

# Preventing suicide

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Guidance for emergency  
departments

Citation: Ministry of Health. 2016. *Preventing suicide: Guidance for emergency departments*. Wellington: Ministry of Health.

Published in April 2016  
by the Ministry of Health  
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-947491-75-8 (online)  
HP 6370

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# 1 Introduction

## 1.1 Overview

Every week around 10 people die by suicide in New Zealand. Every year there are at least 2,500 admissions to hospital for intentional self-harm injuries.<sup>1</sup>

People of all ages and backgrounds may be suicidal, but suicide is a particular issue for Māori people, who have a suicide rate much higher than the non-Māori rate.<sup>2</sup> The suicide rate is also much higher in the most deprived areas compared to the least deprived areas.<sup>3</sup> In 2011 suicide was the most common cause of death for youth, and Māori youth are more than twice as likely to die from suicide as non-Māori youth.<sup>4</sup> There is also a growing concern that suicide is increasing among Pasifika communities.<sup>5,6</sup> One of the main objectives of the *New Zealand Suicide Prevention Action Plan (2013–2016)* is to build the capacity of Māori whānau, hapū and iwi, and of Pasifika families and communities, to prevent suicide.<sup>7</sup>

Around 90 percent of people who die from suicide have a mental health disorder (e.g. clinical depression or another diagnosable mental health disorder).<sup>8</sup> However, suicide can also be caused by other risk factors and life events.

Suicide is extremely traumatic for those left behind and has long-lasting effects on families and communities, who experience a range of conflicting feelings, including intense sadness, relief, guilt, anger, resentment and remorse.

There is a strong stigma associated with suicide, which can affect the person contemplating suicide. Recovery for people at risk of suicide can be highly affected by this stigma (including self-stigma). Cultural values and beliefs can also play a major role, but can also act as protective factors.

## 1.2 Purpose of the guidance document

This guidance document was developed with the assistance of a working group (see Appendix 2) to provide emergency department staff with up-to-date information on caring for people at risk of suicide.<sup>9</sup> It is aimed at improving the quality of care for all people who are at risk of suicide when presenting at emergency departments. Although this guidance is intended specifically for emergency departments, aspects may be helpful for assessing suicide risk in other departments.

The guidance builds on, but does not replace, the 2003 *Assessment and Management of People at Risk of Suicide* guidelines developed by the New Zealand Guidelines Group and the Ministry of Health.<sup>10</sup> It also takes into consideration new and emerging evidence, including the National Institute for Health and Care Excellence (NICE) guideline on self-harm,<sup>11</sup> which is endorsed with adaptations by the Royal Australian and New Zealand College of Psychiatrists. This guidance document is based on existing emergency department systems and pathways for all people presenting to emergency departments for triage and initial risk assessment.

## 1.3 The role of the emergency department

Emergency departments have an important role in the management of people who present as being at risk of suicide. It is essential that all people who present with suicidal thoughts and/or self-harm have a suicide risk assessment. The nature and urgency of this assessment will depend on the needs of the person and the resources and services available to the emergency department. It is also important that emergency staff consider that this may be the first time a person has presented to health services with a mental health problem.

Emergency staff should have access to training and resources so that they have high awareness and the relevant skills when assessing people who may be at risk of suicide. Attitudes have a major influence on the recovery of people at risk of suicide and self-harm. A warm, compassionate approach is important, along with the key competencies (including cultural competencies) needed to manage all the presenting issues.

It is also essential that emergency departments routinely review their quality of care to improve the processes and outcomes for people presenting at risk of suicide.

For people presenting at risk of suicide, the responsibilities of emergency staff are to:

- triage and plan for their safety
- diagnose and treat any concurrent non-psychiatric illness or injury
- perform a suicide risk assessment for all people who have suicidal thoughts or have self-harmed, when they are deemed ready to interview
- assess for the presence of red flags for short-term risk
- identify those who require an immediate comprehensive mental health specialist assessment within the emergency department
- identify those who can safely be discharged with a comprehensive mental health assessment follow-up within 72 hours and who have good support systems
- identify those very-low-risk people with good support systems who can be safely discharged to the community and referred to primary care management
- engage with families to inform and support them.

Emergency departments will vary in their interactions with mental health services. Some departments will refer directly to them from the point of triage. In others, experienced and appropriately skilled emergency department staff may undertake much of the short-term suicide risk assessment.

## 1.4 Key principles

Nine key principles have been developed to assist emergency department clinicians working with people at risk of suicide.

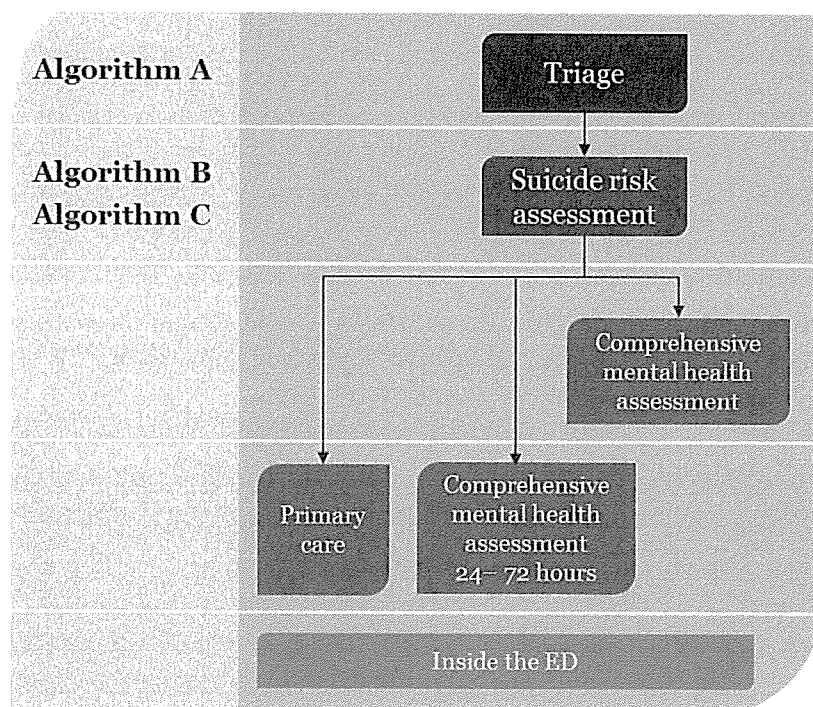
1. There is limited evidence for predicting and preventing short-term suicide risk accurately. However, the structured clinical judgement process outlined in this guidance document provides an acceptable approach to assessing short-term suicide risk.
2. The nature of the interactions between a clinician and a person at risk of suicide can affect short-term risk. A compassionate, empathic and caring approach from the clinician undertaking the interview can be a protective factor.

3. Use culturally appropriate practice (e.g. manaakitanga) by demonstrating care and respect for the individual and their whānau or family. This includes talking, listening, offering food and drink, making use of spiritual practices and acceptance (aroha, karakia), and ensuring connections (e.g. having whānau, kaumātua or Māori health advisors present). It is also important to address the culturally specific needs of Pacific people and people of other cultures.
4. When a person has physical needs and suicide risk needs, further assessment of the suicide risk can occur once the person is able to be interviewed. Assessment and management of suicide risk do not need to wait for medical clearance.
5. Ensure continuity and safety of care within the emergency department when people are discharged to primary or mental health services.
6. Keep the person and their whānau fully informed and involved in their care.
7. The Privacy Act 1993 allows for the disclosure of information to third parties in emergency or life-threatening situations. Guidance on this issue is available at [www.privacy.org.nz](http://www.privacy.org.nz).
8. Don't use language that stigmatises or demeans a person who has attempted suicide (see unacceptable terms in Appendix 3).
9. Local emergency departments and mental health services develop a clear agreement on the point at which people presenting at risk of suicide are seen by mental health staff.

## 2 Initial triage and emergency department suicide risk assessment

This section provides guidance on triage and emergency department suicide risk assessment to support frontline decision-making when a person who may be at risk of suicide presents to the emergency department. Figure 1 summarises the process to follow in the emergency department, including when the person leaves the department to be followed up by mental health services for a comprehensive mental health assessment or management by primary care. Each of these stages is illustrated through Algorithms A, B and C.

**Figure 1: The process inside the emergency department**



### 2.1 Triage

The purpose of triage is to prioritise people presenting at the emergency department to identify those who need to be seen immediately, and determine how long people can wait to have a medical assessment and treatment. The triage nurse assigns a triage code from 1–5, based on a brief assessment.



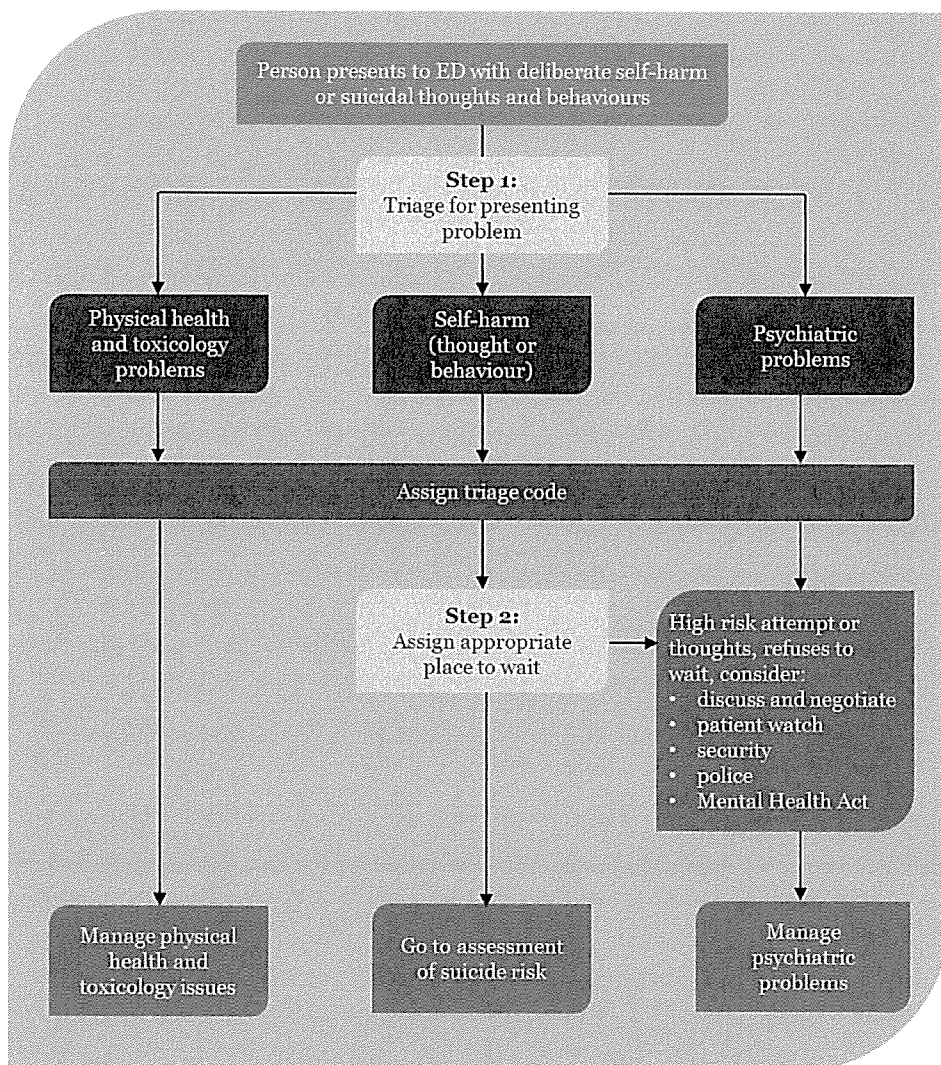
For people presenting at risk of suicide, the purpose of triage is to:

1. identify those people who need to have a suicide risk assessment
2. determine the urgency for that assessment (assign a triage code)
3. assign the person a place to wait and plan for the person's safety until the next point of care.

Triage for people with reported attempted suicide can be straightforward and obvious to the clinician. However, triage of a person who presents with a mental health problem or an injury that is not obviously from self-harm can be more difficult.

Algorithm A (Figure 2) illustrates the process of triage, from identifying people at risk of suicide to making a decision about whether a person needs a suicide risk assessment. Figure 3 outlines the triage codes that are to be assigned in relation to the observed behaviours during the triage assessment. The codes are based on the Australasian triage scales that are currently used in most New Zealand hospitals (also see Appendix 4). An explanation of Algorithm A is provided in the following sections.

**Figure 2: Algorithm A – triaging people who present at risk of suicide**



Note: Assessment of suicide risk and psychiatric problems should begin as soon as the person can be interviewed rather than waiting for medical clearance.

**Figure 3: Triage codes**

Observed behaviours	Triage code and observations
Violent, possesses weapon, self destruction in ED. Poses danger to life. Presents under Mental Health Act.	<b>1. Immediate</b> Observe: Continuously Contact police/security to assist?
Extreme agitation, aggressive, confused, unable to cooperate.	<b>2. Emergency</b> Observe: Maximum of 10 min intervals Consider: 1:1
Restless, intrusive or bizarre behaviour. Confused, psychotic symptoms, ambivalent about treatment.	<b>3. Urgent</b> (seen within 30 mins) Observe: Close (check every 10 minutes)
No agitation, irritable without aggression. Cooperative, coherent history. Reports anxiety or depression.	<b>4. Semi-urgent</b> (seen within 60 mins) Observe: Intermittent (check every 30 minutes)
Restless without aggression, cooperative, communicative and compliant.	<b>5. Non-urgent</b> (seen within 120 mins) Observe: General waiting room

Source: Adapted version of the Australian Mental Health Triage Scale (AMHTS).<sup>12</sup> (See also Appendix 4 for a detailed outline of the observed behaviours and management guidance.)

### Step 1: Triage for presenting problem

When a person first presents at the emergency department, it is important to quickly identify if the person is at risk of suicide. The person may be in obvious distress, have self-harmed or be affected by drugs or alcohol, and they may be at risk of danger to self or others.

To facilitate the triage process it is important, wherever possible, to:

- conduct the assessment in a separate interview room that provides privacy when disclosing sensitive information<sup>13</sup>
- have Māori health workers and emergency department staff available to support Māori people and their family/whānau
- have professional support available for people of other cultures (e.g. Pacific and Asian people)
- involve family/whānau (where appropriate) who can provide important additional information to inform triage.<sup>14</sup>

The quality of the interaction between emergency staff and the person presenting is important because it may affect suicide risk. An empathic and compassionate approach may ease suicide risk, while a judgemental or unwelcoming approach may increase risk.

The person at risk of suicide may present with multiple problems that need to be addressed. These include:

- self-harm
- psychiatric problems
- physical health and toxicology problems.

It is important to identify:

- whether the person has done or taken anything to harm themselves that day or in the past 24 hours
- whether they have been having suicidal thoughts.

It is best to ask the person if they have had suicidal thoughts (in the past few days or weeks) in a direct, non-judgemental way. The following question can help to quickly identify whether or not the person has suicidal thoughts:

Have you had any recent thoughts of harming yourself?

People experiencing suicidal thoughts might deny them initially to avoid talking about it. In this situation it may be useful to continue the discussion with:

Sometimes when we are going through tough times we just want it all to go away.

Then, try asking broader questions such as:

- Have you ever thought about death and dying?
- Have you ever thought about ending your life?

Then, narrow the questions to recent thinking. Table 1 sets out two very brief sets of sample questions that can be incorporated into the triage process if there is sufficient time.<sup>15</sup>

**Table 1: Brief sample question sets to assess suicidal thinking**

Question set I <sup>16</sup>	Guide
Q1) In the past month, have you ever wished you were dead, or could fall asleep and not wake up? (Y/N)	Y/N Ask Q2, regardless of the answer to this question.
Q2) In the past month, have you actually had any thoughts of ending your life?	(Y/N)
Question set II <sup>17</sup>	Prompts
Q1) In the past two weeks, have you been bothered by thoughts that you: <ul style="list-style-type: none"> <li>• would be better off dead</li> <li>• want to hurt yourself in some way?</li> </ul>	<ul style="list-style-type: none"> <li>• No, not at all</li> <li>• Several days</li> <li>• More than half the days</li> <li>• Nearly every day</li> </ul>

Key:

- A positive response to any of the above three sample assessing questions about suicidal thinking, especially in the presence of any of the indicators outlined in Step 1 above, should initiate *safety planning* using a tool like the Emergency Department Mental Health Triage Scale.<sup>18</sup>
- To facilitate engagement and to help develop the best clinical impression for triage, briefly explore those thoughts with the person: “What sort of distress do these thoughts cause?”; “What sort of distress are these thoughts connected with?”; “How frequently do these thoughts occur to you?”; “Are they fleeting thoughts or do you tend to dwell on them?”; “How long?”

### Assigning a triage code

Any person who has attempted deliberate self-harm or who is expressing suicidal thinking should be categorised to triage category 4 and above.<sup>19</sup> The triage code is assigned based on the triage assessment, which estimates the urgency for treatment – not the seriousness – and the need for a suicide risk assessment. A person presenting with suicidal thinking is serious but may not be urgent.<sup>20</sup> Assigning a level of urgency and a waiting time combines many competing factors: the triage code is specific to this person, at this time. It also takes into account the current demand load in the emergency department.

Emergency departments often have to triage and manage people with physical and mental health needs. A rapid decision needs to be made about the prioritisation of those needs and whether assessment is offered sequentially or concurrently for both sets of needs. Depending on the person's condition, management of both needs can often occur in parallel (e.g. rather than waiting for physical and toxicological problems to be managed and medical clearance given before the suicide risk assessment begins).

### **Step 2: Assigning the appropriate place to wait**

In this step it is important to identify the most appropriate place for the person presenting to wait for the suicide risk assessment. Ideally a separate area where stimulation can be reduced or re-directed (e.g. through use of sensory cues or tools),<sup>21</sup> would be available for people assigned to triage levels 2 and 3 to facilitate de-escalation of arousal and optimise observation.<sup>22</sup>

It is essential that a brief explanation of the suicide risk assessment be provided, along with the possible outcomes of that assessment.

In conjunction with the person presenting, determine how to:

- involve family/whānau or friends for immediate support
- support the person to maximise their own safety at this point, including negotiating with them to hand over any means of self-harm.

Family/whānau or accompanying people should be involved to help the person at risk feel safer, especially while waiting for further assessment. If there is no family/whānau available, a person such as a peer support worker should be engaged.

For Māori people this is an opportunity to practise manaakitanga. This includes activities that aim to reduce distress even in a busy environment, such as ensuring the environment is accommodating and as private as possible, offering tea or water, and ensuring that whānau and significant others are kept informed. For Pacific people and people of other cultures it is also important to address cultural needs.<sup>23</sup>

Where there is a high risk of the person leaving the emergency department, or of imminent self-harm or suicide, an increased level of observation is required. Each triage code recommends the frequency of observations required for people waiting for assessment (see Figure 3).

People who are categorised as:

- code 1 are likely to be at considerable risk of suicide and require one-to-one observation in the same room
- code 2 may require one-to-one observation or 10-minute frequent observations
- codes 3 and 4 require frequent observations (at 10- and 30-minute intervals, respectively).

Observing a person at risk of suicide requires an assessment of the person's current state of mood and cognition,<sup>24,25</sup> not just their vital signs. This requires talking to the person so they understand and feel comfortable about being observed until their next point of care.<sup>26</sup> The need for observation should always be discussed and agreed with the person and their family/whānau.

Where possible the triage assessor should personally 'hand over' the person to the next point of care in the assessment process to ensure the person's safety. The practice of having a 'warm transfer'<sup>27</sup> signals to the person that their safety remains of paramount importance, even though their next contact is with a new person. A warm transfer could be very simple, involving personally introducing the person to the clinician who is going to do the suicide risk assessment.

#### When a person declines the invitation to wait

After discussing and negotiating the importance of waiting, a person may refuse to wait for the suicide risk assessment. In these situations the emergency department clinician may need to insist that the person waits for the assessment using the Mental Health Act to stop them from leaving.

If a person at risk of suicide leaves the emergency department without warning, it is important to ensure the person is aware of who to contact and how to get the help they need. In addition:

- family/whānau and/or significant others should be notified
- the police need to be informed, alerted to the potential risks and provided with a clear description of the person
- the mental health crisis team also need to be informed.

## **2.2 Suicide risk assessment in the emergency department**

The emergency department clinician's role in suicide risk assessment is to provide initial assessment and management of short-term risk. In most cases 'short-term' will be a matter of hours or days. In particular, it is important to quickly identify people at low risk of short-term self-harm, who may be discharged home pending subsequent mental health follow-up.

Predicting and mitigating suicide risk in the short term is very difficult for the clinician given the current evidence base, which indicates that:

- most risk factors are poor predictors of imminent and short-term risk<sup>28</sup>
- unconscious or implicit attitudes are arguably the most powerful imminent and short-term predictors of suicide, but currently these are difficult to assess in the clinical setting<sup>29</sup>
- while thought may have gone into a suicide attempt, it is often not a thoughtful act but one made in a state of severe emotional distress, where suicide seems the only solution.<sup>30</sup>

Nevertheless, emergency department clinicians can be confident that assessing and managing people at risk of suicide is likely to reduce the suicide risk. This section provides two structured clinical approaches for assessing suicide risk.

1. The Emergency Department Suicide Risk Assessment (EDSRA):  
The EDSRA is outlined in Algorithm B and consists of eight steps. It has been adapted for New Zealand from the *Suicide Assessment Five Step Evaluation and Triage (SAFE-T)*, which has been developed and validated for use in emergency department situations.<sup>31</sup> This adaptation is based on recent evidence of short-term suicide risk predictors, current

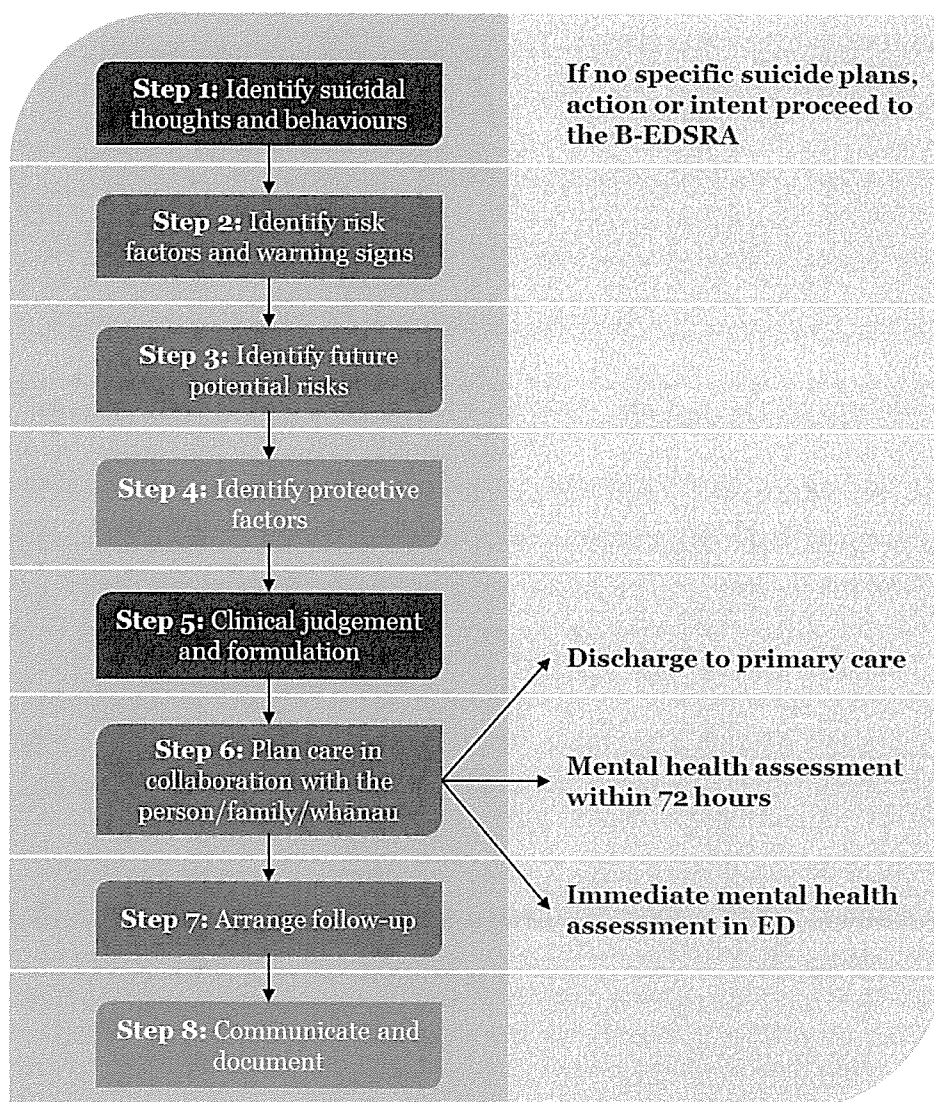
evidence and best practice. Each of the eight steps is explained in the pages following Algorithm B.

2. The Brief Emergency Department Suicide Risk Screening Assessment (B-EDSRA): The B-EDSRA is a subset of the EDSRA. It is focused on identifying those people who are at low risk of suicide over the next few days and who may be discharged, with mental health review occurring after discharge (preferably within 24 hours), thus avoiding a potentially long wait in the emergency department.

If there are no specific suicide plans, actions or intentions, as indicated in Step 1 of the EDSRA (Algorithm B), then the clinician can use the B-EDSRA (Algorithm C).

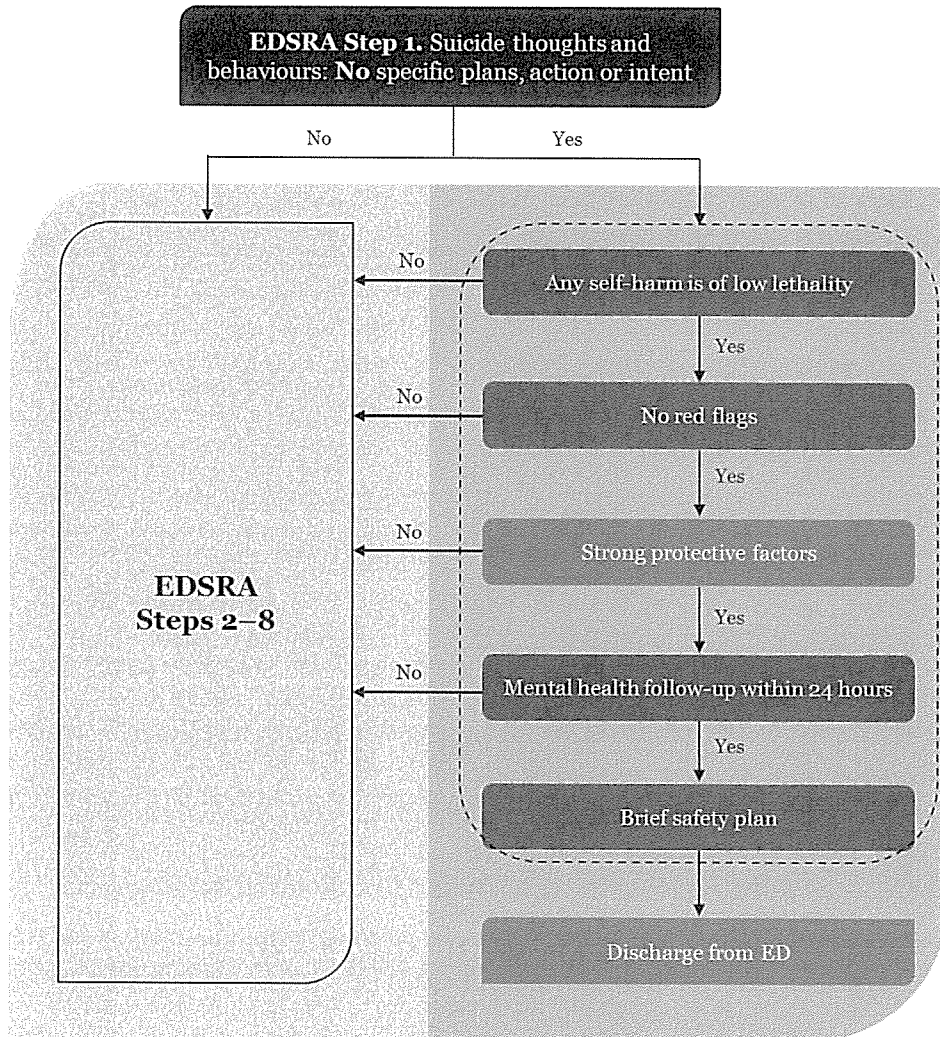
The B-EDSRA includes the steps of the EDSRA that are essential to determine if a person's suicide risk is low in the short term. It is important that the emergency department clinician understands both algorithms. The B-EDSRA is explained in the section following the EDSRA (see Algorithm C and Appendix 6).

**Figure 4: Algorithm B – the Emergency Department Suicide Risk Screening Assessment (EDSRA)**





**Figure 5: Algorithm C – The Brief Emergency Department Suicide Risk Screening Assessment (B-EDSRA)**



### 2.2.1 The Emergency Department Suicide Risk Assessment (EDSRA)

The practice of suicide risk assessment differs within emergency departments throughout New Zealand. The person at risk of suicide could:

- be referred to mental health services for a suicide risk assessment immediately after triage
- be referred to mental health services for a suicide risk assessment after emergency department staff have undertaken an initial brief suicide risk assessment
- have the EDSRA completed by emergency department staff with the training and competence to do so, although this is uncommon.

It is important to note that the EDSRA can be led by a range of health professionals who have responsibility for suicide risk assessment in their department/s.

#### Step 1: Identify suicidal thoughts and behaviours

Step 1 follows triage and is an essential component of the EDSRA. This step is aimed at identifying a person's suicidal thoughts and the degree to which they want to act on those

thoughts. The person may have already presented with self-harm or have made a suicide attempt, or may present with suicidal thoughts or ideation only.

The clinician should assess the following thoughts and behaviours:

1. suicide thoughts and ideation
2. suicide plans
3. suicide actions
4. suicide intent
5. suicide capability.

### 1 Suicidal thoughts or ideation

The presence of recent suicidal thoughts will have been identified at triage, but further exploration may be necessary to identify what people have done and thought regarding suicide. The following table provides questions that can assist the clinical assessment.<sup>32</sup>

**Table 2: Questions for assessing suicidal thoughts or ideation**

Questions	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
What did you do?	✓	
Did you do that as a way to end your life?	✓	
Did you want to die? or Did you think it was possible you could have died?	✓	
Why didn't it work?	✓	
How do you feel about it not working? or How do you feel about still being alive?	✓	
Do you intend to try again? If so, how?	✓	
How often are the suicidal thoughts occurring?	✓	✓
How intense are they?	Ask if needed	✓
How long do they last?	Ask if needed	✓
How recent (e.g. in the past month, in the past two weeks, in the past two days)?		✓

### 2 Suicide plans

The following table includes suggested questions for identifying whether the person has suicide plans.<sup>33</sup>

**Table 3: Questions for assessing suicide plans**

Questions	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
Have you been thinking about how you might kill yourself?	Ask about any further attempts (e.g. "Are you still thinking about how you might kill yourself?")	✓



What have you thought of doing? (Note: be as specific as possible. For example, if someone says they would hang themselves, ask: When would you do it? Where would you get the rope? Do you think it would hold your weight? Where would you hang it from? Do you know how to make a noose? Have you researched it? Where (e.g. on the internet, in books, television programmes)?	Ask about any further attempts	✓
Do you think it would work?		✓
Have you tried to do this in the past?		✓

### 3 Suicide actions

The areas in Table 4 should be considered when assessing if the person has taken any actions towards completing suicide.

**Table 4: Areas for assessing suicide actions**

Areas to assess	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
Preparations taken to act on plan	✓	✓
Rehearsals of the plan, either mentally or physically	✓	✓
Saying goodbyes	✓	✓
Giving away possessions	✓	✓
Suicide note	✓	✓

### 4 Suicide intent

Table 5 suggests questions for assessing suicide intent.<sup>34</sup>

**Table 5: Questions for assessing suicide intent**

Questions	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
How much do you want to be dead?	✓	✓
Do you intend to act on these thoughts and plans?	Question future intent	✓
What has stopped you doing so?		✓

When the clinician is assessing for suicide intent, it is important to consider the person's:

- strength of desire to die
- intention or determination to act on the desire to die
- ability or willingness to resist the desire to die.

### 5 Suicide capability

It is important to assess acquired suicide capability because it captures the ability of a person to act on suicide intent. Those people who have high suicide capability are much more likely to attempt suicide than those with low capability for any given degree of suicide ideation or intent.

Suicide capability is thought to be acquired over time through repeated exposure to and tolerance of pain (such as through physical contact sport or fights), fearlessness of death and repeated suicide attempts.<sup>35,36,37</sup> Suggested questions for identifying suicide capability are outlined in Table 6.

**Table 6: Questions for assessing suicide capability**

Questions	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
Compared to most people, how scared of dying are you?	✓	✓
Compared to most people, how well do you cope with pain?	✓	✓

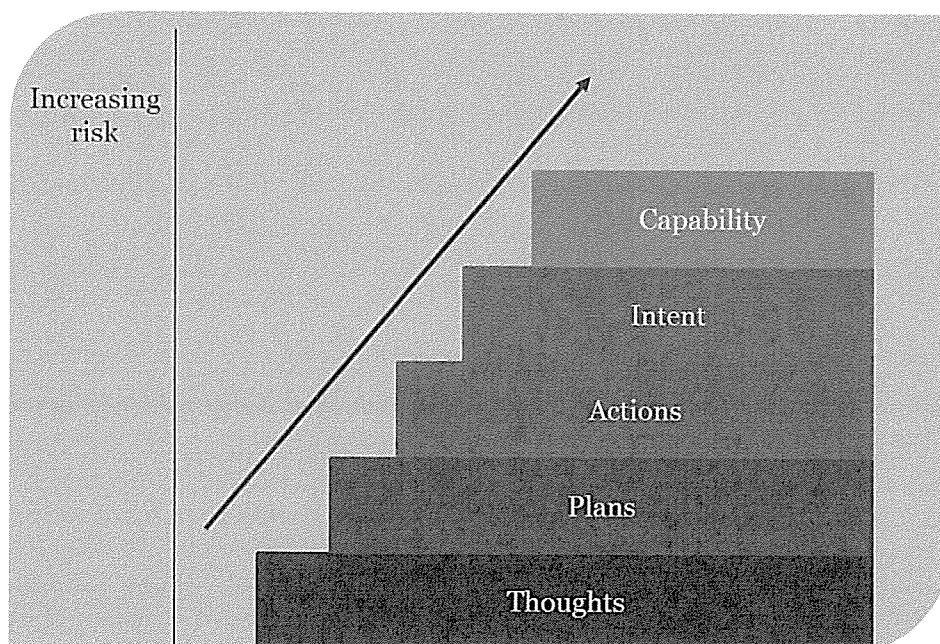
When assessing suicide thoughts and behaviours, it is also important to consider the following possibilities.

- The person may be withholding intent (i.e. not telling you what they have been thinking of planning). This may be because they don't want you to stop them acting on suicidal thoughts.
- A person's suicide intent can change quickly. For example, plans can be developed and put into practice in a matter of minutes.

If possible, supporting information (from family/whānau, partner, husband or wife and friends) may help to reveal withheld intent or changes in state.

Figure 6 illustrates the cumulative effect of thoughts, plans, actions, intent and capability on suicide risk. Taking the cumulative effect into account can help the clinician with their assessment of the level of risk. For example, a person with suicidal thoughts but without the other factors is likely to be at low short-term risk; the person who has high intent but no plans or actions has a lower risk than the person who has intent plus plans plus actions.

**Figure 6: The cumulative effect of factors on suicide risk**



## Step 2: Identify risk factors and warning signs

This step identifies other risk factors and warning signs that are red flags for emergency staff. Risk factors are things that increase the risk of a person attempting suicide. This section focuses on two types of risk factors:

1. short-term
2. dynamic.

See Appendix 7 for information on static risk factors and warning signs.

### 1 Short-term risk factors

Emergency department clinicians should assess for factors that increase the short-term risk of suicide. There is emerging evidence to suggest that the important factors for short-term suicide risk are:

- implicit attitudes
- ruminative flooding and frantic hopelessness
- psychotic symptoms
- past suicide attempts
- substance intoxication
- depression and insomnia.

These are important imminent or short-term risk factors that need to be identified by the clinician during the EDSRA.<sup>38</sup> An explanation of these is provided below, including tools to identify ruminative flooding and frantic hopelessness and depression.

**Table 7: Important factors for short-term suicide risk**

Factors
Implicit attitudes
Ruminative flooding and frantic hopelessness
Insomnia
Psychotic symptoms
Past suicide attempts
Substance intoxication
Depression

#### *Implicit attitudes*

Implicit attitudes have been shown to be the strongest predictors of imminent and short-term suicide risk. They exist at a person's unconscious level and therefore are not able to be accessed through direct questioning. In assessment, they can be detected by observing the person's body language, tone of voice and inconsistencies between what is said and how it is said. This subjective information, along with objective information, can inform clinical judgement.<sup>39</sup>

#### *Ruminative flooding and frantic hopelessness*

The person with ruminative flooding has a confusing, uncontrollable and overwhelming profusion of negative thoughts. They do not believe life can be improved and have feelings of being trapped and of imminent doom. Ruminative flooding and frantic hopelessness are emerging as important imminent and short-term predictors of suicide.<sup>40</sup> They characterise a

state of severe distress, which is often associated with the physical sensation of pressure in the head.

This state can be identified reliably through the abbreviated six-item Suicide Trigger Scale 3 (STS-3) (see Table 8). The STS-3 has been validated in emergency departments.

**Table 8: Suicide Trigger Scale 3 (STS-3)**

STS-3		
I would like to ask you some questions about the way you were feeling over the <u>last several days</u> , when you were dealing with thoughts, feelings and events that brought you to this emergency department. Is that okay?	<i>In the past several days ...</i>	1 Not at all
	1 Did you feel trapped?	2 Somewhat
	2 Did you feel there was no exit?	3 Very much
	3 Did you feel your head could explode from too many thoughts?	
	4 Did you feel bothered by thoughts that did not make sense?	
	5 Did you feel your thoughts were confused?	
	6 Did you feel like you were getting a headache from too many thoughts in your head?	

**Key:**

- A response of 'somewhat' or 'very much' to any of the questions should weight the decision towards referring the person for a comprehensive specialist mental health assessment.
- Two 'very much' responses is considered positive for this state.

In the emergency department context, a single positive response may be considered sufficient to indicate that a comprehensive mental health assessment should be undertaken before the person leaves the emergency department.

*Insomnia and nightmares*

Insomnia and waking due to nightmares can both be independent short-term predictors of suicide. Most suicides (as a percentage of people who are awake at any time) occur between midnight and 6 am.<sup>41</sup>

*Depression*

The two-question abbreviated version of the nine-item Personal Health Questionnaire<sup>42</sup> (PHQ-2) can help the emergency department clinician to identify the presence of depression. It has a diagnostic performance that is comparable with that of longer depression scales.<sup>43</sup> A state of depression is indicated if the person answers either PHQ-2 question with a frequency of several days or more. Sample questions to see if depression is an underlying condition are outlined in Table 9 below.

**Table 9: Personal Health Questionnaire (PHQ-2)**

PHQ-2		
Stem question: <i>In the past two weeks, how often have you been bothered by either of these problems?</i>	Question items: a. little interest or pleasure in doing things b. feeling down, depressed, or hopeless	Response options and scoring: • Not at all • Several days* • Half the time* • Nearly every day*

\* These responses are indicative of the presence of depression.

## 2 Dynamic risk factors

Dynamic factors are risk factors that can change. Assessment of the dynamic risk factors below should follow the assessment of the short-term risk factors identified above. While there is a lack of evidence that they are predictive of short-term suicide risk, dynamic risk factors are important.

The dynamic risk factors for suicide are:

- access to lethal means (e.g. firearms, hanging, medication)
- mental health symptoms: psychotic symptoms, anxiety, depressed mood, anhedonia, hopelessness
- physical health problems (e.g. chronic pain)
- family conflict
- lack of social and family/whānau support
- loss (e.g. relationships, employment)
- whakamā, shame, humiliation, despair, loss of status
- exposure to domestic violence
- homelessness
- cultural and religious beliefs that promote suicide
- legal problems
- financial problems.

### **Step 3: Identify future potential risks**

The dynamic factors identified in Step 2 can change quickly and unpredictably. It is essential that emergency department clinicians identify events that might occur in the short term that have the potential to increase the risk of suicide. Examples include any possibly stressful situations such as periods of isolation, arguments with family or partner, bullying, court appearances, exams, situations encouraging substance use, and financial deadlines.

### **Step 4: Identify protective factors**

Protective factors are factors that reduce or protect against suicide and can be thought of as risk factors reframed in a positive way. Many commonly cited protective factors are based on clinical opinion rather than clear evidence, particularly among population subgroups.<sup>44</sup>

Protective factors that can be explored during assessment are:

- reasons for living
- concern for others: children, parents, friends, pets
- ability to cope with stress; resilience
- frustration tolerance
- access to treatment
- positive attitudes towards treatment
- positive therapeutic relationship/s
- strong connections to supportive family/whānau
- strong connections to positive social supports/friends
- good problem-solving skills

- good conflict resolution skills
- cultural and religious beliefs that do not support suicide
- a sense of belonging and being part of society
- feeling safe and supported at school
- employment; meaningful work.

This should not be treated as a checklist in the assessment process, but used in conjunction with assessing risk factors. For instance, if a person has just lost their job, it can be assumed that employment is not a protective factor.

It is important to identify protective factors during assessment because it draws attention to a person's strengths and resources that can mitigate suicide risk in both the short and long term. Simply asking about and exploring protective factors, especially reasons for living, may reinforce the benefits of protective factors.

Identifying problem-solving skills is particularly important because there are brief interventions that may strengthen this skill set. It is usually evident if a person is unable to problem solve effectively, because they are likely to be conflicted about a particular problem they cannot solve. These people are likely to be ruminating and feel there is no way out. Often they will have framed the problem in abstract terms; for example, 'I am a failure' or 'The world is unfair'. Such abstract thoughts are hard to resolve.

This may be helped by assisting the person to learn to make these thoughts more concrete, by focusing on the specific details of the situation that triggered the thoughts then helping them to generate and weigh up a range of ways to deal with them.

### **Step 5: Clinical judgement and formulation**

This step identifies a person's level of short-term suicide risk. It is a process of structured clinical judgement that is based on the information collected through the structured suicide risk assessment process in Steps 1–4, balanced by clinical intuition and experience.

In this step the risk of suicide can be described as follows:

Risk of suicide = suicidal thoughts and actions + risk factors + future risks - protective factors

In considering the next stage and treatment for the person, clinicians need to be cautious when:

- there are inconsistencies in the history given
- the person's history and behaviour appear to be in conflict
- the person's mental state or circumstances appear to be changing rapidly
- the clinician's intuition conflicts with their rational consideration of factors.

In these circumstances the reliability of a structured clinical judgement may be poor and the clinician should err on the side of caution. The clinician can always phone or meet with the mental health team responsible to discuss their clinical judgement. If the clinician considers that their structured clinical judgement is reliable, it is important for them not to be excessively cautious in considering the best treatment and next stage of care for the person.

Treatment decisions must be based on reducing risk and achieving the following outcomes:

- enhancing wellbeing for the person
- treating the person's emotional and mental health problems
- using the most appropriate and least restrictive setting for the person's treatment
- using a wellbeing or recovery approach that involves empowering the person and their family/whānau, sharing decision-making and taking into consideration the wishes and values of the person and their family/whānau
- using treatment resources efficiently.

Completing a risk–benefit analysis can be very useful to the clinician deciding between several treatment options.<sup>45</sup> For example, an analysis of the risks and benefits can clarify the best course of action when deciding whether a person needs a comprehensive assessment before leaving the emergency department, or whether they can return home and have the assessment done sometime within 72 hours.

### **Step 6: Plan care in collaboration with the person and their family/whānau**

Step 6 involves developing a short-term care action plan in conjunction with the person, their family/whānau (if present) and their support people to manage the current crisis and transition care to either primary or mental health services. It is important to give the wishes of the person and/or their family/whānau prominence in decision-making.

It is important that this action plan include steps the person can take to manage any further distress, including how to seek help and who to contact if risk increases (see Table 10). It is essential that short-term plans developed in the emergency department are consistent with any existing mental health plans the person may already have.

There are three main options for emergency department clinicians when considering further management of a person who has been assessed for suicide risk.

- **Discharge to primary care:** this may occasionally occur when people have presented with self-harm of low lethality. In these cases there will have been no thought or intent to suicide, no red flags present, no evidence of other significant psychiatric problems, and there will be strong protective factors.
- **Comprehensive mental health assessment within 72 hours, but preferably by the next working day:** most people presenting with suicidal thoughts or behaviours will require a more comprehensive assessment prior to leaving the emergency department.
- **Comprehensive mental health assessment before leaving the emergency department:** if a person requires a comprehensive mental health assessment by a mental health clinician in the emergency department, a safety plan also needs to be developed to support the person while they are waiting for the assessment. This plan will include observation levels.

#### Short-term action plan for the person who is discharged

The Safety Planning Intervention (SPI) is considered best practice by the Suicide Prevention Resource Centre and Substance Abuse and Mental Health Services Administration in the USA. It is an acceptable process for developing a short-term action plan. The SPI is designed to be developed in collaboration with the person and their family/whānau, and is ideally written by the person him/herself. Table 10 identifies the six steps for developing a short-term action plan (also see Appendix 8).<sup>46</sup>

**Table 10: SPI and short-term action plan when a person is discharged**

<b>Six steps for developing a short-term action plan</b>	
Warning signs	The first step involves identifying when the plan needs to be implemented and recognition of the signs that precede a significant increase in suicidal thoughts.
Internal coping strategies	The person identifies a range of internal or personal coping strategies aimed at distracting them from their suicidal thoughts.
Social contacts or places that may distract from the crisis	The person identifies social contacts or places that will distract them from their suicidal thoughts. These should be contacted if internal coping strategies do not reduce suicidal thoughts or risk level.
Family members or friends who may offer help	The person identifies and documents the names and contact details of several family members or friends who will be able to provide support should steps 2 and 3 not be helpful.
Professionals and agencies to contact for help	A list of the appropriate health professionals and/or service contact numbers is listed for the person to contact.
Making the person's environment safe	The person identifies items in the environment that could be used to self-harm and is encouraged, or if high risk supervised, to remove access to these items.

The *Safety Planning Guide* is more detailed and includes prompting questions for clinicians. It can be downloaded from the SPRC website:

[www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf](http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf)

### Brief interventions

Some emergency department staff may have the skills to offer brief interventions before the person is discharged from the service. The following interventions may be useful:

- brief problem-solving skills
- medication for insomnia
- some brief sensory modulation strategies.<sup>47,48</sup>

### **Step 7: Arrange follow-up**

It is important that follow-up is arranged for the person who is discharged from the emergency department. Continuity of care is very important because discontinuities and gaps in care can significantly increase suicide risk and are known to make people experiencing mental distress feel unsafe.<sup>49</sup>

It is essential that the appropriate linkages and connections are made for the person in accordance with their short-term action plan (see Step 6). It would also be beneficial for the person if a personal connection could be made with the health professionals and service to which they are being referred.

Where possible, the risk assessor should personally 'hand over' the person to the next point of care. The practice of 'warm transfer' signals to the person that their safety remains assured, even though their next contact is with a new person.<sup>50</sup>

### **Step 8: Communicate and document**

In this step the clinician ensures that the following actions have been completed.

- Important information is obtained.
- Clinical decisions are made.
- Interventions undertaken are communicated effectively to the person and family/whānau.



- Interventions and plans are communicated to all agencies involved between leaving the emergency department and the next point of contact (usually transitioning to primary care or mental health services).

### Communication

It is important that the clinician communicates effectively, as follows.

- Information and explanations are given to the person and their family/whānau.
- Liaison has taken place with the appropriate mental health team.
- Liaison has taken place with all other parties involved in the person's plan.
- Written resources have been provided to the family/whānau.

### Documentation

There are two reasons for documentation:

1. to communicate information to other people who will continue to be involved in the person's care
2. to provide a record of decisions related to care.

Given that documentation is not always possible in the emergency department, clinicians should endeavour to supply important information verbally in support of what is documented. Written information should be sufficient for the person taking over care to be clear about the nature of the issues being addressed and the next actions. This will also ensure that people are not asked the same questions every time care is transferred.

It is important to note that acceptable documentation of a sound clinical process is a good medico-legal defence in situations where there are unwanted outcomes that could not have been predicted for the person who leaves the emergency department.

Documentation should include the following information:

- the circumstances of presentation
- suicide thoughts and actions
- key risk factors and protective factors
- future risks
- clinical judgement and formulation
- a short-term care plan (including a safety plan and short-term action plan)
- involvement of family/whānau and significant others
- follow-up actions
- communications undertaken
- written resources offered to the person or family/whānau.

## **2.2.2 Brief suicide screening to identify people suitable for discharge from emergency departments**

The brief emergency department suicide risk screening (B-EDSRA) is a subset of the EDSRA and provides a structure to organise suicide risk assessment and clinical judgement. It is not a simple checklist, and *all* steps should be taken before a person is judged suitable to be

discharged without mental health review in the emergency department. Note that use of the B-EDSRA relies on an understanding of the EDSRA.

The B-EDSRA is focused on identifying those people who are at low risk of suicide in the days following the initial presentation and who may be discharged, with a mental health review occurring preferably within 24 hours after discharge, thus avoiding a potentially long wait in the emergency department. This is likely to be a relatively small number of people.

The B-EDSRA is initiated following Step 1 of the EDSRA in which the emergency department clinician has determined the lethality and perceived lethality of any self-harm attempt, and has asked about suicidal thinking and behaviours. If there is no evidence of specific plans to suicide, acts indicating suicidal behaviours or suicidal intent, the clinician may proceed down the brief assessment (B-EDSRA) pathway (see Algorithms B and C).

The steps of the B-EDSRA focus on what has been identified during the suicide risk assessment and are as follows.

### **Step 1: Low-risk attempt**

- Any self-harm attempt is of low lethality, and
- Any self-harm attempt is perceived by the person to be of low lethality.

### **Step 2: No red flags**

Red flags for short-term suicide risk include:

- suicidal thoughts and behaviour:
  - specific plans
  - actions
  - intent to suicide/die in near future.
- short-term risk factors:
  - ruminative flooding
  - frantic hopelessness
  - psychotic symptoms
  - substance intoxication
  - severely depressed mood or insomnia (in the presence of other risk factors such as suicide plans and actions)
- other risk factors:
  - access to means to suicide (firearms, medication, hanging) that cannot be removed or secured
  - events in the near future likely to escalate suicide risk (e.g. a pending court appearance, separation, job loss)
  - the clinician's impression that information obtained is unreliable or inaccurate.

### **Step 3: Significant protective factors**

These especially include:

- strong connections to supportive family/whānau with close support
- reasons to live
- open communication between the person and their family/whānau or caregivers

- agreement by the person to let family/whānau or caregivers know if suicidal risk factors become more intense.

#### **Step 4: Brief short-term safety plan**

Essential information includes:

- indicators of increased risk
- contacts and phone numbers of support people, health professionals and services.

Emergency departments may also have pre-prepared information they can give to the person and their family/whānau or caregivers.

#### **Step 5: Arranged mental health follow-up in next 24 hours**

Where possible it is important for the hand over to mental health services to occur person-to-person. If there is any doubt about the suitability for discharge prior to a mental health review, the case should be discussed with a mental health clinician or a mental health clinician should review the person within the emergency department. Please see Appendix 9 for a case scenario.

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## 3 Specific issues in the emergency department

This section presents a short summary of important areas that emergency department clinicians should consider when triaging and assessing people at risk of suicide. The 2003 *Guidelines* have more detailed information and advice regarding these areas. The focus here is on highlighting the important considerations and identifying any updates or changes in advice from the 2003 *Guidelines*.

### 3.1 People who present often

- People who present frequently to the emergency department with thoughts of or attempts at self-harm are at increased risk of suicide and will usually be under the care of mental health services. These people should therefore have crisis or suicide action plans developed by mental health services that can be referred to by emergency department staff.
- Initial emergency department triage will need to estimate the suicide risk and develop a safety plan until mental health services can make contact with the person.

### 3.2 Intoxicated people<sup>51</sup>

- The nature of intoxication and its effect on the risk of self-harm is highly variable depending on the substances used, the dose taken and the person's response to the drug taken.
- While a full assessment of an intoxicated person may be unreliable or impossible to carry out, there are other information sources that can be assessed while someone is intoxicated, including family/whānau and friends, clinical records, and by assessing the person's demeanour.
- Intoxicated people at risk of self-harm should be provided with a safe environment until they are no longer intoxicated.
- A full comprehensive mental health assessment should be carried out after intoxication has resolved to the point that a reliable history can be taken.

### 3.3 Sedation<sup>52</sup>

The use of medication to sedate an extremely distressed or aggressive person with mental health problems, including risk of serious self-harm, may occasionally be considered after other coping strategies have been exhausted.

However, every attempt should be made to use non-pharmacological interventions first. These include:

- building rapport through a compassionate and respectful approach to the distressed person
- providing clear explanations of the process and any delays in the emergency department
- using family/whānau or friends to help calm the person, if it is appropriate and safe to do so

- exploring and correcting any interactions that may have triggered the distress or aggression in the emergency department (e.g. disrespect, or actions leading to loss of mana or breach of tapu)
- using karakia or prayer
- using security staff or police, especially when there is a risk to others.

### 3.4 Working effectively with Māori

A positive outcome for Māori is more likely when there is a cultural match between Māori and their health practitioner.<sup>53</sup> It is essential that medical and mental health issues are assessed and managed alongside cultural issues.<sup>54</sup> This requires emergency department staff to have a sufficient level of cultural competence in working with Māori people.

It is important that emergency staff attend to the principles of manaakitanga. This includes having and demonstrating respect for the individual and their family/whānau, building rapport, providing meaningful engagement, caring and aiming to reduce distress. Manaakitanga can be expressed through talking, listening, offering food and drink, acknowledging spiritual practices (aroha, karakia) and ensuring cultural connections (e.g. having whānau, kaumātua or Māori health advisors present).

The services of a specialist Māori mental health worker or Māori health specialist should also be offered at the outset of the assessment. It is important that emergency department staff have access to cultural training. Please also refer to the 2003 *Guidelines*.<sup>55</sup>

### 3.5 Working effectively with other populations

People from a range of population groups will present at emergency departments with suicidal thinking or having made a suicide attempt. These population groups include:

- children and young people
- older people
- Pacific people
- people of Indian descent
- Asian populations
- refugees and migrants
- people living on the streets or living rough (homeless people)
- people living with disabilities.

It is essential that emergency management staff understand the uniqueness of each of these population groups in order to achieve a positive outcome for people. Note that these population groups are not independent; a person could reasonably be a member of two or more groups. It is also important to understand that in many cultures there are strong stigmas and beliefs attached to suicide. The following important factors are summarised from the 2003 *Guidelines* (please refer to the original document).<sup>56</sup>

## **Children and young people**

It is important that children and young people are assessed by a clinician with experience in this area. The risk assessment should take information from a number of sources in addition to the young person (e.g. parents, teachers and guidance counsellors).

## **Older people**

Suicidal thinking or attempted suicide should be taken very seriously in older people. Risk assessments should consider both mental and physical causal factors and draw on information from relatives and/or friends.

## **Pacific people**

There are 22 different Pacific cultures in New Zealand, and each is unique. As well as undergoing a risk assessment in the emergency department, Pacific people should be offered the input of specialist Pacific mental health workers, where possible. Their preference for family involvement as well as the need for an interpreter should be explored.

## **People of Indian descent**

The Indian population in New Zealand is diverse. It is important to recognise the role and obligations to the family when assessing Indian people.

## **Asian populations**

The Asian population in New Zealand makes up 12 per cent of the total New Zealand population.<sup>57</sup> Within this group there are many different Asian populations; the Chinese population is the largest Asian group in New Zealand (40 per cent of all Asian people). It is important to note when assessing Asian people that while they may appear to be westernised, they may still have strong cultural values, including beliefs about the importance of family.

## **Refugee groups**

When assessing refugees it is important to recognise that many are likely to have been victims of past trauma and may not want to talk about the trauma. Refugees may require the use of an interpreter and may also require a referral to refugee specialist mental health agencies.

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# 4 Implementation

Implementing suicide prevention guidance in emergency departments is essential for improving the care of those at risk of suicide. Please also refer to the *Assessment and Management of People at Risk of Suicide: For emergency departments and mental health service acute assessment settings*<sup>58</sup> for more comprehensive information about implementation.

Successfully implementing suicide prevention guidance in emergency departments requires that:

- a recovery-focused service is already in place
- access to the relevant emergency department and mental health services for people presenting with suicidal thinking and/or suicide ideation or attempt is in line with suicide prevention guidance
- the appropriate service configuration, clinical pathways and service linkages are in place to manage people with suicidal thinking and risk
- suicide prevention guidance is available in different formats for emergency staff (e.g. summaries, posters and decision support tools)
- the emergency department workforce is appropriately trained and/or upskilled in suicide assessment, management, treatment, referral and discharge planning
- the emergency department workforce has completed cultural training to increase skills in effectively managing people with suicidal thinking or risk, and their family/whānau
- emergency staff working with people who are suicidal have regular professional support/supervision to mitigate any personal negative impacts of this work, which may also affect the quality of their work
- a range of resources on suicide prevention are available in emergency departments for people accessing services, and for their families/whānau.

## 4.1 Training and self-care programmes

In order to competently assess and manage people at risk of suicide, it is essential that emergency staff have access to training and resources in:

- managing distress and agitation in the person who presents with a risk of suicide or self-harm
- building rapport, engagement and interviewing, including the ability to ask the necessary questions
- using clinical judgement to weigh up the level of care required (mental and physical health)
- interpreting and applying the Mental Health Act (Compulsory Assessment and Treatment) 1992.

Emergency departments should provide training that aligns with this guidance document. Such training should include the Chronological Assessment of Suicide Events (CASE) approach.<sup>59,60,61</sup>

This is an effective method of teaching techniques for interviewing people at risk of suicide that improves the clinician's ability to obtain good-quality information. This approach could be adapted for use in emergency departments. However, such adaptation is beyond the scope of this guidance document.

## 4.2 Emergency department quality systems and performance

Effective quality management systems improve care for all people, including those at risk of suicide or self-harm. In 2014 the Ministry of Health published a quality framework for emergency departments that was developed by a national advisory group.<sup>62</sup> This framework can be used by emergency departments to develop their quality systems.

A clinical audit package developed by the New Zealand Guidelines Group is also available for emergency services to use to assess themselves against four quality targets.<sup>63</sup> These targets relate to:

- access to a competent health assessment
- provision of a comprehensive assessment
- provision of a discharge plan
- follow-up.

An additional resource for district health boards (DHBs) to help realise quality standards through inter-agency collaboration and cross-DHB sharing is the *Suicide Prevention Toolkit for District Health Boards* available at [www.health.govt.nz/publication/suicide-prevention-toolkit-district-health-boards](http://www.health.govt.nz/publication/suicide-prevention-toolkit-district-health-boards).



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# Appendix 1: Glossary

**Ambivalence:** simultaneous positive and negative feelings or attitudes towards a person, thing, action or event. For example, in the case of suicidal feelings, a person may simultaneously wish to die and fear the pain of dying.

**Anhedonia:** loss of interest in and withdrawal from regular and pleasurable activities; often associated with depression.

**Anxiety (common):** an unpleasant feeling of fear and apprehension accompanied by physiological arousal (e.g. tension, increased heart rate, sweaty palms).

**Anxiety (disorder):** mental disorders in which fear, worry and tension are the primary problem. The fear is recognised by the person as excessive and may result in behaviours to reduce or escape from the fear, such as avoidance (e.g. agoraphobia) or ritualistic behaviour (found in obsessive compulsive disorder).

**Cluster B personality traits:** characterised by dramatic, overly emotional or unpredictable thinking or behaviour. They include antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder.

**Cognition:** the general ability to organise, process and recall information.

**Cultural responsiveness:** a set of values, behaviours, attitudes and practices evident in the work of an organisation or programme that enables it to be effective across cultures. It includes the ability of the programme to honour and respect the beliefs, language, interpersonal styles and behaviours of individuals and families receiving services.

**Depression (common usage):** feelings of sadness, despair and discouragement, which are part of normal experience.

**Depression (mental illness):** persistent and pervasive low mood or loss of interest in all or most usual activities, lasting at least two weeks and associated with other defined cognitive, somatic and emotional symptoms.

**Frantic hopelessness:** see *Ruminative flooding and frantic hopelessness*.

**Helplessness:** the sense of having no control over important events, one's situation or one's emotions. It is considered by many theorists to have an important role in both anxiety and depression.

**Hopelessness:** related to helplessness, the sense that a situation is unchangeable. It is also considered to have a key role in the maintenance of depression and suicidality.

**Insight:** the ability to understand the true cause and meaning of one's situation (such as, that one has a mental illness and requires professional assistance with this).

**Intent:** the degree to which a person plans and intends to act to take their own life.

**Intentional injuries:** injuries resulting from purposeful human action, whether directed at oneself (self-directed) or others (assaultive); sometimes referred to as violent injuries.

**Lethal means:** implements, substances, weapons or actions capable of causing death.

**Manaakitanga:** the concept of manaakitanga includes clinical concepts such as rapport, engagement, caring, reducing distress and treatment. It can be expressed in a number of ways, including physical acts such as talking, listening, offering food and drink; acknowledging spiritual practices (aroha and karakia); and ensuring cultural connections (having whānau, kaumātua and/or Māori health representatives present).

**Means:** the instrument or object by means of which a self-destructive act is carried out (e.g. firearm, poison, medication).

**Means restriction:** techniques, policies and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

**Mental disorder:** a diagnosable illness characterised by alterations in thinking, mood or behaviour (or some combination thereof) associated with disability and distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with 'mental illness'.

**Mental health:** the capacity of individuals to interact with one another and the environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational).

**Mental Health Act:** the Act that defines the circumstances in which compulsory assessment and treatment can occur. It protects the rights of patients and provides a legal framework consistent with good clinical practice. The Act is usually cited as the Mental Health (Compulsory Assessment and Treatment) Act 1992. Section 111 of the Act relates to the powers of nurse where urgent assessment is required that outline criteria for when a person may be detained for assessment by a medical examiner with a view to the issue of a certificate by that examiner.

**Mental health problem:** diminished cognitive, social or emotional abilities, but not to the extent that the criteria for a mental disorder are met.

**Mental illness:** see *Mental disorder*.

**Methods:** actions or techniques that result in an individual inflicting self-harm (e.g. asphyxiation, overdose, jumping).

**Mood:** a pervasive and sustained emotional 'climate' that colours a person's perception of the world (as opposed to 'affect', which is more reactive and fluctuating). For example, a depressed person may still be able to laugh at a funny movie.

**Mood disorders:** a term used to describe all mental disorders that are characterised by a prominent or persistent mood disturbance. Disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states. Mood disorders include depressive disorders, bipolar disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

**Post-traumatic stress disorder (PTSD):** a mental health condition that may develop as a result of exposure to an event that threatens life or safety. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

**Protective factors:** intrinsic or extrinsic features or circumstances that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.

**Psychiatric disorder:** see *Mental disorder*.

**Psychosis:** a disorder characterised by the presence of delusions and/or hallucinations and impaired reality testing. Psychosis is a common feature in some types of schizophrenia, but it can also occur in severe depression, mania or as the result of drug use.

**Resilience:** capacities within a person that promote positive outcomes (such as mental health and wellbeing) and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

**Risk factors:** a complex of features, characteristics or circumstances that make individuals more vulnerable to developing a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family and environment. Static risk factors are fixed and historical (e.g. where a patient has a family history of suicide). There are stable risk factors that are long term and likely to endure for many years, but are not fixed (e.g. in a patient who has a diagnosis of personality disorder). Dynamic risk factors are those that are present for an uncertain length of time. They may fluctuate markedly in both duration and intensity (e.g. where a patient has acute anxiety symptoms).<sup>64</sup>

**Ruminative flooding and frantic hopelessness:** ruminative flooding involves a confusing, uncontrollable and overwhelming profusion of negative thoughts, while frantic hopelessness involves a fatalistic conviction that life cannot improve and an oppressive sense of entrapment and imminent doom.<sup>65</sup>

**Screening:** administration of an assessment tool to identify people in need of more in-depth evaluation or treatment.

**Screening tools:** those instruments and techniques (questionnaires, checklists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

**Section 111 (of the Mental Health [Compulsory Assessment and Treatment] Act 1992):** see *Mental Health Act*.

**Self-harm:** the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

**Self-injury:** see *Self-harm*.

**Somatisation:** physical symptoms that are suggestive of a medical condition (e.g. pain), which cannot be or are not fully explained by the presence of any general medical condition.

**Stigma:** an object, idea or label associated with disgrace or reproach.

**Substance abuse:** a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use. It includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilisers and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

**Suicidal act (also referred to as suicide attempt):** a potentially self-injurious behaviour for which there is evidence that the person probably intended to kill himself or herself. A suicidal act may result in death, injuries or no injuries.

**Suicidal behaviour:** a spectrum of activities related to thoughts and behaviours that include suicidal thinking, suicide attempts and completed suicide.

**Suicidal ideation:** self-reported thoughts of engaging in suicide-related behaviour.

**Suicide:** death from injury, poisoning or suffocation where there is evidence that a self-inflicted act led to the person's death; deliberately bringing about one's own death.

**Suicide attempt:** a potentially self-injurious behaviour with a non-fatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

**Suicide risk:** often referred to as either imminent (immediate), short-term or long-term risk. There appear to be different understandings of the timeframes associated with short- or long-term risk periods. This guidance considers imminent risk to be within the next five days, short-term risk over the next 12 months and long-term risk beyond 12 months.

**Unintentional:** a term used to describe an injury that is unplanned; in many settings these are termed accidental injuries.

**Warning signs:** a suicide warning sign is the earliest detectable sign that indicates heightened risk for suicide in the near term (i.e. within minutes, hours or days). A warning sign refers to some feature of the developing outcome of interest (suicide) rather than to a distinct construct (e.g. risk factor) that predicts or may be causally related to suicide.<sup>66</sup>

# Appendix 2:

## Working group members

Person	Title
Dr Anil Nair	Emergency Medicine Specialist / Clinical Director Adult Emergency Department, Auckland City Hospital
Jim Ewens	Liaison Psychiatry, Adult Emergency Department, Auckland City Hospital
Dr John Bonning	Clinical Director, Emergency Department, Waikato Hospital, Chair of Australasian College of Emergency Medicine, New Zealand
Sharon Payne	Emergency Nurse Specialist, Hawke's Bay DHB
Dr Jay Amaranathan	Emergency Medicine Specialist, Wellington Regional Hospital
Professor Pete Ellis	Professor, Department of Psychological Medicine, University of Otago, Wellington
Dr Fraser Todd	Project Clinical Lead and co-chair; Senior Clinical Advisor, Matua Raki; Senior Clinical Lecturer, National Addiction Centre, University of Otago, Christchurch; Consultant Psychiatrist
Joan Taylor	Nurse Consultant, Specialist Mental Health Service, Canterbury DHB
Caro Swanson	National Service User Lead, Te Pou o Te Whakaaro Nui
Claire Barton	Quality Coordinator, Mental Health, Addictions and Intellectual Disability Services, Capital & Coast DHB
Lisa Cherrington	Clinical Psychologist, Te Rau Matatini
Denise Kingi-Uluave	Clinical Lead and Pasifika Suicide Prevention Lead, Le Va
Jane Bodkin	Senior Advisor Nursing, Office of the Chief Nurse, Ministry of Health
Jane Vanderpyl	Principal Advisor, Research and Evaluation, Te Pou o Te Whakaaro Nui (project member)
Laura Lambie	Project Lead and co-chair of the working group Te Pou o Te Whakaaro Nui
Mike Wilson	Research Associate, Te Pou o Te Whakaaro Nui (project member)
<b>Others consulted</b>	
Sunny Collings	Professor and Director: Social Psychiatry and Population Mental Health Research Unit; Consultant Psychiatrist

Note: while the working group is made up of members of their respective professional colleges, the document has not had the input of the colleges themselves. This was outside the scope of the work to develop the guidance document.

# Appendix 3:

## Unacceptable terms

A Centers for Disease Control and Prevention report outlined the following terms as unacceptable for describing self-directed violence.<sup>67</sup>

Unacceptable term	Explanation	Preferred alternative term
Completed suicide	This terminology implies achieving a desired outcome, whereas those involved in the mission of “reducing disease, premature death, and discomfort and disability” (J Last, <i>Dictionary of Epidemiology</i> , 1988) would view this event as undesirable.	Suicide
Failed attempt	This terminology gives a negative impression of the person’s action, implying an unsuccessful effort aimed at achieving death.	Suicide attempt or suicidal self-directed violence
Non-fatal suicide	This terminology portrays a contradiction. ‘Suicide’ indicates a death, while ‘non-fatal’ indicates that no death occurred.	Suicide attempt
Parasuicide	Formally used to refer to a person’s self-directed violence, whether or not the individual had an intention to die. However, the World Health Organization is now favouring the term ‘suicide attempt’.	Non-suicidal self-directed violence or suicidal self-directed violence
Successful suicide	This term also implies achieving a desired outcome, whereas those involved in the mission of “reducing disease, premature death, and discomfort and disability” would view this event as undesirable.	Suicide
Suicidality	This terminology is often used to refer simultaneously to suicidal thoughts and suicidal behaviour. These phenomena are vastly different in occurrence, associated factors, consequences and interventions so should be addressed separately.	Suicidal thoughts and suicidal behaviour
Suicide gesture, manipulative act and suicide threat	Each of these terms gives a value judgement with a pejorative or negative impression of the person’s intent. They are usually used to describe an episode of non-fatal, self-directed violence. A more objective description of the event is preferable.	Non-suicidal self-directed violence or suicidal self-directed violence

# Appendix 4:

## Australasian Mental Health Triage Tool

The following table provides the detailed criteria for the mental health triage tool.

Triage code: treatment acuity	Description	Typical presentation	General management principles <sup>a</sup>
<b>1</b> Immediate	<b>Definite danger to life (self or others)</b> Australasian Triage Scale <sup>b</sup> states: Severe behavioural disorder with immediate threat of dangerous violence	<b>Observed</b> Violent behaviour Possession of weapon Self-destruction in ED Extreme agitation or restlessness Bizarre/disorientated behaviour <b>Reported</b> Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations) Recent violent behaviour	<b>Supervision</b> Continuous visual surveillance 1:1 ratio (see definition below) <b>Action</b> Alert ED medical staff immediately Alert mental health triage or equivalent Provide safe environment for patient and others Ensure adequate personnel to provide restraint / detention based on industry standards <b>Consider</b> Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient 1:1 observation Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management

Triage code: treatment acuity	Description	Typical presentation	General management principles <sup>a</sup>
<b>2</b> <b>Emergency</b> Within 10 minutes	<b>Probably risk of danger to self or others</b> AND/OR <b>Client is physically restrained in emergency department</b> AND/OR <b>Severe behavioural disturbance</b> Australian Triage Scale <sup>b</sup> states: Violent or aggressive (if): <ul style="list-style-type: none"> <li>• immediate threat to self or others</li> <li>• requires or has required restraint</li> <li>• severe agitation or aggression</li> </ul>	<b>Observed</b> Extreme agitation/ restlessness Physically/verbally aggressive Confused / unable to cooperate Hallucinations / delusions / paranoia Requires restraint/ containment High risk of absconding and not waiting for treatment <b>Reported</b> Attempt at self-harm / threat of self-harm Threat of harm to others Unable to wait safely	<b>Supervision</b> Continuous visual surveillance (see definition below) <b>Action</b> Alert ED medical staff immediately Alert mental health triage Provide safe environment for patient and others Ensure adequate personnel to provide restraint/detention Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act <b>Consider</b> If defusing techniques ineffective, re-triage to category 1 (see below) Security in attendance until patient sedated if necessary Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
<b>3</b> <b>Urgent</b> Within 30 minutes	<b>Possible danger to self or others</b> Moderate behaviour disturbance Severe distress Australian Triage Scale <sup>b</sup> states: Very distressed, risk of self-harm Acutely psychotic or thought-disordered Situational crisis, deliberate self-harm Agitated/ withdrawn	<b>Observed</b> Agitation/restlessness Intrusive behaviour Confused Ambivalence about treatment Not likely to wait for treatment <b>Reported</b> Suicidal ideation Situational crisis Unable to wait safely Presence of psychotic symptoms Hallucinations and/or delusions Paranoid ideas Thought disordered Bizarre/agitated behaviour Presence of mood disturbance Severe symptoms of depression Withdrawn/ uncommunicative and/ or anxiety Elevated or irritable mood	<b>Supervision</b> Close observation (see definition below) Do not leave patient in waiting room without support person <b>Action</b> Alert mental health triage Ensure safe environment for patient and others <b>Consider</b> Re-triage if evidence of increasing behavioural disturbance; i.e.: <ul style="list-style-type: none"> <li>• restlessness</li> <li>• intrusiveness</li> <li>• agitation</li> <li>• aggressiveness</li> <li>• increasing distress</li> </ul> Inform security that patient is in department Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management



<b>Triage code: treatment acuity</b>	<b>Description</b>	<b>Typical presentation</b>	<b>General management principles<sup>a</sup></b>
<b>4 Semi-urgent</b> Within 60 minutes	<b>Moderate distress</b> Australian Triage Scale <sup>b</sup> states: Semi-urgent mental health problem Under observation and/or no immediate risk to self or others	<b>Observed</b> No agitation/ restlessness Irritable without aggression Cooperative Gives coherent history <b>Reported</b> Pre-existing mental health disorder Symptoms of anxiety of depression without suicidal ideation Willing to wait	<b>Supervision</b> Intermittent observation (see definition below) <b>Action</b> Discuss with mental health triage nurse <b>Consider</b> Re-triage if evidence of increasing behavioural disturbance; i.e.: <ul style="list-style-type: none"> <li>• restlessness</li> <li>• intrusiveness</li> <li>• agitation</li> <li>• aggressiveness</li> <li>• increasing distress.</li> </ul> Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
<b>5 Non-urgent</b> Within 120 minutes	<b>No danger to self or others</b> No acute distress No behavioural disturbance Australasian Triage Scale <sup>b</sup> states: Known patient with chronic symptoms Social crisis, clinically well patient	<b>Observed</b> Cooperative Communicative and able to engage in developing management plan Able to discuss concerns Compliant with instructions <b>Reported</b> Known patient with chronic psychotic symptoms Pre-existing non-acute mental health disorder Known patient with chronic unexplained somatic symptoms Request for medication Minor adverse effect of medication Financial, social, accommodation or relationship problems	<b>Supervision</b> General observation (see definition below) <b>Action</b> Discuss with mental health triage Refer to treating team if case-managed

#### **Management definitions**

Continuous visual surveillance = person is under direct visual observation at all times.

Close observation = regular observation at a maximum of 10-minute intervals.

Intermittent observation = routine waiting room check at a maximum of 1-hour intervals.

General observation = routine waiting room check at a maximum of 1-hour intervals.

<sup>a</sup> Management principles may differ according to individual health service protocols and facilities.

<sup>b</sup> Australasian College of Emergency Medicine. Guidelines for the Implementation of the Australasian Triage Scale (ATS) in Emergency Departments; 2000.

<sup>c</sup> South Eastern Sydney Area Health Service Mental Health Triage guidelines for Emergency Departments.

Source: Obtained from [www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg-triageqrg-mh](http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg-triageqrg-mh)

Date accessed 15/05/2015.

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# Appendix 5: The Emergency Department Suicide Risk Assessment (EDSRA)

## 1 Identify suicidal thoughts and behaviours

- **Ideation:** frequency, intensity, duration – in last 48 hours, past month and worst ever.
- **Plan:** timing, location, lethality availability, preparatory acts.
- **Behaviour:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) v non-suicidal self-injury.
- **Intent:** extent to which the person (1) expects to carry out the plan (2) believes the plan will be lethal.
- **Capability:** fear of death, tolerance of pain.

## 2 Identify risk factors and warning signs

### Imminent risk factors

- Ruminative flooding and frantic hopelessness.
- Suicide capability.
- Suicidal behaviours and indicators of implicit suicidal states.
- Substance intoxication.
- Psychotic symptoms.
- Severely depressed mood or recent insomnia (in the presence of other risk factors).

### Other risk factors

- **Access to means:** firearms, medications, rope.
- **Mental health symptoms:** psychotic symptoms, substance use, anhedonia, impulsiveness.
- **Suicidal behaviour:** previous suicide attempts, aborted suicide attempts, self-injurious behaviour.
- **Current/past psychiatric disorders.**
- **Borderline or antisocial personality traits, impulsivity.**
- **Family history:** of suicide, major mental health problems.
- **Precipitants and triggers:** events causing humiliation and shame, despair, loss.

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### 3 Identify future risks

### 4 Identify protective factors

### 5 Clinical judgement and formulation

#### Risk/benefit analysis

Re-assess as presentation or environment changes.

### 6 Plan care in collaboration with person/family/whānau

- Follow-up.
- Short-term action plan.
- Consider specific short-term interventions.

### 7 Arrange follow-up

Ensure continuity of care, especially during transitions of care.

### 8 Communicate and document

**Communicate:** person and family/whānau, appropriate mental health team, all others involved in the short-term care plan.

**Document:** Presentation, suicidal thoughts and actions, key risk and protective factors, clinical judgement and reasoning for formulation and management, care plan to optimise safety until next point of contact, involvement of family/whānau/significant others, follow-up plan, steps taken to action follow-up plan, communication undertaken, resources offered.

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# Appendix 6: The Brief Emergency Department Suicide Risk Screening Assessment (B-EDSRA)

This brief suicide risk screening is based on the essential elements of the Emergency Department Suicide Risk Assessment that will help emergency department staff identify people who are at low risk of suicide in the short-term who may be discharged.

Note that it is a structure to guide clinical judgement. It is advised that all steps be met satisfactorily.

## ✓ **Step 1: Low-risk attempt**

- Self-harm attempt was of low lethality

AND

- Self-harm attempt was perceived by the person to be of low lethality.

## ✓ **Step 2: No red flags**

Red flags include:

- specific suicidal plans
- specific suicidal actions
- intent to suicide/die in near future
- ruminative flooding
- frantic hopelessness
- psychotic symptoms
- substance intoxication
- severely depressed mood or insomnia (in the presence of other risk factors such as suicide plans and actions)
- access to means to suicide (firearms, medication, means for hanging) that cannot be removed or secured
- events in the near future likely to escalate suicide risk (e.g. pending court appearance, separation, job loss)
- clinician's intuition that information obtained is unreliable or inaccurate.

### ✓ **Step 3: Significant protective factors**

Especially:

- strong connections to supportive family/whānau with close support
- reasons to live
- open communication between person and their family/whānau or caregivers
- agreement by the person to tell family/whānau if risk factors increase.

### ✓ **Step 4: Brief short-term safety plan**

Essential information includes:

- important indicators of increased risk
- important contacts and phone numbers in case of an increase in suicide risk.

### ✓ **Step 5: Arranged mental health follow-up in next 24 hours**

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# Appendix 7: Static risk factors and warning signs

## Static risk factors

Static factors are risk factors that do not change significantly over time but may be correlated with increased risk of suicide (e.g. age, gender, past suicide attempts, marital separation).

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### Static risk factors for suicide

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Male gender

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Previous suicide attempt or self-harm behaviour

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Change in treatment (e.g. recent discharge from psychiatric inpatient unit, discharge from outpatient service)

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History of substance use disorder

---

Mental health disorders, especially mood, anxiety and psychotic disorders

---

Borderline and antisocial personality disorders

---

Impulsive and aggressive personality traits

---

History of neglect or abuse

---

History of trauma

---

History of self-harm

---

Family history of suicide

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Serious or chronic physical illnesses (e.g. chronic pain)

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Loss – relationships, employment, financial

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Exposure to others who encourage suicide – friends, internet or text

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## Warning signs

Warning signs indicate to the person or others that the risk of suicide has increased.

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### Common warning signs for suicide

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Threatening to hurt or kill themselves

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Looking for ways to kill themselves: seeking access to pills, weapons or other means

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Talking or writing about death, dying or suicide

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Expressions of hopelessness

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Rage, anger, seeking revenge

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Acting recklessly or engaging in risky activities, seemingly without thinking

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Feeling trapped – like there is no way out

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Increasing alcohol or drug use

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Withdrawing from friends, family or society

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Anxiety, agitation, unable to sleep or sleeping all the time

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Dramatic mood changes

---

No reason for living; no sense of purpose in life

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Adapted from SPRC: Suicide Prevention Resource Centre, [www.sprc.org/bpr/section-II/warning-signs-suicide-prevention](http://www.sprc.org/bpr/section-II/warning-signs-suicide-prevention)

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# Appendix 8:

## Short-term action plan

(Also see Step 6: Plan care in collaboration with the person and their family/whānau.)

<b>Step 1: Warning signs</b> Thoughts, images, mood, situation, behaviour indicating that a crisis may be developing.	
<b>Step 2: Internal coping strategies</b> Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activities, etc).	
<b>Step 3: People and social settings that provide distraction</b>	
<b>Step 4: People I can ask for help</b>	
<b>Step 5: Professionals or agencies I can contact during a crisis</b>	
<b>Step 6: Making the environment safe</b>	
The one thing that is most important to me and worth living for	

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# Appendix 9: Case scenario

The case scenario below follows Rachel from her presentation to the emergency department following an overdose, through triage, to the Brief Emergency Department Suicide Screening process.

Rachel is a 30-year-old Caucasian female who is brought to the emergency department by her partner, having taken an overdose of 15 paracetamol tablets.

## Triage

The triage nurse identifies two key issues for Rachel:

- 1 physical complications of paracetamol overdose
- 2 suicide risk.

She is triaged as code 2 and asked to wait briefly in a quiet and private space for further assessment and management, which she is happy to do. Her partner remains with her and is made aware that he should contact staff if there are any further concerns.

### **Comment**

*Emergency department practices at this point vary. In some emergency departments Rachel would be referred to the mental health team, who would see her once she was assessed as being able to be interviewed. In this case she is to be seen by emergency department staff.*

## Emergency department treatment

Rachel's physical health is assessed and she is found to be stable. Blood tests, including a paracetamol level, are taken.

While waiting for the blood test results she and her partner are seen by an emergency department nurse for an assessment of her suicide risk.



## Suicide risk assessment

The emergency department nurse/clinician starts the EDSRA process.

### **Step 1: Suicidal thoughts and actions**

The overdose occurred after an argument with her partner about her drinking. She has often had thoughts that she would be better off dead, especially during periods of low mood, and she decided that the easiest way to do this would be to take an overdose of medication. She was aware that there was paracetamol in the house. However, she had not previously developed plans any further than this, and while she describes times when she would like to have gone to sleep and not woken up, she has never had the intent to act on these thoughts.

Rachel reports that the overdose was impulsive; prior to the argument she had not been thinking of it but decided she had had enough and took the paracetamol after her partner had gone to bed. She regretted it almost immediately, thinking of her responsibilities towards her daughter and, scared that the overdose might kill her, woke her partner, who took her to the emergency department.

### **Comment**

*Rachel has experienced suicidal thoughts over a long period of time and has thought that overdosing on medication would be one way of doing it. However, she had not thought about when or how she would do this and her planning was therefore not detailed. She had taken no steps to prepare to suicide, there was no real intent to die, and after the overdose her fearfulness of coming to harm showed a low level of suicide capability.*

*Notably, the attempt was unlikely to be lethal and she did not expect it to be.*

*Her risk in terms of the contribution of suicidal thoughts and action is therefore probably low in the immediate short term.*

### **Step 2: Risk factors and warning signs**

Given the low lethality of the attempt, and the lack of a detailed plan, specific actions or intent, the emergency department nurse quickly screens for the presence of any red flags; short-term risk factors.

Rachel notes that during and immediately after the argument with her partner she experienced a strong sense of hopelessness about her life and her future. She had thoughts going over in her head about not having the strength to cope with life anymore and about being a burden on others. She also says that before the argument she and her partner had consumed quite a bit of alcohol together.

On direct questioning, Rachel denies experiencing ruminative flooding; her sense of hopelessness was associated with despondency rather than frantic agitation. She and her partner agree to avoid intoxication over the next few days at least. She has experienced insomnia and mild to moderate depressive symptoms.

There are no stressors likely to occur in the next few days that might increase Rachel's risk.

The emergency nurse decides to follow the process of the brief emergency department suicide screen.

### **Comment**

*Screening of risk factors detects no significant red flags, other than periods of low mood and insomnia, which, in the absence of other risks and suicidal behaviours, are of limited relevance. Rachel appears to be at low risk of suicide in the immediate future.*

*The emergency nurse is of the opinion that if there are strong protective factors present, Rachel is likely to be able to return home with her partner before seeing a mental health clinician.*

*Assessment of other risk factors at this point is unlikely to influence this decision, and therefore questions about them are superfluous at this point.*

### **Step 3: Protective factors**

Rachel's partner says he will make sure all medication is secure and there are no other potential means of suicide available to Rachel at home.

The emergency nurse quickly checks out protective factors further: Rachel has strong reasons for living (daughter), her relationship with her partner appears strong and supportive, and there are no lingering problems from the argument that might undermine this.

The emergency nurse feels a good rapport has been established with Rachel and her partner, and that Rachel is being open and honest with them, and she has no concerns that Rachel is withholding information or giving inaccurate answers. They discuss the case with a senior emergency department doctor and the decision is made for Rachel to be discharged home with mental health follow-up within 24 hours.

### **Comment**

*There are strong protective factors present and the emergency nurse does not pick up any sense that Rachel is not giving an accurate history. At this point the assessment has been sufficient to indicate that Rachel is at low risk of suicide over the next few days and therefore is able to return home with her partner before mental health review occurs.*

*Note that given Rachel's history of depressed mood and hopelessness, the suggestion of possible relationship difficulties and substance use, a full suicide risk assessment and comprehensive assessment are necessary. However, this does not need to occur before she leaves the emergency department as long as there is close follow-up.*

*It is advisable that Rachel is seen by a staff member who is skilled at suicide risk assessment. In many cases this will be a senior emergency department doctor.*

### **Step 4: Brief short-term safety plan**

A short-term safety plan is developed with Rachel and her partner, which includes indicators of increased risk, some basic coping strategies, and contact details in case of increased risk and the need for increased support. A pre-prepared information sheet is given to her that outlines these steps.

### **Comment**

*Given that Rachel is judged low risk of suicide and will have mental health follow-up within 24 hours, a detailed safety plan is not needed at this point.*

**Step 5: Arranged mental health follow-up in the next 24 hours**

The mental health team liaising with the emergency department is contacted by telephone and Rachel's situation is discussed with them. They support the decision for her to be discharged home and confirm they will organise community mental health follow-up for a comprehensive assessment. They will phone Rachel and her partner the next day to pass on the details of the assessment and to check in with her regarding her safety. They will visit her in person if necessary.

Rachel is then discharged home with her partner.

**Comment**

*In most cases Rachel should be contacted within 24 hours by mental health staff. The advice in this document that mental health follow-up occurs within at least 72 hours is designed to cover situations where there is no mental health response team that can deal with follow-up (rather than emergency presentations) over weekends or public holidays. Optimally, all DHBs should have the capacity for mental health follow-up within 24 hours, even outside usual working hours.*

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# Endnotes

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- <sup>15</sup> Consideration should be given to using the questions drawn from tools that have demonstrated validity for identifying suicidal ideation. The questions provided here have been evaluated as reliable and valid assessors of the presence of recent suicidal ideation, and are useful both in the context of an established rapport and as a tool to maintain rapport.
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