenced by external forces, or distracted by internal stimuli? Perception can also refer to other perceptual disturbances (derealisation; depersonalisation; heightened/dulled perception).</p>
Thought form or process	<p>This refers to the organisation of a person's thoughts (logical/linear, circumstantial, tangential, flight of ideas, racing, loose associations, derailment, poverty of thought or thought blocking). The person may show a loosening of associations, where the logical connections between thoughts are esoteric or bizarre. Is the person displaying a high level of disturbed behaviour that suggests psychosis and/or immediate (within the next few minutes or hours) risk?</p>
Thought content	<p>What are the basic themes preoccupying the person; e.g. suicidal or homicidal ideation, paranoia, persecutory thoughts, delusions, ideas of reference, obsessions, compulsions? If there is suicidal or homicidal ideation, is there a plan, intent? Has the person begun to give away possessions or prepare a will? Content of thought also relates to amount of thought and rate of production, continuity of ideas.</p> <p>Delusional ideation needs to be assessed in relation to content and actions that a person believes they are required to perform which may place them at risk of harm to self or others. By knowing content, we can then assess risk. There must be careful discernment and assessment as to whether the thought content is an over-valued idea or delusions.</p>
Insight and judgment	<p>How much is the person aware of their illness and/or need for treatment/hospitalisation? A strong lack of insight can be an important indicator of unwillingness to accept treatment. It also refers to an awareness of the nature and extent of the problem, the effects of their problem on others and how it is a departure from normal. The ability to make sound decisions can be compromised for a number of reasons. Judgment is best determined by history of patterns of behaviour and current attitude.</p>
Memory, orientation, intelligence, attention and concentration	<p>Is the person oriented and coherent? Are attention, concentration and memory intact? Is the person able to focus their cognitive processes upon a given target?</p>

* Adapted from *Foundations of Clinical Psychiatry*, 2007, 3rd ed. Sidney Bloch, Bruce S Singh, editors. Melbourne University Press, Melbourne.

↳ Tip

Certain 'at-risk' mental states that alert the clinician to a greater likelihood of suicide include the expression of hopelessness, despair, agitation, shame, anger, guilt, humiliation or abandonment [34, 123].

2.4.10 Involving a mental health service

As mental illness often underlies suicidal behaviour, a suicide risk assessment should always be followed up with a psychiatric assessment. Following triage and initial risk assessment in the ED, referrals can be made to the local AMHS for a comprehensive mental health status examination and psychiatric assessment for people who present:

- after a suicide attempt or episode of self-harm
- with probable mental illness or dual diagnosis
- after recent discharge from a psychiatric inpatient unit
- with probable suicidal behaviour and who are adolescent or elderly
- following repeat presentations for somatic symptoms [124].

Some people who present to EDs may be chronically suicidal and known to a mental health service. In such cases, notify the relevant AMHS by phone and consult them regarding the person's management plan and appropriate further action.

↳ Tips

Principles of effective referral pathways between EDs and AMHS

- Establish criteria for referral and discharge between EDs and AMHS.
- Develop crisis care plans with agreed contact points for frequent attendees and ensure the plans are available between services.
- Establish or join inter-professional and multi-agency education, e.g. suicide risk assessment and management.
- Rotate staff between services for cross-educational purposes and relationship building.
- Keep robust records.
- Carry out regular audits

2.4.11 Documentation

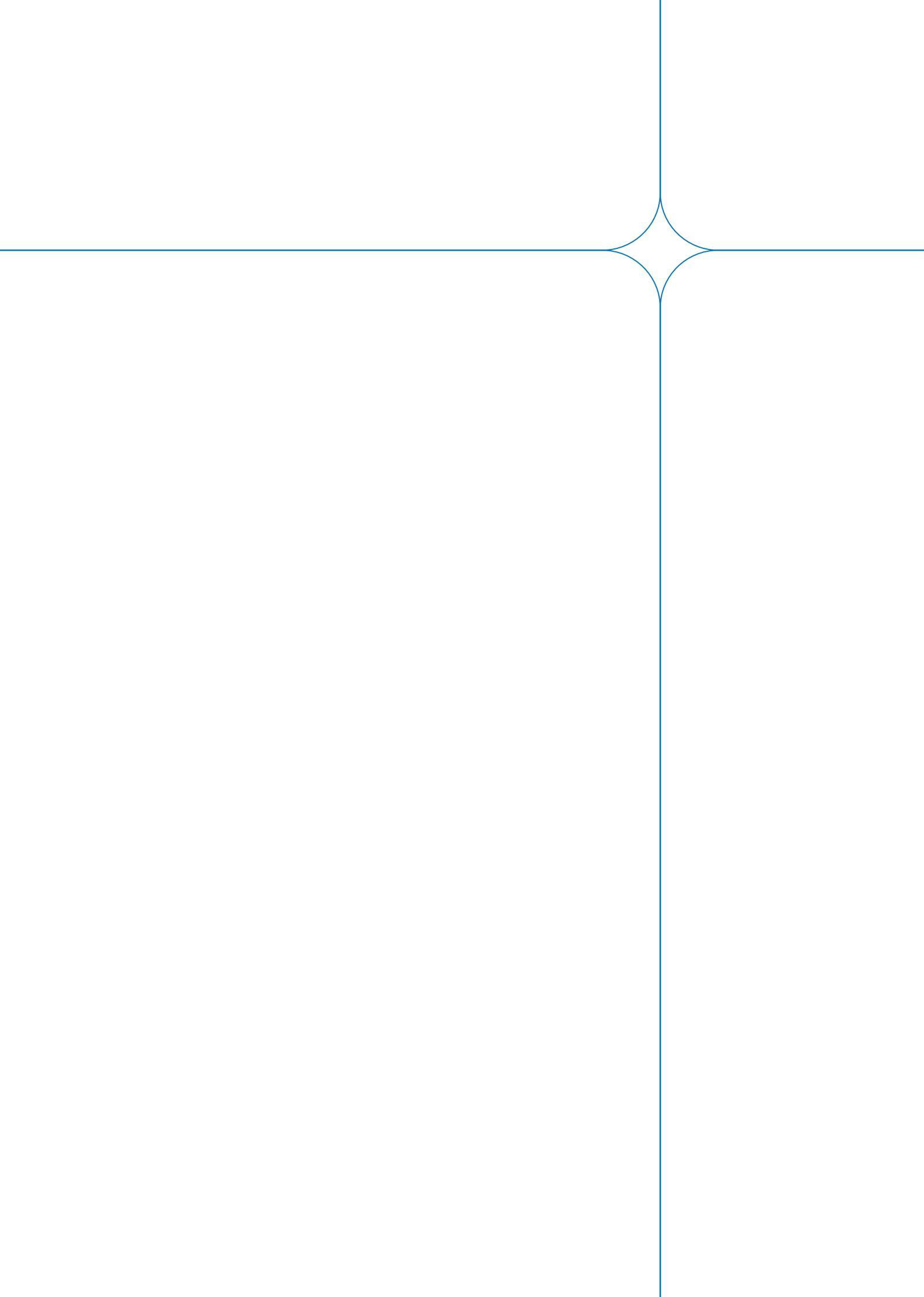
Careful and detailed record keeping is an important part of all clinical work, but is particularly relevant in the active, crisis-oriented assessment and management of people who are suicidal [125]. Documentation includes evidence of a suicide risk assessment, the decisions made based on documented risks, a plan of action to address those risks in a timely fashion, and evidence of consultation that supports this plan of action. Collateral contacts should also be documented, as well as any efforts to obtain ancillary information from them.

Evidence suggests that aftercare is improved by timely contact with primary care providers [126,127]. To facilitate this, provide a detailed record of contact with the person's primary care provider in a timeframe commensurate with the assessed level of risk.

↳ Tips

Suggested strategies for working with the suicidal person.

1. **Empathise with the person** – they are experiencing a crisis and stress, hopelessness and helplessness.
2. **Complete assessments take time** – sufficient time is not always available for ED presentations; at a minimum, assess intent, means, plan and presence of depression or psychosis.
3. **Evaluate risk** – intent, means and plan.
4. **Check for psychiatric medication** – especially antidepressants for adolescents.
5. **Consult** – ideally with a mental health team or more-experienced colleague. This allows for another opinion, better care, and helps you articulate your course of action.
6. **Formal referral** – to the mental health service where indicated.
7. **Document** – every action taken, every person you talk to.
8. **Talk to the family or significant other/s** – the family, friend or partner who keeps an eye on the person should be told who to contact for help in an emergency. Family members can also take an active role in removing means of suicide from the home.
9. **Recognise the unique characteristics of people with complex needs** – these may elevate risk for suicidality and/or impact prevention, and management considerations.
10. **Counter-transference** – carefully monitor and respond to your own reactions as they may interfere with the assessment or management of a suicidal person (particularly for people who are chronically suicidal).
11. **Hospitalisation** – for intense assessment or more direct supervision and care may be the best option, particularly when there is no family support, or in cases of mental illness, with substance use or impulsiveness. Be aware that family and friends cannot provide monitoring or protection comparable to that of a hospital or similar facility, and that the person may not want to be with family at this time.



3. Management of suicide risk

The previous chapter focused on the initial assessment of risk conducted in the ED. 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 off site. The method of consultation between services will vary depending on available resources (for example, telephone contact in rural areas or face-to-face with CAT or ECAT team members).

3.1 Immediate management in the ED

3.1.1 Assigning a level of risk

Outpatient management is feasible for people with suicidal ideation assessed as being at either mild or moderate suicide risk [66].

The risk assessment guidelines presented in **Table 5** can assist clinicians in assigning a level of suicide risk following comprehensive assessment, and thus influence the management plan for the individual.

3.1.2 Environmental assessment

Evaluation of the person’s home and social environment is as important as the evaluation of the person. Enquire about social supports (including individuals, organisations and activities) because they may be necessary in planning a safe clinical intervention. Identify potential stressors, as well as gaps in support or resources in the person’s environment. This assessment provides a description of the person’s ability to access their support system. It should also reflect whether the person has access to lethal means and, if so, what they are, as well as what efforts have been made to remove them [125].

Table 5: Risk assessment guidelines
(NOTE: this table is to be used in conjunction with clinical judgement)[†]

Issue	Mild	Moderate	High
Ideation	Periodic intense thoughts of death or not wanting to live, that last a short while.	Frequent, intense thoughts of death and/or wanting to die, which are often difficult to overcome.	Intense thoughts of death or wanting to die, which seem impossible to get rid of.
Plan	No immediate suicide plan. No threats. Does not want to die.	Not sure when, but soon. Indirect threats. Ambivalent about dying.	Has imminent date/time in mind. Clear threats. Doesn’t want to live. Wants to die.
Method/lethality	Means available, unrealistic or not thought through. No precautions against discovery. Possibly timed so that intervention is probable.	Lethality of method is variable with some likelihood of rescue or intervention. Passive precautions, e.g. avoiding others, but doing nothing about preventing intervention (alone in room, door unlocked).	Lethal, available method. Active prevention, such as locking doors. Timed so that intervention is highly unlikely.

Issue	Mild	Moderate	High
Emotional state or mood	Sad, cries easily, irritable. Mild emotional hurt.	Pattern of up-and-down mood swings. Rarely expresses feelings. Moderate anger and hostility. Some symptoms of psychosis. Moderately intense emotional distress.	No vitality. Emotional turmoil (angry, hostile). Unbearable emotional distress or despair. Feels rejected, unconnected and without support. Severe depression or psychosis.
Support/connectedness/protective factors	Person is accepting help. Feels cared for by family, peers and/or significant others. Support persons are willing/capable of helping.	Person is ambivalent about receiving help. Minimal or fragile support. Moderate conflict with family, peers and/or significant others. Supports are unable or unwilling to provide help consistently.	Person is socially isolated. Person is refusing help. Intense conflict with family, peers and/or significant others. Supports unable or unwilling to protect or monitor the person. Abuse/violence in the home.
Previous attempt(s)	None.	Previous attempts. Some suicidal behaviour.	Previous attempts with lethal intent. Note that any previous attempt in the elderly is significant.
Reason to live/hope	Feels hopeful about the future. Wants things to change. Person has some future plans.	Pessimistic. Vague, negative future plans.	Feels hopeless, helpless and powerless. Sees future as meaningless, empty. Recent medical care (e.g. serious health problems, recent diagnosis).
Collateral history	Able to access or verify information. Person's account of events is considered plausible.	Access to only some information. Some doubts about plausibility of account of events.	Unable to access or verify information, particularly where the person refuses that clinician talk to any family, friends or carers. Conflicting account of events to those of the person at risk.
Substance use disorder	Nil or infrequent use of substances.	Risk of intoxication, abuse or dependence.	Current substance use, abuse or dependence.

Issue	Mild	Moderate	High
Suggested actions	<ul style="list-style-type: none"> • Gather collateral history • During regular hours at an ED, refer for non-urgent contact with a mental health team, ideally within 72 hours of presentation, or when uncertain, escalate to on-call mental health clinician • Out-of-hours, ED staff can seek advice from on-call mental health staff • Usually won't require admission • Family/carer information for post-discharge care, and psycho education • Follow-up plan documented and communicated to the person and significant others • If the person is not currently linked to an AMHS, ensure they are linked to a GP or psychiatrist prior to discharge • Aim for reassessment by mental health clinician within 1 month, or if discharged from an inpatient psychiatric unit, within 7 days • Regular review by mental health team 	<ul style="list-style-type: none"> • Gather collateral history • Face-to-face mental health assessment within 24 hours (physical condition permitting) • Some people (those still intoxicated or with borderline personality disorder) may require short-term admission (24 hrs) to an ED observation ward or other suitable short-stay unit, awaiting a mental health assessment or until safe discharge can be arranged • Family/carer information for post-discharge care, and psycho education • Follow-up plan documented and communicated to the person and significant others • If person is currently known to mental health services, inform the relevant team of their attendance • Mental health team follow up all people within 48 hours of discharge, where possible • Mental health clinicians to re-assess risk within 7 days • Regular review by mental health team 	<ul style="list-style-type: none"> • Gather collateral history • Inform security personnel and police if person leaves without assessment • Will require one-to-one nursing contact until completion of mental health assessment • Family/carer information and psycho education • Follow-up plan documented and communicated to the person and significant others • All reasonable attempts should be made to prevent the person from leaving prior to an assessment • Consider admission to the appropriate inpatient service for urgent psychiatric consultation • Mental health reassessment required before discharge can be arranged • On discharge, a mental health team provides rigorous and long-term follow-up • Mental health clinicians to re-assess risk within 24 hrs, where possible

† Adapted from *Guidelines for the management of deliberate self-harm in young people*. ACEM 2000; Beck Suicide Intent Scale[128]; *Working with the client who is suicidal: a tool for adult mental health and addiction services*. British Columbia Ministry of Health, 2007; *Suicide Risk Assessment and Management: Emergency Department*. NSW Health 2004; *Suicide Risk Assessment and Management Protocols: Community Mental Health Service*, NSW Health 2004; and Patel AS et al.[129]

3.2 Subsequent management

3.2.1 Inpatient management

When a person is dangerously suicidal and has severe psychiatric illness, marked suicidal ideation and inadequate social supports, hospitalisation and close supervision are clearly indicated [31]. However, it is important to remember that hospitalisation does not necessarily prevent suicide. Suicides do occur in hospitals and during day leave and abscondments [31,130–133]. Nevertheless, hospitalisation is a necessary part of management when greater control over a patient's life and environment than can be managed as an outpatient is indicated.

Involuntary hospitalisation under the *Mental Health Act 1986* may be necessary. However, it may create barriers to effective management through the person resisting forming or maintaining a therapeutic alliance [66]. The decision to hospitalise should reflect consideration of these criteria and be well documented [98].

A person who is hospitalised because of imminent suicide risk should be continuously monitored. Vigilance through direct observation and supervision by a calming support person is necessary to prevent possible suicide attempts by newly admitted patients [58]. Depending on the acuity of the risk, the level of supervision may range from management in a high-dependency area or one-to-one continuous observation, to the use of mechanical restraint or seclusion when risk is imminent and cannot be managed in a less-restrictive way [66].

When a person is identified as needing admission as an inpatient but no bed is available, refer to your service's escalation policy to resolve the delay in accessing an inpatient bed¹⁶.

A threshold issue in considering options for appropriate treatment and care is to establish whether the person is subject to an order under the *Mental Health Act 1986*. If this is the case, 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 appropriate and a 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*. However, in cases of this type, 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, and should contact family and friends so that they can provide informed ongoing support.

¹⁶ Section 2.4 in *Mental health care: Framework for emergency department services*. Victorian Government Department of Human Services (available at <http://www.health.vic.gov.au/mentalhealth/emergency/framework.htm>) and Chief Psychiatrist's guideline, *Access to beds* (available at <http://www.health.vic.gov.au/mentalhealth/cpg/beds.htm>)

3.2.2 Treatment plan for outpatient management

Section 19A of the Mental Health Act requires all patients treated under the Act to have a treatment plan. Although this requirement relates only to involuntary patients, 6A(j) of the Act envisages that all consumers will have a treatment plan that is regularly reviewed and revised as necessary. This position is consistent with the National Standards for Mental Health Services.

Where a decision has been made for the AMHS to manage a person on an outpatient basis, either by CATT or through case management, there must be a written treatment plan derived from the assessment **to which the person has agreed**. This should include a written crisis plan developed by the treating clinician or treatment team 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 [125]. Check if there is an existing treatment plan before proceeding to develop one. A copy of the crisis plan component of the treatment plan should be retained by Mental Health Triage, the CATT team and the person themselves.

↳ Tips

What to include in a crisis plan [134]:

1. **Warning signs** of a suicidal crisis specific to that individual, such as increased depression, hopelessness or negative thinking, withdrawal, increased organisation of personal affairs
2. **Coping and problem solving skills** that the individual can perform on his or her own
3. **Therapist or GP's** contact information
4. **Phone numbers** of emergency services and hotlines available 24 hrs daily
5. **Contacts for family members and significant others to use** in times of crisis

When making a decision to actively involve the person's significant others in the outpatient management strategy, the clinician must work with the person to decide which members of their support system will be helpful (willing and able to help), neutral (perhaps willing to support, but may be uninformed or unsure of how to help), or harmful (exhausted by the person's behaviour, hostile or blaming) [125]. Be aware that family members may appear fatigued and helpless, particularly when there is a history of suicidality. Educating the family about what might trigger suicidal behaviour, or how to identify when the risk level has changed for an individual, can be beneficial for both the family and the suicidal person by improving support and understanding of their difficulties.

If appropriate, obtain consent to limited communication with family members, with explicit agreement not to discuss areas that the person wishes to remain private.

Management of both alcohol or drug problems and mental illness requires individualised intervention, provided simultaneously and preferably in a single-treatment program or by a single provider [39]. It is wise to anticipate difficulties with engagement in and adherence to medical care in people with a dual diagnosis. Augmenting treatment with case management, even if only in the short term, can improve adherence to treatment and mental health treatment outcomes, and reduce fragmentation of care. It is most valuable during vulnerable periods [117]. Ensure that the treatment plan addresses the possibility of either substance use or mental health relapse in discussion with the person.

Adolescents who are considered to be at mild risk of future suicide, and who have strong supervision and support in the home by adults who are well informed of the issues, may be considered for outpatient management [73,135]. A clear evaluation, treatment and follow-up plan is necessary before discharge from the ED or AMHS. Schedule follow-up appointments and make the young person and their family aware of 24-hour crisis services [73,135].

↘ Recommendations

- No patient with suicidal ideation/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, AMHS triage is available 24 hours a day to provide telephone advice.
- Community management by an AMHS is not appropriate if the risk of suicide is assessed to be high (high lethality and intent), or there is a lack of social supports. 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 and/or significant others with written information regarding available community support resources (for example, helplines, AMHS 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, social networks
- Educate the person and their family about strategies for dealing with symptoms and distress (problem solving and coping skills)
- Provide instruction for 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 (e.g. 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.



3.2.3 Referral of people from culturally and linguistically diverse (CALD) backgrounds

Studies have suggested that people from CALD backgrounds are accessing specialist mental health services at a lower rate than the Australian-born population [18,19]. Family members and close friends play a key role in a person's health care in many cultures and may facilitate the consultation and referral process, as well as compliance with a management plan [122].

↘ Recommendations

- 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 <http://www.vtpu.org.au/resources/bilingualdirectory.html>
- Negotiate a management strategy that is meaningful and acceptable to the person, family and clinician.

3.2.4 Reassessment of risk of suicide

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 (see Table 2 as a guide to assessing risk level). Reassessment of risk provides an opportunity to consolidate the person's (and their carer/s') sense of connectedness with the clinical team. It also 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.

↘ Recommendations

- Aim to reassess suicide risk within:
 - 24 hours for the person at **high risk**
 - 7 days for the person at **moderate risk**
 - 1 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.

3.2.5 No-harm or no-suicide contracts

'No-harm' contracts are based on a statement from the person that they will not harm themselves, or will contact the clinician or other specified person if they feel unable to maintain their own safety. There is no empirical evidence on the effectiveness of such contracts [66]. Therefore, clinicians are to **avoid the use of 'no suicide' or 'no harm' contracts** as they are ineffective in the management of suicidal clients, are not supported by evidence and are no substitute for a thorough clinical evaluation [66].

↘ Recommendation

'No-suicide contracts' are unreliable and are not recommended.

C

3.2.6 Documentation

Good, clear documentation helps to clarify the management plan and assists with communication to other care providers in the continuum of care [80]. Suicide risk fluctuates, so keep the management plan up to date with the most current information available from assessments and contacts, appropriate to the current level of risk.

↘ Recommendations

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 re-assessment of suicidality.

✓

3.3 Discharge planning and follow up

3.3.1 General discharge

Risk assessment and management or intervention represent the beginning rather than the end of a satisfactory standard of care [7]. There is evidence that a person remains at risk of suicide after a suicidal crisis is over, and this may be alleviated by appropriate and systematic follow-up (see next section), including assertive outreach where indicated [24,58]. Follow up through active clinical contact has been shown to encourage people to participate in treatment after discharge [136]. While face-to-face follow up is preferable, a phone call may be the only tool available for follow up in rural areas.

↘ Recommendations

- The evidence suggests close monitoring through follow up during the period of transition from hospital to the community, as this is a time of **increased risk** of suicide.
- Active clinical contact after discharge encourages the person to participate in post-discharge care.

B

↘ Tips

Criteria for discharge planning [137]

1. A comprehensive suicide risk assessment has been conducted and an appropriate management plan is in place.
2. The person is medically stable.
3. The person is not intoxicated.
4. The person has adequate social supports.
5. There is good rapport with the person.
6. Where appropriate, the mental health service has been consulted and referral to a mental health team has been arranged.
7. The person has agreed to return to the ED or mental health service if suicidal intent returns.
8. The primary care provider, family or significant others, and the person have been provided with written copies of the treatment plan, including details of medications (if applicable), ways to deal with symptoms and distress, dates of face-to-face review appointments (as determined by the level of risk at the previous assessment) and contact numbers for times of crisis.
9. Attempts have been made to remove potentially lethal means of self-harm.
10. Treatment of underlying psychiatric diagnoses has been arranged.
11. Appropriate steps have been taken to address psychosocial precipitating factors.
12. General practitioners, counsellors, social supports and other community services have been consulted and are in agreement with discharge arrangements.
13. A written report is sent to health providers (GP, psychiatrist/psychologist) within 72 hours, where possible.
14. Follow up with the person is conducted as soon as possible, ideally within 72 hours.

3.3.2 Discharge from a medical or short-stay unit

Some people may have a persistent wish to die that is no longer verbalised at time of discharge, and some can regress quickly to a suicidal state [66]. Close monitoring may be necessary for the person who has been hospitalised for any length of time for suicidal ideation, suicide attempt or depression [33]. The first week after admission or discharge from inpatient units is one particular time when suicide risk is greatest [58]. The increased risk for suicide is also believed to remain for at least five to 10 years after last discharge [2,65,138].

↘ Recommendations

The following recommendations apply to people being discharged from a short-stay unit.

- Provide a risk assessment before discharge to ensure that the acute risk of suicide has been alleviated.
- The person and their primary care provider or continuing care team, family or significant others have been provided with written copies of a management plan, including details of any medications, dates of follow-up appointments and contact numbers for times of crisis.
- It is suggested that no more than one week of medication is provided at discharge from hospital 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.

D

4. Assessment and management of special populations

Although the aforementioned principles of suicide risk assessment and management for the general population still apply, this chapter highlights people with complex needs, such as the chronically suicidal, the elderly and Aboriginal people, who require close attention when they present to EDs and mental health services.

4.1 The chronically suicidal

The problem of repeated self-harm, particularly among younger persons, is increasing [139]. EDs and AMHS frequently deal with people who intentionally harm themselves, most often by poisoning or cutting in response to personal crises [140,141]. Two thirds of those who repeatedly self-harm are under the age of 35 (many of them adolescents), and the majority of this age group are female [139].

At presentation, people who have self-harmed may be extremely distressed and vulnerable to impulsivity, rapidly changing emotions and angry outbursts. When a person repeatedly presents to ED following self-harm, staff may feel powerless to relieve the person's seemingly unrelenting crises. At times of crisis, it is easy to disempower the person who has self-harmed by dismissing their behaviour as attention-seeking or manipulative [97, 142]. This is not always the case, however, so it is very important that clinicians do not make assumptions about the function of a particular episode of self-harm without understanding both the behaviour itself and the person who has harmed. Most people who self-harm will describe their behaviour, not as 'deliberate', but rather as 'losing control' [143]. They often have limited coping strategies, low self-esteem, and perceptions of lack of control and safety in their lives. Poor problem-solving skills are prevalent in those who self-harm, and many acts of self-harm are impulsive and an immediate response to a situation the person feels is unsolvable. For many people, self-harm is not so much about the inflicting of physical pain as the cessation of emotional pain.

4.1.1 Why does the person self-harm?

As suggested earlier, self-harming behaviours resulting in presentation or admission to a hospital are only part of the total picture of self-harming behaviours and their consequences. Often people who self-harm will have an underlying psychiatric disorder (such as depression, substance abuse, eating disorders or PTSD) or borderline personality disorder (BPD), or more than one co morbid condition [144–146]. While there is considerable clinical overlap between people who repeatedly self-harm and those who have BPD, one cannot assume that all those who present with repeated self-harm have BPD [147].

Many people who engage in self-mutilation or take overdoses, do it in response to multiple life problems, such as unemployment, housing issues, domestic and childhood sexual abuse, illness and interpersonal problems [148]. Such self-harm is driven by a variety of psychological motives including self-punishment, tension relief or gaining attention.

Often, people attending EDs following self-harm are initially incapable of making important healthcare decisions for themselves [149]. Impaired decision-making ability most likely reflects the physical and mental distress that a person is experiencing at the time. It has been suggested that these people would benefit from supportive steps such as the provision of written information and verbal explanation about the purpose of the treatment being offered [149]. This may also assist ED staff in dealing with clinical and ethical dilemmas relating to obtaining consent from this vulnerable group.

4.1.2 Increased risk of suicide

A significant number of people who present following self-harm, leave the ED before a physical or psychosocial assessment is completed [150]. However, they are at high risk of repetition, or even suicide, in the weeks immediately following a self-harm episode, so effective management after an episode of self-harm is very important. A caring and positive attitude by the staff who first deal with people who have self-harmed may encourage them to stay [151].

Suicidal ideation is often a chronic state in some people, including those with BPD, and it does not always represent sincere life-threatening intent. However, at least three-quarters of people with BPD will eventually attempt suicide and approximately 10 per cent will complete suicide [145], so threats of suicide by those diagnosed with BPD must always be taken seriously.

↳ Tips

Tips for first contact with people who have repeatedly self-harmed.

- Recognise the distress associated with deliberate self-harm and treat the person with respect.
- Expect people with underlying BPD to have a heightened vulnerability to rejection. Issue(s) that led the person to seek help at an ED or AMHS may be longstanding. At each presentation, it is important to enquire about any recent changes in the person's situation or relationships.
- Avoid minimising the seriousness of the risk of suicide.

4.1.3 Assessment and management

Detailed guidance about the standards for clinical procedures relating to self-harm by youths or adults can be found in the published clinical guidelines of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian College of Emergency Medicine (ACEM) [92,152]. As an initial priority, ensure the person's physical condition is thoroughly assessed and appropriately managed. A detailed psychosocial assessment can be carried out concurrently.

Psychosocial assessments can be performed by any emergency staff, provided there is suitable training in self-harm and supervision is available. In most cases, the assessment will be carried out by a psychiatrist or mental health team member.

↘ Recommendations

- Avoid hospitalisation of people for repeated self-harm where possible, as it is considered counter-therapeutic [153, 154]. 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.
- AMHS can refer case-managed clients with underlying personality disorder to professionals with expertise in the area of personality disorder treatment (e.g. **Spectrum, (03) 9871 3900**)
- ED management guidelines could include a multidisciplinary review of the person's health records and/or the person, and include background information such as typical presentation, past medical and psychiatric history, suggestions for future care, and contact details for professionals involved in ongoing care.



4.2 The elderly

Clinicians are advised to remain vigilant towards the presence of suicide risk factors (refer Chapter 2, Table 3) in older people who present to EDs and AMHS. Clinicians also need to be skilled to assess and identify signs of suicidality in order to develop a management plan for the person [55,56,83,155–157]. The presence of physical illness should not detract from a close mental state examination, with particular regard to depression and suicidal feelings. Equally importantly, the presence of mental illness must not blind the clinician to the importance of a full medical assessment, particularly with regard to the presence of any sequelae from self-harm.

↳ Recommendations

- Ideally, all older adults presenting with self-harm or attempted suicide should be referred for a specialist psychogeriatric assessment by a suitably trained medical practitioner. As a general rule, consider all such aged people for admission to an aged psychiatry inpatient unit.
- Mental health problems may present differently in older people. For example, depression may present with pronounced physical symptoms such as pain. The presence of physical illness should not detract from a close examination of the mental state and vice-versa.
- 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).
- Re-assess older people at risk of suicide after the appropriate length of time indicated by the level of assessed risk.



↳ Tips for the assessment and management of the older person at risk of suicide

Assessment

- Use multidisciplinary teams to provide rapid assessment of older people in EDs, but augment this with a specialist assessment at the registrar level or above.
- Enquire about medication history. Seemingly low quantities of ingested medications can have adverse effects in the elderly.
- Both depression and lack of social supports, which are significant risk factors for suicide among the elderly, can be readily screened for at presentation and are amenable to intervention.
- Assessing depth of hopelessness is equally relevant in older adults as it is in younger individuals.
- Consider the possibility of more than one diagnosis to explain the presentation, since multiple pathologies are common; liaise with aged psychiatry services.
- Assess possible sensory impairment and communication problems. Is there a hearing problem? Is there a language difficulty? Does the person understand the clinician's questions? Is the person oriented? Is any confusion longstanding or has it arisen only as a sequel to an act of self-harm?
- Assess reasons for living (e.g. having a hobby, religious practice, integration in social networks and clubs, perceiving that life is meaningful and worth living).
- Assess the older person's functional status, e.g. activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Management

- Where a clinical decision results in the person going home, follow-up assessment through specialised aged psychiatry services is highly recommended.
- Make a detailed record of contact and pass a copy onto the person's GP within 48 hours by fax.
- Schedule follow-up appointments and pursue missed appointments.
- Assign a case manager to encourage collaboration among care providers, e.g. social workers, GP, meals-on-wheels, home help, informal caregivers, family members.
- Make every effort to ensure that the person does not return to the same state of social isolation from which they came.

4.3 Indigenous Australians

4.3.1 Patterns of suicide

The literature reviewed in relation to Indigenous people included a number of national studies; hence, the term Indigenous is used when referring to the literature, rather than the term Aboriginal or Koori, which is preferred by the Victorian Aboriginal community.

Aboriginal and Torres Strait Islander peoples represent approximately 2.4 per cent of the Australian population. Many of the mainstream social risk factors for suicide cannot be broadly applied to the Indigenous population [22,158]. In addition to the well-documented individual and family-level risk factors for suicide in the general community, Indigenous people experience risk factors unique to their communities [159–161]. Moreover, there are cultural differences in what constitutes suicidal behaviour; self-harm behaviour may range from cutting, burning and hitting one's head on something, to the more traditional cultural self-harm behaviour of cutting hair [161,162]. Indigenous suicide and self-harming behaviours are often reckless and impulsive.

Any models of mental health understanding and prevention of suicide need to be grounded in Indigenous concepts and approaches [21,22,160,163]. For example, the Indigenous community may attribute the origin of drinking or drug-taking problems as being related to external and uncontrollable forces such as the stolen generation, racism and poor prospects of employment, among other issues [163,164]. Mental illness might be perceived as 'payback' under tribal law for a previous transgression, which in turn may be linked to other family members' transgressions [165]. Indigenous communities will also try to care for persons within the community until they become extremely violent [165], and may not seek help from mental health services until times of great crisis [164]. Some communities may feel stigmatised or shamed by seeking support [165].

The patterns of gender predispositions to suicide in the mainstream are the same for the Indigenous population. Among Indigenous Australians, the group who are most likely to commit suicide (young adult males) have predisposing lifestyle factors such as high alcohol consumption and recklessness, depression and anxiety, and immediate socio-cultural factors such as unemployment, social change, and cultural and family conflict that put them at risk, as well as the developmental experiences of a disadvantaged demographic [22,166]. Many young Indigenous people have been affected by the suicide of another family or community member and this may increase the likelihood of a contagion effect.

Co-morbid factors are prevalent in Indigenous populations, and substance and alcohol abuse are associated with Indigenous suicide. Indigenous men are five times more likely to die of alcohol-related conditions than non-Indigenous men, while the risk for Indigenous women is four times greater than their non-Indigenous counterparts [167]. Young Indigenous men typically choose violent means of suicide, such as hanging or firearms. Suicide is usually an impulsive act and often occurs in the context of intoxication [22].

A major issue for Indigenous Australians accessing mainstream health services is the need for these services to be culturally sensitive and take a holistic view of the person's health issues, which may often include family and community. It is recognised that there is no homogenous Indigenous culture. Differences in family group, language, custom and involvement with mainstream systems, compound the diversity within the Indigenous population and their experiences as a whole [168]. Appropriate training in Indigenous culture and history for non-Indigenous workers, and perhaps even some Indigenous workers who have grown up predominantly in the mainstream system, is necessary to improve links to specific services for Indigenous people [169].

4.3.2 Suicide risk assessment

Hospital emergency services are often a point of first contact for Indigenous people at risk of self-harm, many of whom present with a confounding association of alcohol and self-harm [22]. This means that clinicians must also have expertise in working with Indigenous people affected by alcohol and ensure that the person's care is not compromised because they are intoxicated. Clinicians are advised to familiarise themselves with the Commonwealth Government practitioner guidelines¹⁷ for the management of alcohol-related problems in Indigenous primary care settings, particularly the section covering alcohol with potential or attempted self-harm.

Mental health in Indigenous communities is holistic and should be considered in the context of social and emotional well-being [164–166,170].

Tip

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.

¹⁷ National Recommendations for the Clinical Management of Alcohol-Related Problems in Indigenous Primary Care Settings, 2000. Available at www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-alco.htm

Engaging an Aboriginal person in a psychosocial assessment poses unique cultural challenges for the clinician as their interpersonal interaction styles may differ markedly from non-Aboriginal Australians. For example, the typical question-and-answer style of eliciting information is foreign to many Indigenous people, who tend to use a non-intrusive and indirect style of relating [171]. Indigenous people are more familiar with narrative story telling than they are with question-and-answer responses. Such a style of interaction requires time, which is not often afforded in the clinical setting.

Building rapport is especially relevant when interviewing Aboriginal people for whom personal relationships and respect among others in their own community is highly valued. Clinicians who take the time and energy to find out who the Aboriginal person is as an individual and where they stand in the community will increase their capacity to forge a genuine therapeutic alliance with the person. Overcoming communication barriers with this group requires clinicians to be able to identify, empathise and accept the circumstances that have brought the person into the ED or mental health service. Where possible, engage an Aboriginal health worker¹⁸ to ensure common meanings and experiences are shared, and compliance to a management plan [172].

↳ Tip

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.

While it is beyond the scope of this guideline to provide detailed advice on effectively engaging Aboriginal people in suicide risk assessments, some key elements of communication with this group are provided below.

¹⁸ Aboriginal Health Liaison Officers and Koori Mental Health Liaison Officers are employed by Health Services that serve large Aboriginal communities, particularly in rural/regional settings. The Improving Care for Aboriginal Patients (ICAP) program requires health services with Aboriginal patients to undertake initiatives to improve quality of care for Aboriginal patients.

↳ Tips

Basic guidelines for engaging with an Aboriginal person in a suicide risk assessment interview [165, 171, 172]

- **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.
- **Suggested reading:** *Working with Indigenous Australians: a handbook for psychologists* (Pat Dudgeon, Darren Garvey, and Harry Pickett, eds.), published in 2000 by the Curtin Indigenous Research Centre (CIRC), in association with the Australian Psychological Society and the Curtin School of Psychology. This handbook is a practical guide for psychologists and associated mental health professionals, and addresses the practical issues of working in settings and with Aboriginal people in urban, rural and remote environments. It covers individual, family and community approaches, and describes appropriate models of intervention for children, youth and adults.

4.3.3 Management

There are no published studies on effective interventions for Indigenous people at risk of suicide, or research conducted in an acute care setting. The widespread belief among Indigenous people that Western-style interventions are culturally inappropriate or irrelevant is a barrier to management, and there is considerable work to be done to modify therapies to ensure cultural sensitivity. Individuals may be uncomfortable with, or mistrust, mainstream facilities or programs because they see these programs as unresponsive to their needs.

It will take time for a non-Aboriginal health professional to establish a level of trust on the part of an Aboriginal client [165]. Community and mental health services must strive to increase the cultural awareness, not only of their staff, but also of their service provision systems and practices [161].

↳ Tips

- Be aware of gender sensitivity issues: for example, an Aboriginal man may find it awkward to talk to a female clinician and may prefer to have a family member or an Aboriginal health worker present.
- Acknowledge and respect Aboriginal cultural belief systems where suicide or mental illness is concerned [165].
- Mobilise personal, family and community resources to address the problem(s) identified by the person and clinician [172].
- Negotiate a therapeutic strategy that is meaningful and acceptable to the person, family, cultural consultant and clinician [172]. Consider barriers that may impede an effective intervention with the client, such as gender issues, age concerns, cultural factors and family dynamics [165].
- 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 [165], or ensure cultural safety through the use of an Aboriginal health worker.
- Determine if the person is willing to be seen in their own community or would prefer to go outside; preferred options can be addressed to enhance engagement.
- 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 [165, 172].
- Consider involving family members, close friends of the person or community elders in the discussion about treatment (after first seeking approval of the person) [165], and accommodate their views of the treatment, as they may be essential to treatment compliance.

5. Specific issues in the emergency department

5.1 Aggression

The management of aggression in EDs is beyond the remit of these guidelines. However, some general principles are provided here, in the context of suicide risk assessment. Further guidance on the implementation and support of occupational violence prevention in health services can be found in the Victorian Department of Human Services document *Preventing occupational violence in Victorian health services*¹⁹. This document explains the overarching policy framework for the prevention and management of occupational violence and bullying within Victorian public health services. It contains the guiding framework and rationale for health services to ensure that safe, healthy and productive workplaces are maintained.

A common scenario in the ED is the arrival of a person who either is already agitated or who becomes agitated as they wait to be seen, which may take some time. It is not hard to imagine that an individual in a suicidal, intoxicated or psychiatric crisis, waiting alone for several hours might lose their usual impulse control. There are many reasons for this, some of which are outside the control of ED staff, such as crowding, insufficient space, staff shortages, delays in the availability of a CAT team, collection of collateral information or waiting for diagnostic or medical tests.

Circumstances where violence or aggression is more likely to occur in an ED include:

- alcohol or substance misuse, including intoxication, withdrawal and drug-seeking behaviour
- long waiting times, especially if a person feels that staff are uncaring
- lack of training of staff in interacting with people in psychiatric crisis
- medical conditions that lead to confusional states [173,174].

Ideally, identification of potentially violent people will occur at the triage stage and the general management principles outlined in the *Victorian Emergency Department Mental Health Triage Tool*²⁰ will apply. Collecting information from previous records about past violent behaviour or from collateral sources is important, as is the person's current condition.

In order to ensure the safety of patients, staff and members of the public, it is desirable that all staff working in an ED have training in managing potentially violent situations, including de-escalation techniques. Ideally, staff should firstly make every effort to establish whether the potential for agitation can be managed at a verbal or behavioural level before proceeding to management with medications, which carries a risk of undesirable side effects [113,175].

¹⁹ Available at http://www.health.vic.gov.au/__data/assets/pdf_file/0015/101643/nurse_safe_policy-Final.pdf

²⁰ Available at <http://www.health.vic.gov.au/emergency/mental.htm>

↳ Recommendations

- Early identification of agitation and consideration or use of de-escalation techniques should occur before more restrictive means of containment are considered.
- Every effort is 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.

D

↳ Tips

Environmental variables that can be modified in the ED to reduce the potential for escalation of violence in the agitated person include [176]:

- 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 possible²¹
- attending potentially violent people promptly to prevent a minor incident becoming more serious. Obtaining collateral information is often helpful in this regard.

21 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.

↘ Safety tips

Safety is a prime consideration for ED staff, the person and the public. Suggested requirements for a psychiatric interview room in an ED follow [174]*:

- It is located in the main ED area and not isolated.
- It is well lit.
- It is comfortable, with heavy furniture that cannot easily be lifted or used as weapons.
- It has two doors with observation windows that open outwards and are not lockable from the inside.
- It has an alarm system with a 'panic' button.
- CCTV may be an added security measure.
- There are agreed procedures regarding use of chaperones and checking by staff during interviews.
- A person who is in seclusion is checked frequently, as clinically indicated, but at least every 15 minutes.

* Further guidance can be found in the *Guidelines on Emergency Department Design*, Australian College for Emergency Medicine, March 2007. Available at: http://www.acem.org.au/media/policies_and_guidelines/G15_ED_Design.pdf

5.2 People who do not wait to be seen

A significant proportion of people who do not wait to be seen or discharge themselves against medical advice will have harmed themselves, and will be at further risk of self-harm or suicide [177]. If the risk assessment conducted at triage identifies that the person is at risk of harming themselves or others, then duty of care indicates that all efforts should be made to prevent self-discharge, pending further assessment.

Proactive steps can be taken with every person who presents with suicidal behaviour or a mental health problem. For example, the first healthcare professional to come into contact with the person could record a description of the clothes they are wearing in case they leave the ED before a comprehensive evaluation can be carried out. Close monitoring of the individual in the waiting area is also warranted.

Each service should have a clearly articulated local policy, which provides guidance for staff regarding required notifications and actions in the management of this group of patients.

↘ Recommendations

- 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 healthcare 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.



6. Bereavement services

6.1 Guidelines and training for mental health services

Best Practice Bereavement guidelines and a DVD training resource are available to EDs and mental health services to support best practice and assist service enhancements.

SANE Australia was funded through the Australian Government's National Suicide Prevention Strategy to conduct research into improving supports and services for the family and friends of people with a mental illness, who have died by suicide or have gone missing. In their consultations with 50 service providers in government and non-governmental health services and bereavement services across Australia, SANE found that over 70 per cent of mental health services did not have formal policies to support the family after a suicide or when someone has gone missing. Moreover, deficiencies in support and referrals from mental health services, timely information and follow-up care, were identified by bereaved family members who were consulted.

Tip

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)

Just as each loss to suicide is unique, so is a survivor's grief process. When a loved one has been lost through suicide, some families may only require guidance and understanding from a service provider about what has happened, at the time of crisis. Other families may require ongoing support, but may not be ready for immediate counselling. It is recommended that AMHS offer support and referral soon after a suicide, and re-offer about six weeks later if the person doesn't feel ready to accept help at first. This is the time when family members feel the full impact of the suicide, and it is also the time that initial support from services, extended family and friends tends to reduce, creating a sense of isolation. Therefore, services need to be alert to requirements for professional help as the weeks and months pass after a suicide. Further guidance for services and bereavement support is provided in the *Best Practice Bereavement Guidelines*.

↳ Tips

- It is suggested that each hospital and AMHS makes themselves aware of what local bereavement support services are available and make appropriate referrals.
- For more information
 - 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 & Grief: www.nalagvic.org.au/fh-wherefindhelp.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 & 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

6.2 CALD and Aboriginal communities

Language barriers, as well as the stigma associated with suicide, can potentially act as a barrier to accessing bereavement services by some ethnic minority groups. Health care professionals need to be cognisant of this as it has implications for cross-cultural practice in the area of grief and loss counselling. The cultural appropriateness of the bereavement services offered is also important. Where possible, use interpreting services, help family members and close friends of the deceased identify culturally appropriate community-based bereavement support, and offer a culturally appropriate case manager as a liaison person.

Tip

The Ministerial Council for Suicide Prevention publishes free downloadable fact sheets for Aboriginal peoples, including *Grieving Aboriginal Way*.

(State versions of the bereavement pack are available at www.mcsp.org.au/bereavement_pack)

Glossary of terms

ABS	Australian Bureau of Statistics
AMHS	Area mental health service
ATS	Australasian Triage Scale
BPD	Borderline personality disorder
CAT	Crisis assessment and treatment
DSH	Deliberate self-harm
DSM	Deliberate self-mutilation
DSP	Deliberate self-poisoning
ED	Emergency department
GP	General practitioner
HPP	Health privacy principles
MHS	Mental health service
MSE	Mental state examination
NCS	National Comorbidity Study
NHMRC	National Health and Medical Research Council of Australia
PTSD	Post-traumatic stress disorder
RCT	Randomised controlled trial
RSQ	Risk of Suicide Questionnaire
SIGN	Scottish Intercollegiate Guideline Network
SIQ	Suicide Ideation Questionnaire
SIS	Suicide Intent Scale
SUAS	Suicide Assessment Scale
TERG	Technical Expert Reference Group
VEDMHTT	Victorian Emergency Department Mental Health Triage Tool
WHO	World Health Organisation

Appendices

Appendix A: Stakeholder consultations

Members of the working groups responsible for the development of these guidelines include:

Technical Expert Reference Group

Dr. Peter Burnett MBBS FRANZCP	Director of Clinical Governance NorthWestern Mental Health Melbourne, Victoria
Mr A (Tony) Catanese BSc, PGDipAppPsy (Adelaide University) MPsych (LaTrobe University)	Clinical Psychologist Melbourne, Victoria
Dr. Angelo De Gioannis MD (Rome) FRANZCP	Consultant Psychiatrist Australian Institute for Suicide Research and Prevention National Centre of Excellence in Suicide Prevention Griffith University, Queensland
Professor James Ogloff JD, PhD, FAPS	Director of Psychological Services Victorian Institute of Forensic Mental Health Melbourne, Victoria
Professor Bruce Singh MBBS (Syd) PhD (Newcastle) FRACP FRANZCP	Professor of Psychiatry and Deputy Dean Faculty of Medicine, Dentistry and Health Sciences University of Melbourne, Victoria

The role of the Technical Expert Reference Group was to assist the project team in guideline scoping, content development and formatting of the product as well as provide advice on best practice in areas where research evidence is absent, weak or equivocal, and advice on recommendations for implementation and evaluation.

The role involved:

- Preparatory reading and attendance at meetings, either face-to-face or by teleconference
- Providing ad hoc expert input as required, e.g. via email, telephone
- Reviewing draft documents/project outputs
- Advising on the key organisations and persons that may provide input into the project outputs
- Advising on peer reviewed and grey literature pertaining to their area of expertise.

Sector Consultative Group

A/Prof Steve Ellen (Chair)	Royal Australian and New Zealand College of Psychiatrists
Ms Sandra Inglis	Australian College of Mental Health Nursing
Dr Peter Ritchie	Emergency Physician
Ms Cath Roper	Consumer Academic, Centre for Psychiatric Nursing, University of Melbourne
Mr Warren Jenkins	Executive Director, ARAFEMI Victoria
A/Prof Steve MacFarlane	Clinical Director (Aged), Alfred Health
A/Prof Richard Newton	Medical Director, Mental Health Clinical Services Unit, Austin Health.
Dr Peter Jenkins	Clinical Director (Youth/Adult), Eastern Health
Mr Chris Schaffer	Acute Inpatient Unit Manager, Alfred Health
Ms Marty Andison	Triage Nurse, Bendigo Health Mental Health Service
Mr Bryan Bowditch	Manager, CAT/Psychiatric Triage, St Vincent's Mental Health
A/Prof. Harry Minas	Director, Victorian Trans-cultural Psychiatry Unit
Mr Jeremy Sheppard	Manager, Casey-Cardinia CATT, Southern Health
Ms Bev Schumacher	Senior Nurse, Goulburn Valley Health
Ms Suzanne Stewart	Senior Clinician, Plenty Valley Community Health Centre
Ms Nicole Cassar	Team Leader, Health and Wellbeing Programs, VACCHO
Prof. George Braitberg	Director Emergency Medicine, Southern Health
Ms Sue Cowling	Nurse Unit Manager, St Vincent's Health
Mr Peter Kelly	Mental Health Service Manager, NorthWestern Mental Health
Assoc. Prof Steve Elsom	Director, Centre for Psychiatric Nursing
Ms Judy Hamann	General Manager Victorian Operations, MIND Australia

CATT/ECAT Consultative Group

Steve Elsom (Chair)	Centre for Psychiatric Nursing
Neville Baker & Nick Gaynor	Austin Health
Chris Healey	South West Healthcare
Edward Aquin & Neil Smyth	Barwon MHDAS Education Team
Kylie Burns & Debbie Orchard	Latrobe Regional Hospital
Belinda McCullough, Paul Grech & Steve Brown	NorthWestern Mental Health
Donal Twomey & Gerard Holdstock	Mid West Area Mental Health Service
Marty Andison	Bendigo Health Psychiatric Services
Bryan Bowditch & Narelle Gilmore	St Vincent's Mental Health
Tamara Irish & Ian Edgar	Ballarat Health Psychiatric Services
Tracey Morgan, Michael Rogers & Michael Sillekins	Southern Health (Casey)
Phil Terrell & Ivan Baker	Wodonga Regional Health Service
Tanya Mularczyk	North West Area Mental Health Service
Kerryn Devenish	Inner West Area Mental Health Service
Brett McKinnon	Ramsay Health

The role of both the Sector Consultative Group and the CATT/ECATT was to assist the project team through the exchange of information, views and experience on policies and good practice for the assessment and management of suicide risk in the context of Victorian area mental health services and hospital EDs.

The role involved:

- preparatory reading and attendance at face-to-face meetings
- providing ad hoc expert input as required, for example, via email, telephone
- reviewing draft documents/project outputs
- advising on the key organisations and persons that may provide input into the project or are integral to the implementation of the guidelines
- advising on strategies for dissemination and implementation the guidelines, and potential barriers to its implementation.

Consumer and carer involvement

Consumers and carers with personal or family experience of suicidal behaviour were involved in the guideline development process through focus groups conducted in both metropolitan and regional areas, which were organised by Carers Victoria and the Victorian Mental Illness Awareness Council.

Appendix B: Evidence and guideline recommendation grading system

The Technical Expert Reference Group used the Scottish Intercollegiate Guidelines Network SIGN evidence grading system to assess the validity of the literature and rate each study's level of evidence.

SIGN Evidence Grading System for Clinical Practice Recommendations: Levels of Evidence²²

1++	Evidence obtained from a high-quality systematic review or meta-analyses of all relevant RCTs, or RCTs with a very low risk of bias.
1+	Evidence obtained from at least one properly designed RCT or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias
2++	Evidence obtained from well-designed case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Evidence obtained from well-designed cohort or case-control studies with a low risk of confounding or bias, and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees

²² The Scottish Intercollegiate Guidelines Network (SIGN) Methodology Checklists 1–5 accessed online 21 January 2009: www.sign.ac.uk/methodology/checklists.html

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