BEST PRACTICE
EVIDENCE-BASED
GUIDELINE
SUMMARY

THE ASSESSMENT AND MANAGEMENT OF PEOPLE AT RISK OF SUICIDE

EMERGENCY DEPARTMENTS

KEY MESSAGES

- Anyone who talks about suicide should be taken seriously.
- People who present following a suicide attempt are usually in a state of extreme distress.
- Asking about suicide does not create risk in people who do not have suicidal thoughts.
- Training in suicide assessment improves staff performance, appropriate referrals and overall care.
- Case Notes should be augmented with structured assessments (such as the Rapid Assessment tool).
- Clinicians should involve whānau/family/support people of the suicidal person whenever possible.
- Information from significant others is helpful when assessing a young person provided this does not compromise safety.
- Culturally appropriate services should be offered to the suicidal person whenever available.
- A suitably trained mental health clinician should be contacted whenever anyone seeks assistance following an act of deliberate self-harm or expressing suicidal ideation.
- People expressing suicidal ideation who try to leave before an assessment is completed may be detained, as a last resort, under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- If acute sedation is necesary, and calming measures have been unsuccessful, prescribe short to medium acting benzodiazephine or if violent agitation or symptoms of psychosis are present, an antipsychotic.
- A safe environment should be provided for people who are intoxicated/cognitively impaired by drugs until they are sober. Then they should be further assessed.

MINISTRY OF HEALTH
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OVERVIEW

Suicidal behaviour is one of the most stressful of psychiatric emergencies. Around ten percent of people presenting at an emergency department have made a suicide attempt.

There is no single explanation for suicide attempts nor any simple solutions to treatment. However, people who present to emergency departments with suicidal ideation or following an attempt are at increased risk of making further attempts. They should not be allowed to leave before they have received a full medical examination and a psychiatric/psychosocial assessment. Emergency department clinicians who conduct risk assessments and contain people at risk until they can be assessed further by mental health services are in a position to save people's lives.

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ASSESSMENT

The low base rates of suicide make it a difficult to predict tragedy. Despite best efforts, some people will complete suicide. The reasons for a person attempting suicide are usually complex. Understanding key risk factors making a person vulnerable to attempting suicide raises a clinician's index of suspicion for suicide risk.

Key Suicide Risk Factors

- The majority of people who die by suicide suffered an associated psychiatric disorder at the time of their death. People who meet the criteria for more than one disorder at a time are at even greater risk.
- Substance abuse and intoxication are strong risk factors. Up to half of those who die by suicide have consumed alcohol before taking their lives.
- Recent loss, loved ones dying or committing suicide, isolation, depression or bipolar disorder, previous attempts, serious physical illness and a past history of abuse are key risk factors. In youth, an identifiable stressful event (relationship break-up, bullying) precedes most suicide attempts.
- The highest rates for suicide are among males 20–34 years. Māori youth have higher rates than non-Māori youth. However, 75% of all suicides occur in people over the age of 24.

When a person presents in an emergency department with a suspected suicide attempt or expressing suicidal ideation, staff need to determine:

- whether the person's injury was caused by self-harm
- how serious the deliberate self-harm was (including the seriousness of intent)
- the key precipitants to self-harm/ideation
- the current level of risk
- the urgency for assessment by mental health services
- the best way to keep the person safe and supported until further assessed.

The triage decisions and RAPID Assessment tool facilitate assessment of the above.

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This guideline is endorsed by: ACEM; The Royal Australian and New Zealand College of Psychiatrists - New Zealand Branch.; Mental Health Commission; Council for Mental Well-Being Trust; NZNO Mental Health Nurses Section

MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

Sections 110C, 111 and 113 of the Act allow police, registered nurses, and the person in charge of a hospital to detain a person where they are until a medical practitioner has assessed them if there are 'reasonable grounds for believing that the person may be mentally disordered'. Suicidality may be considered such reasonable grounds.

This means that emergency department staff can, as a last resort, legally prevent a suicidal person from leaving or absconding prior to completion of the assessment if there is serious concern that the person is mentally disordered and/or at suicidal risk.

SEDATION

Sedation can be considered to reduce a person's level of distress sufficiently so that an assessment of their situation or risk of harm can be resumed.

- When acute sedation with medication is necessary, consider prescribing a short to medium-term benzodiazepine (lorazepam), or clonazepam (which is presently the only intra-muscular benzodiazepine available), or if symptoms of psychosis are present, an antipsychotic (such as haloperidol).
- Haloperidol is contraindicated for cases of depression, or those whose CNS may be depressed due to drugs or alcohol.
- Haloperidol can cause painful dystonic reactions for some people, particularly among people who have never taken an antipsychotic before. In such cases, the co-prescription of an anticholinergic agent (such as benztropine) is advised. The newer antipsychotic medications have not yet been formally evaluated for use in this setting.
- Benzodiazepines should only be used for sedation as a short-term measure. They must be administered under supervision.
- Check for allergic reactions to some sedating drugs.
- If a person has been sedated and then needs to be transported to another assessment place, medical support must be provided during transit. The accompanying clinician needs to be aware of potential medical complications of sedation (eg, respiratory arrest following intravenous benzodiazepine use).

DISCHARGE FROM THE EMERGENCY DEPARTMENT

Any person expressing suicidal ideation should be assessed before they are allowed to go home. If risk remains, emergency department staff should work collaboratively with mental health services to complete the handover.

- Suicidal intent is not present and the acute crisis has in some way been diminished.
- The person is medically stable.
- The person is not intoxicated (intoxicated people are at an increased risk of acting impulsively).
- Attempts have been made to ensure objects that could be used to self-harm have been removed from the person.
- Whānau/family have been consulted and informed as appropriate. Arrangements have been made for the person to return to a safe environment and advice given about removing ropes, guns, medications and chemicals from the home.
- Social supports/case workers/counsellors ideally have been consulted, informed and mobilised (if the person is being discharged out of work hours, ensure that the contact information is available for the next working day).
- The person has been given information about medications, emergency contact persons or services and some strategies to deal with continuing problems.
- Some treatment for the underlying psychiatric illness has been arranged, including referral to mental health services.

EMERGENCY DEPARTMENT MENTAL HEALTH TRIAGE

Triage Code	Description	Treatment Acuity	Typical Presentation	General Principles of Management
1	**Definite danger to life (self or others)**	**Immediate**	**Observed** Violent behaviour Possession of a weapon Self-destructive behaviour in the emergency department Requires restraint	**Supervision** 1:1 observation **Action** Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
2	**Probable risk of danger to self or others** Severe behavioural disturbance	**Emergency** Within 10 minutes	**Observed** Extreme agitation/restlessness Physically/verbally aggressive Confused/unable to co-operate **Reported** Attempt/threat of self-harm Threat of harm to others	**Supervision** 1:1 observation **Action** Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
3	**Possible danger to self or others** Moderate behavioural disturbance Severe distress	**Urgent** Within 30 minutes	**Observed** Agitation/restlessness Intrusive behaviour Bizarre, disorganised behaviour Confusion Withdrawn and uncommunicative Ambivalence about treatment **Reported** Suicidal ideation **Presence of** Psychotic symptoms Affective disturbance (low or elevated)	**Supervision** 1:1 observation **Action** Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
4	**Mild to moderate distress**	**Semi-urgent** Within 60 minutes	**Observed** No agitation/restlessness Irritability without aggression Co-operative Gives coherent history Reported symptoms of anxiety or depression without suicidal ideation Is actively seeking assistance for their distress	**Supervision** Intermittent observation **Consider** Re-triage if evidence of increasing behavioural disturbance: • restlessness • intrusiveness • agitation • aggressiveness • increasing distress 1:1 observation if needed **Action** Referral to mental health service

Adapted from the NSW *Mental Health for Emergency Departments - A Reference Guide.*

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