AUSTRALASIAN
PSYCHIATRY

# Assessing and managing suicidal patients in the emergency department

Australasian Psychiatry
2015, Vol 23(5) 513–516
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DOI: 10.1177/1039856215597536
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**Abstract**

**Objective:** The objective of this article is to set out consensus guidelines for the assessment and management of "suicidal patients" in the emergency department.

**Conclusions:** Clinicians should be respectful and reassuring. They should review old notes, conduct a full history and examination, and talk to friends, family and any practitioners already involved in the patient's care. Management should be guided, where possible, by the patient's preferences, not by notions of risk. Every negotiated management plan and its rationale should be carefully documented.

**Keywords:** suicide, attempted suicide, suicidal ideation, emergency department, practice guideline

Many people who present to the emergency department raise concerns in clinicians about the possibility of suicide. This may be because they have expressed suicidal ideation or have attempted suicide, or because they exhibit severe depression, an angry and unstable mood, intoxication or psychosis. In writing this paper, six psychiatrists who between us have decades of experience working in six large emergency departments in and around Sydney came together to offer practical advice to clinicians working with these patients. For want of a better term, we will refer to them as "suicidal patients".

A number of documents with the same aim appear in the academic literature[1–3] or as part of government policy.[4–8] In our view, though, no published guideline takes sufficient account of the recovery movement, of recent reforms to mental health legislation, or of the lack of utility of suicide risk assessment.[9,10]

## Principles of assessment and management of suicidal patients

Suicidal patients are an extremely heterogeneous group and consequently their assessment and management will vary enormously. However, all suicidal patients will experience one or more stressors that threaten to overwhelm their available resources, and in all cases three principles should guide the clinician.

1. Almost all suicidal patients will benefit from feeling listened to and understood.

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2. Most of the stressors suicidal patients experience ease with intervention and/or time.
3. People who can make decisions for themselves should be allowed to.

## Assessment

Contrary to some published guidelines,[5,8] it is not the case that every suicidal patient should see a mental health clinician. For a significant number of patients, statements about "wanting to die", especially uttered whilst intoxicated, are an expression of more general distress. In these cases concerns about future suicide may be short-lived and any signs or symptoms may resolve quickly with simple interventions and/or the return of sobriety. In these situations, senior emergency physicians may determine that additional specialist psychiatric assessment may be unhelpful and unnecessarily delay more appropriate disposition and referral, such as review by addiction medicine or social work, or return to a trusted general practitioner. A clinician with expertise in psychiatry should assess all other suicidal patients.

There are no tools that allow clinicians to usefully categorise suicidal patients into those at relatively higher or lower likelihood of suicide; so-called clinical assessment of suicide risk is of no proven benefit; and there is no place for any sort of screening test aimed at allowing some suicidal patients to be discharged and assessed later.[9,11] All suicidal patients seen in the emergency department are at a greatly elevated risk of suicide compared to the rest of the community – irrespective of any risk or protective factors.[12] That said, the likelihood of any individual suicidal patient completing suicide in the near future is very low.[13]

The aim of assessment for suicidal patients is the same as it is for any other patient – to understand the person's predicament. This can be achieved only by conducting a full psychiatric history and mental state examination, by reviewing the patient's previous medical record, and by discussion with the patient's family or friends and any professional currently providing treatment.

Begin the clinical interview by trying, as much as possible, to put the patient at ease. Remember that although for you this may be just another assessment, for most patients and their families this is one of the most important episodes in their lives. Introduce yourself and explain that seeing someone from psychiatry is routine in this situation. Establish yourself early as a warm, friendly, open person with the experience and authority to provide real help.

When patients have attempted suicide, you should spend a great deal of time trying to gain insight into their state of mind at the time. Ask the patient to take you through the events leading up to the attempt and the events subsequent. Some of the most important questions appear in Table 1, but the most frequently asked question should be, "And then what happened?" By the time the history is complete you should be able to picture the scene as if it were a movie. This is important since details such as the degree of consideration the person gave to the attempt, the efforts taken to avoid discovery, and whether the person was intoxicated at the time are vital as you try to place yourself in the position of the patient.

Many suicidal patients will be intoxicated. Sometimes the intoxication will be a result of a suicide attempt, while at other times the intoxicant may be largely responsible for any suicidal ideation voiced. There is no point in conducting a detailed interview with a heavily intoxicated patient. First, it is likely that some of the history gained will be inaccurate and, secondly, intoxicants have profound transient effects on a person's mental state that can interfere with an accurate assessment. Some emergency medical staff who lack expertise in psychiatric assessment fail to appreciate the importance of seeing a person sober, or judge too early that clinically relevant intoxication has resolved. If requested to see an intoxicated patient, do not simply refuse. Make a preliminary assessment and then explain to the emergency clinician why a delay is unavoidable; although it may be appropriate to gain collateral history while the patient recovers sobriety.

Almost all suicidal patients raise the clinical possibility of cognitive impairment, either due to the effects of a suicide attempt (such as overdose or attempted hanging), or to an underlying condition (such as severe depression). As a result almost all suicidal patients should have basic bedside cognitive testing performed and documented.

Towards the end of the interview you should ask for the patient's views on management from this point. This vital inquiry is often neglected, even though this is the issue that will, more than any other, help shape the management plan. If the person's reply raises genuine doubt about his or her decision-making capacity, it may be necessary to formally assess this.

A corroborative history should be sought wherever possible. Patients who are determined to kill themselves may withhold vital information that might be obtained only from friends and family members. Collateral history should be gained to corroborate the patient's account and to gain the perspective of the patient's major personal and professional supports. Collateral history may also provide information about access to means of suicide, such as firearms or stockpiles of medication.

Occasionally suicidal patients will forbid contact with friends and family or other health care professionals. Assuming this prohibition is competently made, it should usually be honoured. However, it is usually best to explain to the patient that his or her assessment may not be able to be completed until some corroborative history is gained and that this may delay discharge. It is usually possible to negotiate agreed contact with someone. Also recall that although you may not contact and



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**Table 1. Useful questions**

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| I have seen some paperwork, but I wonder if you could let me know what happened? |
| While you were taking the tablets, what was going through your mind? |
| Did you think you had any other options? |
| What did you think was going to happen? |
| How long have you been thinking about this for? |
| If you could change a couple of things in your life, what would they be? |
| How are you feeling now? |
| What has changed that means you are no longer feeling suicidal? |
| How are you coping in the ED? |
| Who is important to you? Do they know what has happened? |
| Are you thinking you need to be in hospital? |
| If you went home now, do you think you'd be OK? |
| Do you have any plans as to how to address the issues that led you to feel suicidal? How can we help? |

ED: emergency department.

disclose information to third parties, if permission is competently denied, third parties are at liberty to contact and disclose information to you.[14]

If a suicidal patient demands discharge before any sort of assessment can be completed, the law allows temporary detention to allow assessment of his or her capacity to request discharge.[15] Before any suicidal patient is discharged against medical advice, the case should be discussed with a consultant psychiatrist.

## Formulation

After completing your assessment, you should organise all the documented information in a way that succinctly describes the predicament faced by the patient and how he or she came to be in that predicament. This should identify the stressors that the person is subject to and attempt to explain why the person's resources for dealing with these stressors were, or still are, temporarily overwhelmed. The formulation should include any underlying psychiatric or medical conditions, personality style, the patient's strengths and resources, and goals from this point on.

If, at the end of an assessment, the person's predicament does not make "psychological sense" – if it is not possible to understand how the patient came to this point – you should return to the patient, explain your perplexity, and seek to resolve it together.

There should be no speculation as to the person's future risk of suicide. For all suicidal patients in the emergency department, the relative risk of suicide in the future is high and the absolute risk of suicide low.[13,16]

The formulation and management of all suicidal patients should be contemporaneously discussed with a consultant psychiatrist and the emergency team. This not only allows access to the expertise of the consultant, but, just as importantly, it allows ideas and assumptions to be voiced, reflected upon and challenged.

## Management

The heterogeneity of suicidal patients allows few blanket statements about their management, but in all cases this will be guided first and foremost by the patient's views of how best to help themselves.

Management begins at the beginning of the interview. All suicidal patients will be distressed – some about being in the emergency department, some about being alive. Many will feel stigmatised and ashamed. Try to offer comfort, reassurance and hope. Do not judge. Be aware of any negative countertransference and keep it on a short leash.

Review with patients those circumstances or events that led up to their crisis or suicide attempt. Examine for example: the bereavement, the argument, the non-adherence, the uncharacteristic intoxication, the established alcohol dependence, the depressive illness, the loss of hope, the loss of supports, or the easy access to pills. Try to identify together issues that might be open to intervention. Obviously the heterogeneity of the circumstances that result in people becoming suicidal patients means that any attempt to outline specific management plans is beyond the scope of this paper. However, all such plans should be tailored to the particular patient, negotiated with him or her, and where relevant the patient's family or friends. All should be based on the best available evidence.

On occasion, patients' views on management will appear wildly contrary to the views that most would express; or,



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more importantly, to the extent that it is possible to determine this, contrary to what they themselves would normally express. At these times you may feel that if the patient's preferences were enacted he or she might come to significant harm. In these circumstances it is appropriate to formally assess the patient's decision-making capacity, recalling that as part of this you must do everything possible to support the person's ability to make a decision, and that a patient may retain decision-making capacity and still make decisions that you may regard as dangerous or foolish.[10,17]

A management plan should contain elements contrary to the patient's voiced preferences only if he or she lacks decision-making capacity around those elements, and those elements represent the best practically available management option least restrictive of the patient's freedom. Even in these circumstances the management plan should engage what would have been the person's preferences had they retained decision-making capacity, at least as far as these are possible to ascertain from the views of friends and family or from a valid advance directive.[10]

Involuntary admission is a last resort. Clinicians should be mindful that suicide rates among psychiatric inpatients are very high[18] and that the trauma and stigma of hospitalisation might even precipitate some suicides.[19] That said, there is no doubt that some people do benefit from (even involuntary) psychiatric admission, and admission can represent the most effective management option that is most consistent with the protection of patients' rights. Regardless of whether the patient is admitted, clinicians should carefully document their reasoning for using, or not using, mental health legislation, focusing not upon risk, but upon the patient's preferences, his or her capacity and the clinician's reasoning regarding options for safe and effective care.[20]

Contrary to the pronouncements of some guidelines,[4] it is not the case that all suicidal patients discharged from emergency should receive formal follow-up.[8] However, given that there is evidence that suicidal people are most at risk of completed suicide in the days following assessment and evidence that formal follow-up may decrease the rate of completed suicide in the coming months,[21] the reason for a decision to *not* arrange formal follow-up should be carefully documented. Usually such a decision will be based on a patient competently declining follow-up despite recommendation of its worth.

## Conclusion

Though designed for clinicians, these guidelines should also provide an insight into mental health practice for legal professionals and members of the public. We welcome correspondence to augment or challenge our advice and encourage psychiatrists from other subspecialties to create their own similar guidelines.

### Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

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