



BEST PRACTICE
EVIDENCE-BASED
GUIDELINE

THE ASSESSMENT AND
MANAGEMENT OF
**PEOPLE AT RISK
OF SUICIDE**



Endorsements



The Royal Australian and
New Zealand College of Psychiatrists
- New Zealand Branch.



NZNO Mental Health
Nurses Section

Council for Mental
Well-Being Trust

**Best Practice Evidence-based
Guideline**

**THE ASSESSMENT AND MANAGEMENT
OF PEOPLE AT RISK OF SUICIDE**

**For Emergency Departments and
Mental Health Service
Acute Assessment Settings**

MAY 2003



STATEMENT OF INTENT

Clinical guidelines are produced to help health professionals and consumers make decisions about health care in specific clinical circumstances. Research has shown that if properly developed, communicated and implemented, guidelines can improve care. The advice on the assessment and management of people at risk of suicide given in this guideline is based on epidemiological and other research evidence, supplemented where necessary by the consensus opinion of the expert development team based on their own experience.

While the guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), they are not intended to replace the health professional's judgment in each individual case.

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FOREWORD

Suicide is a devastating event for those close to the person who died, with enduring emotional consequences. It also affects the wider community, both emotionally and economically. It is generally, although not always, associated with mental illness. Effective treatment of the mental illness can reduce or abolish the risk of suicide. Effective treatment requires effective recognition and a reduction in the barriers to appropriate care. These barriers include stigma against mental illness and limited public knowledge about symptoms indicating mental illness. They also include difficulties accessing affordable available services, adequately staffed by suitably trained clinicians. Such services need to interface effectively with other relevant organisations and people to provide a full range of appropriate interventions. These need to be continued for long enough to reduce suicide risk and improve mental health in the long-term. It is clear from recent reports such as the Mental Health Commission Review of Crisis Mental Health Services¹ that this ideal is not currently achieved in New Zealand.

These guidelines are intended as a resource for clinical staff in emergency departments and mental health clinicians when assessing and working with people who have made a suicide attempt, or are at risk of taking their own lives. They are intended as a teaching resource and as a guide to daily practice, both for individuals and for systems of care. They are based on explicit evidence where possible and synthesised expert opinion on other issues. They are complemented by summary material for each service group.

Developing a guideline is, in many ways, the easy part of the task of improving practice. Achieving commitment to changes in practice and changes in systems of care requires effective implementation. This must be backed by quality educational measures, which are maintained over time and supported by adequate supervision on a regular basis, clinical audit, and quality improvement processes. These strategies require appropriate piloting, evaluation, and adequate resources if the promise of this document is to be achieved. The Ministry of Health is committed to reducing the rate of suicide and suicide attempts. We urge them to ensure that these guidelines are implemented by District Health Boards to achieve these goals.



Professor Pete Ellis

Chair, Guideline Development Team



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ABOUT THE GUIDELINE

Suicidal behaviour is one of the most common and stressful of psychiatric emergencies.^{2[3]} There is no single explanation for suicide attempts nor any simple solutions to treatment.^{3,4[1+]} Survivors of suicide attempts indicate that the central reason for their suicide attempt was not death but rather the stopping of consciousness, or pain that was perceived as unbearable.^{5[3]}

Overseas, a large proportion of people who arrive at accident and emergency departments following an attempted suicide are discharged without follow-up and without having been formally assessed for psychiatric illness or psychosocial stressors, some even before they have been 'medically cleared'.^{6[2-]} Typically these people are young, male, intoxicated, have difficulty coping with strong feelings and have a history of previous attempts. Given these risk factors, it is not surprising that they more frequently go on to make further attempts at suicide.^{7[2-]} This has particular implications for accident and emergency staff, who need to be able to carry out an initial psychosocial risk assessment, provide an environment that can contain such at risk people until they can be assessed in more detail, and access psychiatric assistance quickly.

The purpose of these guidelines is to guide those working in emergency departments and in acute psychiatric services in the appropriate assessment and early management of suicidal people. They complement the related primary mental health guidelines for use in general practice,⁸ schools,⁹ and also the *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (1998).¹⁰ They replace the earlier guideline for mental health services prepared by the Ministry of Health in 1993.¹¹

These guidelines focus on intervening with people who have made a suicide attempt with the intent (or partial intent) of ending their lives and those who are at risk of taking their own life. Some people harm themselves deliberately without suicidal intent, such as by repeated cutting or other forms of deliberate self-harm. While some of the management principles described in these guidelines may be helpful for assisting these people, additional measures are necessary, which are beyond the scope of these guidelines. The Royal Australian and New Zealand College of Psychiatrists is currently developing guidelines for the treatment of adult deliberate self-harm which are due for release in 2003.

These guidelines are evidence-based. Where clear recommendations for action are made, there are statements about the strength of supporting evidence that these are built upon. In the absence of research evidence, recommendations are made on the basis of the expert opinion of a working party of nominated individuals, substantiated by a wide peer review process.

It is acknowledged that the low base rates of suicide make it difficult to predict such a tragedy and that despite best efforts some people will nevertheless complete suicide. These guidelines describe current New Zealand and international best practice to limit the mortality and reduce the morbidity associated with future attempts.

THE GUIDELINE DEVELOPMENT TEAM

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Declarations of Competing Interests

Pete Ellis has accepted support from Janssen-Cilag to attend a recurring scientific meeting in New Zealand as a presenter and part organiser.

Brian Craig has received travel support to attend an overseas conference from Janssen-Cilag.

CONSULTATION

A draft of this guideline was widely circulated to consumer groups, emergency departments, crisis mental health services, provider organisations, expert reviewers and clinicians for comment. It has been extensively modified to address the feedback received. Over 60 copies of the draft were circulated. Comments were received from the following individuals/organisations:

- Alan Chapman, Manager, Refugees as Survivors, Wellington
- Alan Gundesen, Middlemore, Nurse DAO
- Andrew Curtis-Cody, Nurse, Adult Community Mental Health Team (CMHT), Capital Coast Health
- Angela Kelly, Manager, Wellington Mental Health Consumers Union
- David Ramsden, Team Leader, Adult CMHT, Hawkes Bay
- Diana Grice, Service Manager, Canterbury DHB Mental Health Services
- Don Smith, Living Stones
- Dr Alan Faulkner, Consultant Psychiatrist, Psychiatric Emergency Service, Christchurch
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- Dr Anthony Duncan, Consultant Psychiatrist, Deputy Director of Mental Health, Ministry of Health
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- Dr Richard Mullen, Consultant Psychiatrist & Senior Lecturer in Psychological Medicine, Otago DHB
- Dr Simon Hatcher, Head of Division of Psychiatry, University of Auckland
- Dr Sunia Foliaki, Visiting Research Fellow, Public Health Research, Massey University
- Dr Tom Flewett, Consultant Psychiatrist, Personality Psychotherapy Service, Capital Coast Health
- Maria Baker, Te Hauora O Te Hiku O Te Ika
- Maria Cotter, Ministry of Health
- Mental Health Commission
- Ministry of Health, Mental Health Rights and Protection
- Ministry of Youth Affairs
- Paul Hirini, Te Rau Matatini
- Privacy Commission
- Professor Cindy Farquhar, Effective Practice Informatics Quality Improvement
- Professor Mason Durie, Consultant Psychiatrist, Head of Māori Studies, Massey University
- Professor Michael Ardagh, FACEM
- Robyn Byers, Nelson Marlborough Health Services, Mental Health Services
- Sharon Lambert, Nga Ngarua Hauora O Aotearoa
- Sue Ellis, Mental Health Commission
- Suicide Prevention Information New Zealand (SPINZ)
- Te Puni Kokiri
- Wellington Supporting Families
- Women's Health Action Trust.

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- **Sharon Lambert**, Chief Executive of Nga Ngaru Hauora O Aotearoa (National Māori Health Providers Association, Auckland) and also the National Council of Māori Nurses
- **Maria Baker**, Māori Registered Nurse, Mental Health Co-ordinator for Iwi provider Te Hauora O Te Hiku O Te Ika and Ngāpuhi-Nui-Tonu, Kaitaia
- **Dr Siale Foliaki**, Psychiatric Registrar, Faleola Service, Auckland, Member of Pacific Peoples Advisory Committee to the Mental Health Commission.

Special thanks are also due to **Kim Narsi** (Clinical Psychologist, Wellington), **Alan Chapman** (Manager Refugees as Survivors, Wellington), **Paul Hirini** (Clinical Co-ordinator, Registered Psychologist Te Rau Matatini - Māori Mental Health Workforce Development Programme, Massey University, Palmerston North), **Dr Ate Moala** (HRC Training Fellow, Public Health Research, Massey University, Wellington; NZGG Board member), **Dr Anthony Duncan** (Deputy Director of Mental Health, Ministry of Health, Wellington) and **Dr Sai Wong** and the Chinese Mental Health Service, Auckland, for their specialist advice and contributions to key parts of the text.

The guideline team would also like to thank **Dr Annette Beautrais** for her work and advice on the relevant literature.

A systematic literature review was prepared by New Zealand Health Technology Assessment (NZHTA) and is available at www.nzgg.org.nz – click on ‘Guidelines’ then ‘Mental Health’ then ‘Supporting Materials’ for this guideline.

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The guideline has been developed by the New Zealand Guidelines Group and funded by the Ministry of Health.

EVIDENCE AND RECOMMENDATION GRADING SYSTEM

The grading system is a two-tier system where the INDIVIDUAL STUDIES are each given a level of evidence from 1 to 4 (refer Appendix 8 for the details). Throughout the guideline, the level of evidence has been included alongside the references. This is formatted as ^{reference}[level of evidence].

The second step in grading is to consider the WHOLE BODY OF EVIDENCE ie, all the studies relevant to the issue, and decide on a recommendation and grade based on all of the individual studies.

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

GOOD PRACTICE POINT	
Recommended best practice based on the clinical experience of the guideline development team.	

The grades A to D and the good practice points are a measure of the strength of evidence underlying the recommendations and should not be construed as an indication of the relevant importance of the recommendations. For example, in this guideline the good practice point on sedation which states, 'benzodiazepines should only be used for sedation as a short-term measure and must be administered under supervision' is extremely important but has a low level of supporting evidence.

SUMMARY

- **Anyone who talks about suicide should be taken seriously.** People who die by suicide have often previously expressed suicidal thoughts or displayed warning signs.
- **Clinicians should involve whānau/family/support people** of the suicidal person wherever possible when working with that person.
- **Any person at risk should be re-assessed regularly,** particularly if their circumstances have changed. A suicidal person's mental state and suicide risk can fluctuate considerably over time.
- **Emergency department staff should contact a suitably trained mental health clinician** whenever anyone seeks assistance following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation.
- **Case notes should be augmented with structured assessments.** Clinicians often overlook key information when recording their suicide assessments in case notes. Adding structured assessments provides a systematic approach to avoiding such oversights.
- **A person's clinical case notes should include the following** information if they have been assessed for suicide risk:
 - relevant suicide risk assessments
 - whānau/family members' concerns
 - previous psychiatric history
 - previous treatment received
 - risk/benefit assessments of key clinical decisions.
- **People should be followed up closely over the week following discharge** after an inpatient admission, even if they fail to attend their outpatient appointment. The week following discharge is a very high-risk time for people who have been suicidal.
- **Training in suicide assessments improves staff performance, appropriate referrals and overall care.**
- **All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision** to mitigate the negative impact that this work can have, both on them and on the quality of their work with suicidal people.
- **Culturally appropriate services** should be offered to the suicidal person whenever available.

RECOMMENDATIONS

RISK FACTORS

Anyone who talks about suicide needs to be taken seriously. People who die by suicide have often expressed suicidal thoughts or displayed warning signs to families or health professionals.

D

All people who report self-harm or suicidal intent should be treated as being in a state of potential emergency until clinicians are convinced otherwise.



X

ESTABLISHING A THERAPEUTIC ALLIANCE

A key component to working with anyone who presents in a state of distress following a suicide attempt or expressing suicidal ideation is the conscious attempt to establish rapport with that person. This facilitates their disclosure of information and may serve as a protective factor by encouraging a sense of hopefulness and connectedness.



THE CHALLENGE OF WORKING WITH PEOPLE WHO SELF-HARM OR ATTEMPT SUICIDE

All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have both on them and on the quality of their work with suicidal people.



INVOLVING WHĀNAU/FAMILY/SUPPORT PEOPLE OF THE SUICIDAL PERSON

Whenever possible clinicians should involve whānau/family/support people/carers of the suicidal person when working with that person. This is equally true for the assessment component, crisis management and subsequent treatment. At any time families can give information to the clinician without it compromising the person's privacy.



If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe.



KEY - Grades indicate the strength of the supporting evidence, rather than the importance of the recommendations - see page vii for details

- A Well designed meta-analysis (MA) or RCT, or a body of evidence which is consistently applicable
- B Very well designed observational studies or extrapolated evidence from RCTs or MAs
- C Lower quality observational studies or extrapolated evidence from B
- D Non analytical studies or expert opinion
- ✓ Good Practice Point

ASSESSMENT OF SUICIDE RISK	
Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated by a suitably trained mental health clinician.	D
Culturally appropriate services should be involved with assessment, crisis management and service liaison where possible, and if agreed to by the suicidal person.	✓
A suicide assessment should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material.	✓
There is no evidence to suggest that directly asking about the presence of suicidal ideation or intent creates the risk of suicide in people who have not had suicidal thoughts, or worsens the risk in those who have. It is more likely that a calm and matter-of-fact approach discussion of suicidality may allow people to disclose their previously 'taboo' thoughts.	✓

TRIAGE	
No person who has attempted deliberate self-harm or who is expressing suicidal ideation should be categorised to triage category 5 ie, waiting beyond one hour to be seen by a doctor.	✓

GENERAL ASSESSMENT PRINCIPLES	
Case notes should be augmented with structured assessments.	C
Training in suicide assessments should be provided to all appropriate staff.	C

MEDICAL CLEARANCE	
Clinicians should maintain a high index of suspicion when a person arrives following an overdose. People will often under-report quantities consumed.	✓
Emergency department staff are encouraged to use the triage protocol described (see page 12) and the RAPID Assessment tool (Appendix 1) to assess the urgency of need for mental health referral and security measures.	D

SEDATION

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

ASSESSMENT OF INTOXICATED PEOPLE

People who present to emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk (whilst they are still intoxicated). Enduring risk cannot be judged until the person is sober.	✓
People at risk of suicide should be strongly advised to stop using alcohol or illicit drugs due to their potential disinhibiting effects. Whānau/family members should also be told of this.	✓

REFERRAL TO MENTAL HEALTH SERVICES

Mental health services should at least be contacted (or existing management plan consulted) by the assessing emergency department clinician whenever suicidal ideation, intent, or a suicide attempt or self-harm is present.	✓
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- A Well designed meta-analysis (MA) or RCT, or a body of evidence which is consistently applicable
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- D Non analytical studies or expert opinion
- ✓ Good Practice Point

KEY COMPONENTS OF A PSYCHIATRIC/PSYCHOSOCIAL ASSESSMENT

When conducting an assessment of suicide risk always be mindful of the presence of concomitant mental illness, particularly the following diagnoses, which are associated with increased risk.

- Major depression - acute risk factors: severe anhedonia, insomnia, anxiety, substance abuse.
- Substance abuse - acute risk factors: co-morbid depression, recent interpersonal loss or disruption.
- Schizophrenia - acute risk factors: age <40, chronicity of illness with frequent exacerbations, awareness of deterioration and poor prognosis, depression.
- Borderline Personality Disorder or Antisocial Personality Disorder – acute risk factors: co-morbid Axis I disorders, particularly depression.

B

USE OF SCREENING MEASURES

The Beck Hopelessness Scale has the best generic application for screening for suicide risk amongst adults, adolescents, inpatients, outpatients and people seeking assistance from emergency departments.

B

FORMULATING RISK

Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk should be re-assessed regularly, particularly if their circumstances have changed.



CRISIS/INITIAL MANAGEMENT

The presence of a 'safety contract' does not in any way guarantee the person's actual safety. There is no evidence that it acts as a deterrent to suicide.

D

MANAGEMENT AS AN OUTPATIENT

Providing people with 'green cards' (24-hour access to a crisis team) is a useful but insufficient treatment strategy and other interventions should also be provided.

A

THE DECISION TO HOSPITALISE

The following people with suicidal ideation should be admitted when:

- they are acutely suicidal
- medical management of an attempt is required
- they require more intensive psychiatric management
- the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal.

D

When no suitable caregivers/support people are available respite care options may be considered as an alternative to admission.

D

In order to reduce the person's risk of suicide, admission should be for more than 4 days.

A

For a chronically suicidal person short admissions (1– 4 days) may be appropriate.

C

If the person is not admitted, appropriate arrangements must be made for timely follow-up with the relevant health provider (eg, care manager, therapist etc) within 24 hours.



The reasons for not admitting must be clearly documented in the person's file.



MANAGEMENT AS AN INPATIENT

People assessed as being at high risk of suicide should be under close supervision. (See Appendix 6 for guidelines for supervision.)



The level of support and observation should reflect the person's changing suicide risk.



Inpatient unit staff need to be vigilant, particularly when the person is not well-known and for the first week after admission.

C

Treatment (both psychopharmacological and psychological) of underlying mental illnesses should be initiated as early as possible.

D

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DISCHARGE PLANNING

Follow-up should occur in the first week post-discharge, as this is the highest risk time for a person discharged from hospital. This should happen even if the person fails to attend their outpatient appointment.	A
If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm.	D
The discharge plan should be developed in consultation with the person and their key support people (including whānau/family if appropriate) and clinicians.	<input checked="" type="checkbox"/>
Before leaving the hospital the person should have a clear understanding of discharge arrangements that have been made and a written copy with information about medication, treatment plans and key contacts to call, if needed.	<input checked="" type="checkbox"/>
If appropriate, the person's whānau/family or nominated next of kin should be informed of the person's risk, told of their next appointment and invited to attend. They should also be involved in discharge planning processes.	<input checked="" type="checkbox"/>
The continuing care provider/team must get at least a verbal report prior to discharge. They should also be included in any discharge planning meetings/decision-making processes.	<input checked="" type="checkbox"/>
The person's general practitioner should also get a full copy of the discharge plan including any medication recommendations. If the general practitioner is the sole care provider, he/she should receive this prior to the person's discharge from hospital.	<input checked="" type="checkbox"/>

INTERVENTION/TREATMENT STRATEGIES

Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to taking medication and to attend appointments.	A
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PRESCRIBING ISSUES

Clinicians need to monitor suicide risk closely irrespective of the antidepressant/drug used. This is essential both to rule out any paradoxical increase in suicidality and also to ensure that risk does not increase as the treatment begins to work, relieving the motor symptoms and lack of drive first, but not the mood related symptoms.	C
Clinicians should be cautious when prescribing benzodiazepines (both acutely and in the medium-term), especially if the person may also be suffering from depression or have risk factors for suicide.	C
In general, if a person is suspected of being at risk of suicide, appropriate medications should be prescribed and dispensed in dosages and quantities that are less likely to be lethal in overdose or in combination with other drugs or alcohol.	<input checked="" type="checkbox"/>

CHILDREN AND ADOLESCENTS

Self-harm among children is rare and should be treated very seriously.

D

The assessment of suicidal young people should be carried out by a clinician who is skilled in interviewing and working with children and adolescents whenever possible.

D

Risk assessments should draw on information from multiple sources, including the young person, their teachers/guidance counsellors, parents etc.



THE ELDERLY

Any elderly person who is expressing suicidal ideation or has presented following an attempt should be treated very seriously. The clinician should consider whether the symptoms could be related to self-neglect or reflect a passive death wish.



Clinicians should treat symptoms of depression in an older person assertively. If depression and/or suicidality is suspected, physical causal factors need to be ruled out.



Assessments should also draw on information from relatives or friends who can comment on whether the person is different from 'their usual self'.



MĀORI

Assessment of Māori people requires consideration of their cultural context and meaning associated with their identity as Māori. Specialist Māori input is important when cultural issues or issues of identity arise among tāngata whaiora. Māori people who are suicidal should be offered the input of specialist Māori mental health workers.



People's preference should be sought and respected for involving whānau or support of others in assessment and developing a treatment/management plan.



PACIFIC PEOPLES

Assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Specialist Pacific input is important when cultural issues or issues of breaches of protocol are present among Pacific peoples. Pacific peoples who are suicidal should be offered the input of specialist Pacific mental health workers.



Pacific peoples' preference should be sought and respected for involving family or support of others (eg, church leaders, traditional healers) in assessment and developing a treatment/management plan.



Language barriers may be an issue for some Pacific peoples. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Pacific communities and the shame associated with suicide and attempted suicide among Pacific peoples.



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PEOPLE OF INDIAN DESCENT

Indian people come from many diverse cultures and assessment should acknowledge their specific cultural contexts and beliefs.



Indian people consider family roles and obligations of primary importance and assessment should acknowledge their needs within the context of their family.



Problem-solving, psycho-education and the use of trusted intermediaries can help counter some of the shame or 'loss of face' associated with mental illness.



ASIAN POPULATIONS

Cultural values and beliefs vary depending on the person's subculture and degree of acculturation to Western values. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others, as a gap in views can be a source of stress.



Language barriers may be an issue for some Asian people. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Asian communities.



When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways.



REFUGEE GROUPS

Refugees are most likely to have been victims of some level of trauma. They may be distrustful of official agencies and health systems. Clinicians need to proceed respectfully and carefully, explaining the intention behind any action and potential consequences for the person. Clinicians should not push for accounts of past trauma experiences, and may need to focus more on the 'here and now'.



If an interpreter is needed care must be taken over confidentiality issues as many of the communities are small and people may know each other.



Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors.



ASSESSMENT AND MANAGEMENT OF CHRONICALLY SUICIDAL PEOPLE

Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated.

C

Emergency departments should always contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts.

C

When a person who is well-known to the service arrives at the emergency department it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or a significant change in their mental illness(es).

D

Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.

D

APPENDIX 6: LEVELS OF OBSERVATION IN INPATIENT UNITS

It is vital to review regularly the mental state of the individuals under such close observation. This should be done formally at the nursing handover at the end of each shift. Senior nursing and psychiatric staff should review the level of observation at least daily when the overall management plan is reviewed.



The levels of observation and changes to this should be documented separately in the clinical notes, with counter-signatures from senior staff and the responsible clinician. The documentation will include date, time and signature, level of observation, stop date and role of each person signing.



Changes to closer levels of observation may be initiated by any senior clinical team member.



Reduction of the level of observation must be approved by two senior members of the clinical team.



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BACKGROUND ISSUES

EPIDEMIOLOGY

Recent figures show over 500 New Zealanders die by suicide each year.¹² While suicide rates for youth have been gradually decreasing over the last five years, overall rates remain substantially higher than those of 20 years ago (12.5 per 100,000 in 1999 – the most recent year for which complete data are available – vs 9.9 per 100,000 in 1980). Furthermore, these figures are likely to underestimate the true numbers as they are based on hospital data and coroners' reports (Figure 1).

Figure 1: Total suicide rate per 100,000, 1980-1999 (NZHIS, 2002)

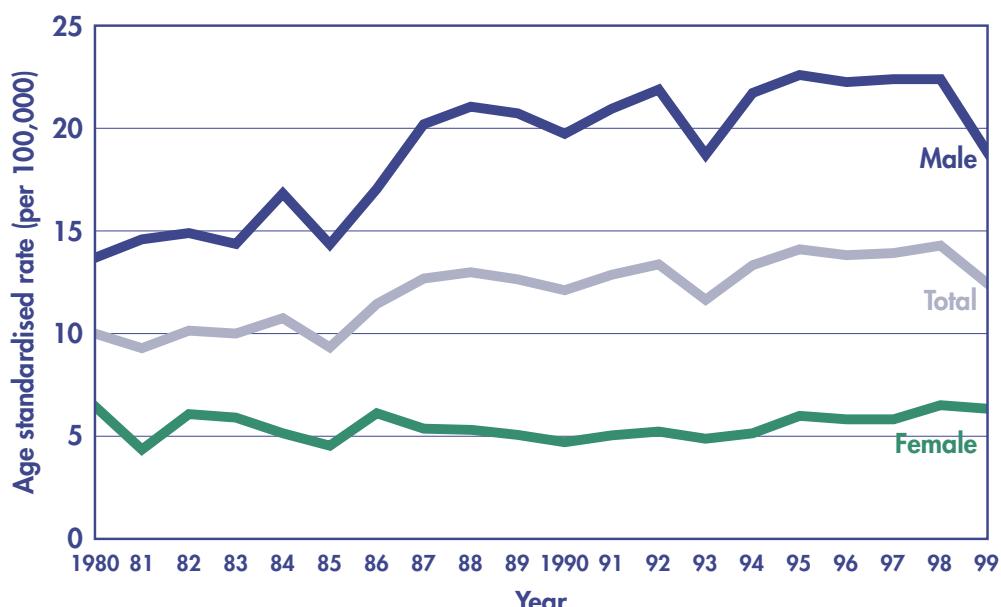


Figure 2 (next page) shows the rates of suicide by age and gender in 1999. The highest rates of suicide were found among males aged 20–34 years. Among females, the highest rates of suicide were for women aged 15–24 years. Suicide rates among young women have increased dramatically in the last few years (not shown here). This is probably due to a change in the pattern of methods of suicide attempts, with young women using increasingly lethal methods such as hanging (previously more commonly used by males).¹²

While suicidal ideation occurs in children and is relatively common in adolescents, actual suicide attempts are rare before puberty.¹² It may be that children and younger adolescents are less likely to make suicide attempts because they lack the cognitive ability to plan and carry out an attempt.⁹[4] They are also less likely to have developed psychiatric disorders such as depression and substance abuse, which are associated with suicidal behaviour.¹³[2++]

Adolescent suicides can often be preceded by stressful events such as the loss of a romantic relationship, disciplinary problems at school or with the law, or academic or whānau/family difficulties. These stresses may result indirectly from the underlying mental disorder itself, or add to the pressures on an already vulnerable individual.¹⁴[2++]

Whilst the rate of youth suicide has decreased in recent years, New Zealand still has one of the highest rates of youth suicide amongst OECD countries.¹² Furthermore, although attention has focused mainly on responding to the suicide rates for adolescents, the majority of suicides in New Zealand (approximately three-quarters) occur in people over the age of 24 years.

2

Figure 2: Suicide rates by age-group per 100,000, 1999 (NZHIS, 2002)

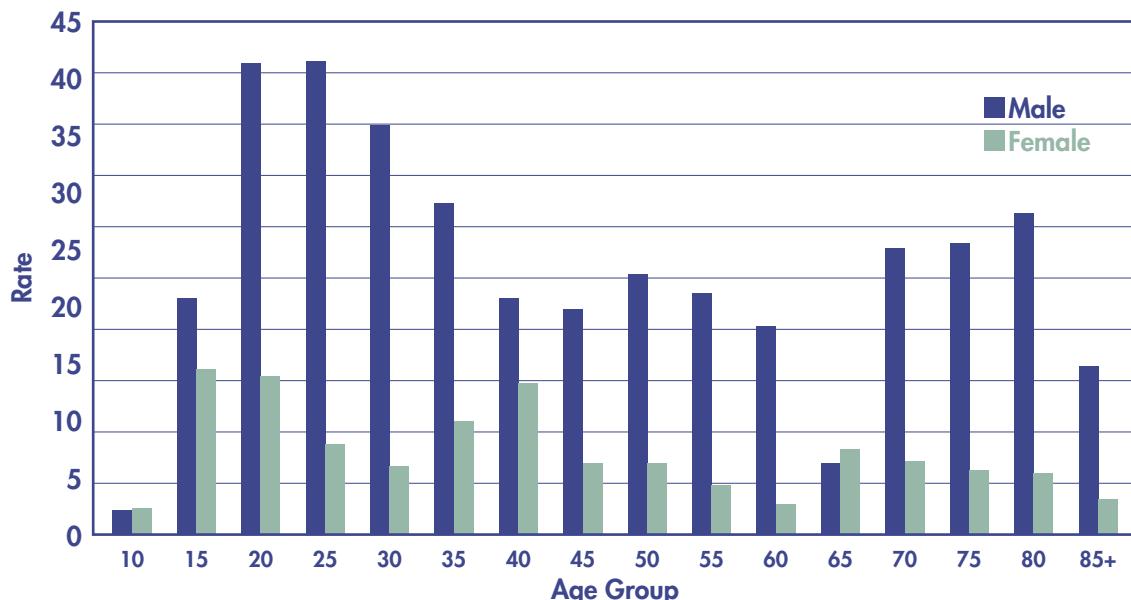
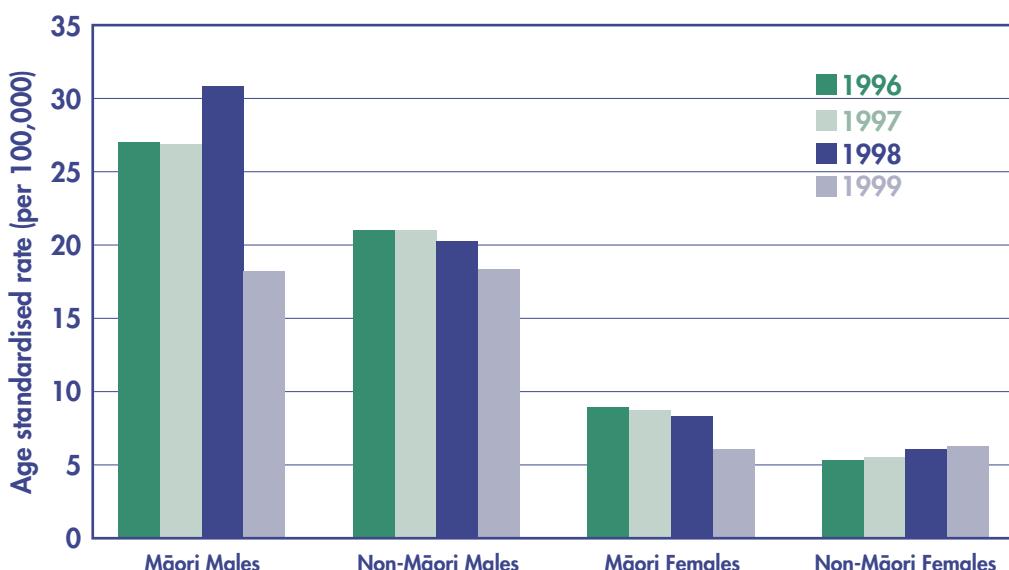
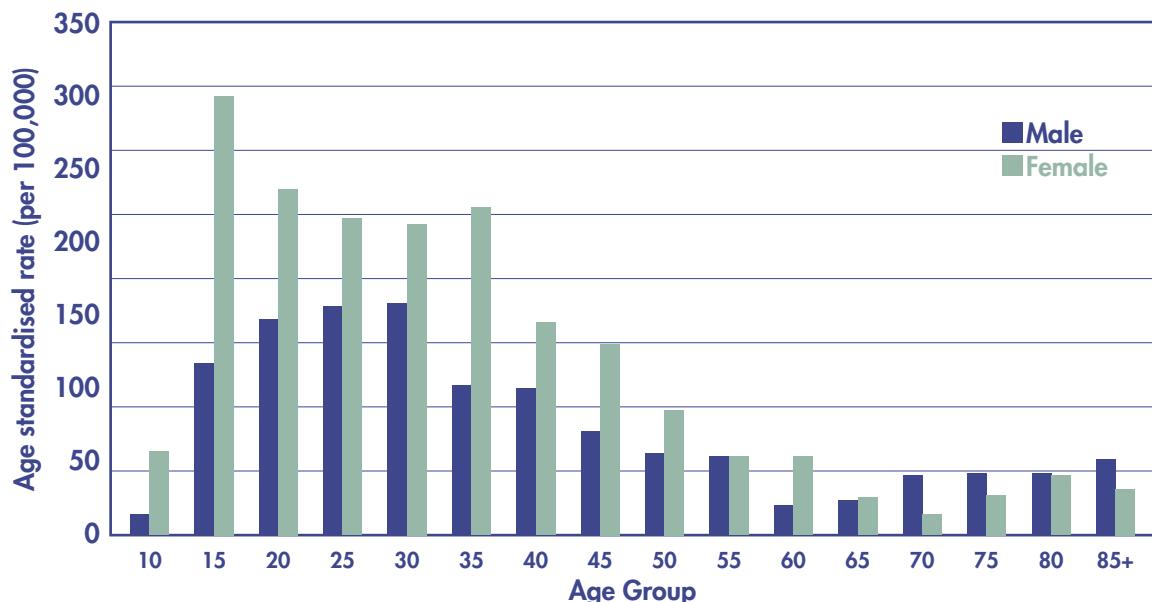


Figure 3: Suicide death rates by ethnicity, 1996-1999 (NZHIS 2002)



In 1999 the overall rates of death by suicide for Māori and non-Māori was almost identical (Figure 3). However, the rate of suicide for Māori youth continues to be higher than for other youth (30.6 per 100,000 compared to the non-Māori rate of 20.5 per 100,000).

Figure 4: Suicide and self-inflicted injury hospitalisation rate across different age groups per 100,000, 1999/2000 (NZHIS, 2002)



Overall, nearly twice as many females as males are hospitalised following self-inflicted injury (Figure 4). This is mainly due to females making more frequent but less lethal attempts and being more willing to seek medical assistance following an attempt than their male counterparts. Youth (male and female combined) have the highest hospitalisation rates of all age groups.

There are some difficulties with the above data, as it only includes people who are admitted to hospital as inpatients or day patients. The data does not distinguish between those who intended death and those who self-harmed for other reasons. This does not include people who were discharged from emergency departments, or who were seen by their general practitioner.

Given that people who have made one or repeated suicide attempts are at greater risk of dying by suicide, the above figures suggest that we need to focus efforts on ensuring that such people get effective follow-up treatment and support.

Suicide amongst inpatient populations

Suicide occurs at a significantly higher rate in those admitted, or recently admitted, to psychiatric wards than among the general population. The peak incidence of deaths by suicide occurs in the first few months after discharge, but is especially high in the first four weeks, indicating the need for good discharge planning and community support after discharge.^{15,16,17[3]}

RISK FACTORS

Developing a therapeutic relationship with a person at risk and understanding each individual as a unique person is essential to developing an understanding of that person's risk of suicide.^{18[4]}

It is important to distinguish between risk factors and risk prediction. Risk factors are usually studied in large populations as isolated factors. In contrast, risk prediction for individuals who may face complex multifactorial problems cannot be achieved merely by adding up the risk factors derived from these population studies. However, an awareness of these risks can alert the clinician to particular areas of people's lives to explore.

There are a number of risk factors that predispose people to suicide, including pre-existing psychiatric disorders, and both biological and psychosocial facilitating factors. Key risk factors include:

- recent loss
- loved ones dying or committing suicide
- isolation
- previous attempts
- depression or bipolar disorder
- serious physical illness.

Experiences of great adversity are also risk factors for suicide. In youth, an identifiable stressful event preceded 70 – 97% of suicides.¹⁴[2++]

The experience of abuse and sexual abuse have been particularly linked with suicide as has a whānau/family history of suicide.¹⁴[2++]

Suicide risk and psychiatric disorders

The overwhelming proportion of both adolescents and adults who die by suicide (over 90%) suffered from an associated psychiatric disorder at the time of their death, most commonly an affective disorder, substance use disorder, psychosis or to a lesser extent an anxiety disorder.^{14,19}[2++/2+] More than half of these people will have suffered from a psychiatric disorder for at least two years prior to their death. People who meet the criteria for more than one disorder at a time are at an even greater risk. Although mental illness is an important risk factor for suicide, it is important to recognise that the majority of those with mental illness do not attempt or commit suicide. The link between depression and suicide is especially important given the high prevalence of depression. One of the diagnostic criteria for a Major Depressive Episode is persistent suicidal ideation or a suicide attempt.

Substance abuse and intoxication are also strong risk factors for suicidal behaviour.^{19,20}[2++]

Of people who die by suicide, 25 – 50% consume alcohol before taking their lives.²¹[2++]

Suicide risk is substantially higher among people with co-morbid substance abuse, depression and hopelessness.^{14,19,22}[2++]

Around 25% of people who die by suicide had been in contact with mental health services in the year before their death. Approximately 12.5% of those who died by suicide made contact in the week prior to committing suicide and 8% were inpatients at the time. Of concern, the majority of people who were seen by mental health services, and subsequently committed suicide, were thought to be at no or low immediate risk at the final service contact.^{15,16}[2++/3]

There is an increased risk of suicide in the three months after discharge from inpatient care. The risk of suicide post discharge is especially elevated in the first week and is highest on the day after discharge.^{15,16}[2++/3]

People who had a short-term admission (lasting less than seven days), who had been re-admitted within three months of their previous admission, or who were discharged/discharged themselves against medical advice, are also at much greater risk of suicide.^{15,16}[2++/3]

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RECOMMENDATIONS

Anyone who talks about suicide needs to be taken seriously. People who die by suicide have often expressed suicidal thoughts or displayed warning signs to families or health professionals.	D
All people who report self-harm or suicidal intent should be treated as being in a state of potential emergency until clinicians are convinced otherwise.	

Establishing a Therapeutic Alliance

The therapeutic alliance is a conscious collaboration between the clinician and the person for the purpose of a mutual exploration of the person's problems. It is:

the ongoing development of a sense of safety and respect from which a person can feel increasingly free to share their problems, while gaining increased confidence in the clinician's potential to understand them.^{18[4]}

The processes that are crucial to developing a strong alliance are empathy, active listening, trust and transparency.^{18[4]} This is a developmental process, which deepens as the therapeutic relationship progresses over time.

If at least tentative rapport is not established early in the assessment process, then the validity of the information collected will be impaired. Put simply, a person will not trust a clinician with their sensitive information if they do not feel heard, respected and understood. A clinician needs to convey a sense of warmth, non-judgmental acceptance, and a strong interest in understanding them and the nature and cause of their pain/distress.^{23[4]}

There is a strong suggestion that a therapeutic alliance may act as a protective factor against suicide. The better the person and the clinician understand each other, the more protection that understanding potentially offers. Fostering a therapeutic alliance may be crucial in people who have difficulty in reaching out to anyone and in counteracting a sense of hopelessness that may lead people to believe there is no-one who can relieve their pain. It also allows a clinician to more accurately gauge if a person's risk is changing and to respond rapidly to that change.^{23[4]}

RECOMMENDATION

A key component to working with anyone who presents in a state of distress following a suicide attempt or expressing suicidal ideation is the conscious attempt to establish rapport with that person. This facilitates their disclosure of information and may serve as a protective factor by encouraging a sense of hopefulness and connectedness.	
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The Challenge of Working with People who Self-harm or Attempt Suicide

Working with people who attempt suicide, perhaps repeatedly, or seek assistance following a self-harm attempt inevitably affects the clinicians involved.^{2,24[3]} Suicidal behaviour can elicit intense emotional responses from clinicians.^{2[3]} When these feelings are unrecognised, they can create negative reactions on the part of the clinician that limit their ability to work effectively with people who are acutely suicidal.^{18[4]}

It is easy for the clinician to forget that, whatever the motivation behind the act, people who seek assistance following these actions are usually in a state of extreme distress. These people will not

benefit from rejection, minimisation of their symptoms as 'attention seeking', or from ridicule. They require help and empathy.^{23,25}[4]

A key strategy for assisting people who are suicidal, particularly people who are chronically suicidal, is to seek supervision and the input of a multidisciplinary team. This is important both in terms of relieving some of the stress involved when working with suicidal people and also for assistance with assessing risk, getting second opinions with diagnosis and treatment, and developing management plans.^{18,23,26}[4]

RECOMMENDATION

All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have both on them and on the quality of their work with suicidal people.



Confidentiality

Confidentiality refers to the person's right to not have personal information disclosed to outside parties without their permission. This right is not absolute. When a person is considered acutely suicidal, the clinician's first responsibility is to work to protect the person's safety. This may involve breaching confidentiality through contacting, consulting and informing whānau/family members or significant others. The appropriateness of involving a person's whānau/family or next of kin is determined by several factors. If the person does not wish them to be notified and this does not compromise the safety of the person at risk, then confidentiality must be maintained. In some cases, whānau/family members or partners may be contributing to a person's suicidal risk (eg, in abuse situations), in which case the clinician's responsibility is to do what they can to protect the person at risk of suicide.

The Privacy Act (1993) and Health Information Privacy Code (1994) describe people's rights and limits to confidentiality.*

It is important that the person at risk is made aware of the above limitations to confidentiality, for example, by a statement such as:

What you say is confidential to the service, unless I believe that you are at serious risk of harm to yourself, or others. In such a case I will take the necessary steps to protect your safety, although wherever possible I will discuss these steps with you before I take them.

Involving Whānau/Family/Support People of the Suicidal Person

It is important to determine the degree of support that significant others can reasonably provide the person when considering discharging a suicidal person. It is not always realistic to expect whānau/family or friends to stay with a person until their next scheduled appointment. Appendix 5 contains a handout about keeping a suicidal person safe at home, which may be given to whānau/families/support people of the suicidal person and talked through before they take the person home.

If whānau/family or friends are to play an important part in supporting the suicidal person, it is important that they and the suicidal person are included in discussions about safety management plans.

*Both can be downloaded from the Privacy Commission's website www.privacy.org.nz/top.html

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On occasion, whānau/family members or significant others may play a role in perpetuating a person's ongoing suicidal risk²⁷[3] (eg, abusive parent, difficulties in relationship with partner etc), and this needs to be understood and managed sensitively. The Ministry of Health has recently published some guidance notes, *Involving Families. Guidance for involving families and whānau of mental health consumers/tāngata whaiora in care, assessment and treatment processes* (2001), which provide more detailed information. These can be obtained through the Ministry of Health.

RECOMMENDATIONS	
Whenever possible clinicians should involve whānau/family/support people/carers of the suicidal person when working with that person. This is equally true for the assessment component, crisis management, and subsequent treatment. At any time families can give information to the clinician without it compromising the person's privacy.	
If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe.	

Consent

It is an ethical and legal requirement²⁸ under the New Zealand Code of Health and Disability Services Consumers' Rights that a person give informed consent to any treatment offered to them. Informed consent includes information about:

- the type of treatment
- details about its known efficacy and any side-effects
- estimation (if possible) of the likely duration of treatment
- any alternative options.

This information should be presented in jargon-free language so that the person can understand the different options that they are weighing up.

At times a suicidal person may not be able to exercise their usual degree of judgment and autonomy in making such a decision. Where it is necessary to act against a person's wishes in order to prevent them killing or seriously harming themselves or others, it is necessary to invoke the processes of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and to involve a Duly Authorised Officer in these processes. In an emergency, a clinician may act to save life and treat a person without their consent or prior to the sectioning process being completed (eg, if they need to perform a medical procedure to save a person's life).

Mental Health (Compulsory Assessment and Treatment) Act 1992

On occasion staff within emergency departments will have to work with people who have been brought into the department either because they have made a suicide attempt, or have said that they intend to commit suicide and are insisting that they be allowed to leave before they have been fully assessed.

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

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

Before initiating legal proceedings under the Mental Health (Compulsory Assessment and Treatment) Act 1992, all effort should be made to engage with the person, and develop their trust and a collaborative treatment plan. When this process fails, or is insufficient to maintain a person's safety (from themselves or towards others), as a last resort, the Mental Health Act should be initiated. Principles of acting in the least restrictive manner, while balancing safety requirements and the dignity and rights of the individual, should be adhered to.

Assessment of Suicide Risk

It is important to remember that suicide risk can change rapidly and reflects the end point of a range of difficulties, illnesses and disorders.

An important part of conducting an assessment is creating an atmosphere that is conducive to discussions of sensitive and distressing material. As already stated, an important part of conducting an assessment is to create a sense of rapport between the suicidal person and clinician to elicit critical information.^{18[4]}

Staff in emergency departments need to determine specifically:^{29[4]}

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

These specific tasks are outlined in the next section. Appendix 2 provides key questions that a clinician may ask to aid in assessing the risk of suicide.

RECOMMENDATIONS

D
Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated by a suitably trained mental health clinician.
Culturally appropriate services should be involved with assessment, crisis management and service liaison where possible, and if agreed to by the suicidal person. <input checked="" type="checkbox"/>
A suicide assessment should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material. <input checked="" type="checkbox"/>
There is no evidence to suggest that directly asking about the presence of suicidal ideation or intent creates the risk of suicide in people who have not had suicidal thoughts, or worsens the risk in those who have. It is more likely that a calm and matter-of-fact approach discussion of suicidality may allow people to disclose their previously 'taboo' thoughts. <input checked="" type="checkbox"/>

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Mental health workers should conduct a more detailed psychosocial assessment and assessment of underlying mental illness. They can then develop a formulation of why the person is suicidal now, what predisposed them to this happening, what is perpetuating the problem and then develop an individualised management plan to manage this risk.

Mental health workers also need to differentiate between immediate risk and chronic/ongoing risk of suicide. This is described in Chapter 3, 'Detailed Suicide Assessment/Assessment by Mental Health Services'. For centres that do not have access to on-call mental health teams, the emergency physician will also need to conduct this more detailed level of assessment and treatment planning.

It may be that under some circumstances, for example, where the person is well-known to the service, or where the involvement of a mental health professional would add little to the assessment (eg, in the case of someone presenting with very minor self-harm with no intent to die), that telephone consultation with a mental health clinician, preferably the person's care manager, will suffice. This decision can only be made when the assessing clinician has adequate knowledge of the person and the circumstances leading up to their presenting to the emergency department.

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ASSESSMENT OF SUICIDALITY BY EMERGENCY DEPARTMENTS

TRIAGE

Anyone seeking assistance from an emergency department should be triaged by an emergency department nurse who should be specifically trained and experienced in the process of triage.^{29,30}[4] Pre-hospital information provided by paramedics, caretakers or referring doctors should also be utilised by staff, wherever available, to determine the severity of the physical or mental condition.^{29,31}[4] This will enable emergency staff to prepare appropriately to receive and manage the person's symptoms.

Paramedic staff, whānau/family/support people will accompany most people but some will arrive alone. Acutely distressed/unwell people need an immediate response to ensure their safety. Immediate response means not letting the patient wait in the waiting room unsupervised. It implies immediate triage, initiation of one-to-one supervision and urgent assessment by emergency department doctors.

Where there is no apparent medical condition or risk to the person from an injury they should be triaged in accordance with the severity of the behavioural disturbance. Table 1 (over page) highlights the different triage decisions that should be made to minimise risk of the person absconding from the emergency department in the first instance and to manage their suicide risk.³¹[4]

RECOMMENDATION

No person who has attempted deliberate self-harm or who is expressing suicidal ideation should be categorised to triage category 5 ie, waiting beyond one hour to be seen by a doctor.



Table 1: Emergency Department Mental Health Triage

Triage Code	Description	Treatment Acuity	Typical Presentation	General Principles of Management
1	Definite danger to life (self or others) Severe behavioural disturbance	Immediate	Observed Violent behaviour Possession of a weapon Self-destructive behaviour in the emergency department Requires restraint	Supervision 1:1 observation Action Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
2	Probable risk of danger to self or others Severe behavioural disturbance	Emergency Within 10 minutes	Observed Extreme agitation/restlessness Physically/verbally aggressive Confused/unable to co-operate Reported Attempt/threat of self-harm Threat of harm to others	Supervision 1:1 observation Action Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
3	Possible danger to self or others Moderate behavioural disturbance Severe distress	Urgent Within 30 minutes	Observed Agitation/restlessness Intrusive behaviour Bizarre, disorganised behaviour Confusion Withdrawn and uncommunicative Ambivalence about treatment Reported Suicidal ideation Presence of Psychotic symptoms Affective disturbance (low or elevated)	Supervision 1:1 observation Action Provide safe environment for the person and others Ensure adequate personnel to provide restraint/detention Alert/consult mental health service/specialist
4	Mild to moderate distress	Semi-urgent Within 60 minutes	Observed No agitation/restlessness Irritability without aggression Co-operative Gives coherent history Reported symptoms of anxiety or depression without suicidal ideation Is actively seeking assistance for their distress	Supervision Intermittent observation Consider Re-triage if evidence of increasing behavioural disturbance: <ul style="list-style-type: none">• restlessness• intrusiveness• agitation• aggressiveness• increasing distress 1:1 observation if needed Action Referral to mental health service

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

GENERAL ASSESSMENT PRINCIPLES

- People should be asked to hand over objects of potential self-harm such as sharp objects, belts, sheets or cords. Medications should be removed. If the person has a dangerous weapon that they are not willing to relinquish the police should be called. All DHBs should have specific protocols in place that outline procedures for searching people and removing their possessions.^{32,33[4]}
- The person should be placed in a special room where there is no access to potentially injurious material and where safe observation is possible.^{32,33[4]}
- People may need monitoring and observation for their physical condition in an acute area. Even so, they may still need to have someone sitting watch beside them.^{32,33[4]}
- The assessment should occur as quickly as possible. If the person makes to leave prior to the assessment being completed, and attempts to calm them and persuade them to remain are unsuccessful, a decision should be made regarding the use of restraint.^{32,33[4]}
- Accompanying friends and relatives of the person need to be supported by staff.^{32,33[4]}
- Appropriate medical treatment should be initiated.^{32,33[4]}
- Where transfer to a psychiatric facility is to follow, appropriate arrangements need to be made to complete any further required medical procedures.^{32,33[4]}
- If the person is being held by the police, or has been brought into the emergency department by the police, they should still be followed up by mental health services.^{32,33[4]}
- Anyone who talks about suicide should be taken seriously. People who die by suicide have often previously expressed suicidal thoughts or displayed warning signs to families or health professionals.^{15,16[2++/3]}
- Case notes should be augmented with structured assessments. Clinicians have often been shown to overlook key information when recording their suicide assessments in case notes. This can be avoided by augmenting case notes with structured assessments.^{34[2-]} The information should include the following if the person has been assessed for suicide risk:
 - relevant suicide risk assessments
 - whānau/family members' concerns
 - previous psychiatric history
 - previous treatment received
 - risk/benefit assessments of key clinical decisions.
- Training in suicide assessments can improve the performance of all staff in assessing, documenting and making appropriate referrals for people with suicidal ideation.^{32[3]}

RECOMMENDATIONS

Case notes should be augmented with structured assessments.	C
Training in suicide assessments should be provided to all appropriate staff.	C

MEDICAL CLEARANCE

Initial psychiatric assessment need not await a full medical clearance if the person is sufficiently well and alert enough to co-operate in an interview. For example, there is no reason to delay the assessment of an otherwise well person with a potentially significant overdose of paracetamol who is awaiting

a paracetamol blood level. In contrast, a person who is still intoxicated with benzodiazepines may have no subsequent recollection of the interview and may have described a quite unrealistic account of their situation. The section on assessment of intoxicated people on page 15 describes interventions for dealing with people who are intoxicated with alcohol or other substances and unable to give a good account of themselves.

If someone has taken an overdose they are often under the influence of the medication and unable, or sometimes unwilling, to provide an accurate account of the type and amount of medication they have taken. It can be helpful to persist in inquiries into this and to repeat these questions when re-interviewing the person later. For example, when someone says they have taken some tablets of a particular kind, ask 'and anything else?' and if someone says, 'just a few,' ask how many. If they are not forthcoming, suggest a higher range, such as '20 – 30?'

A thorough physical examination and relevant investigations are mandatory when a person is suspected of having taken an overdose of either prescription or non-prescription drugs. Drug levels, as appropriate, can guide management and a drug screen (plasma and/or urine) can establish whether other drugs have been taken. Ongoing monitoring (eg, of ECG following an overdose of tricyclic antidepressants) may also be necessary.

NB The medical management of overdose or physical injury as a result of self-harm is beyond the scope of these guidelines.

RECOMMENDATIONS

Emergency department staff are encouraged to use the triage protocol (page 12) and the RAPID Assessment tool (Appendix 1) to assess the urgency of need for mental health referral and security measures.

D

Clinicians should maintain a high index of suspicion when a person arrives following an overdose. People will often under-report quantities consumed.



SEDATION

Someone who is extremely distressed or agitated, even though they may not be immediately threatening self-harm or trying to leave, may benefit from some pharmacological sedation. The aim is to decrease their distress sufficiently that they can describe what is troubling them, or so that treatment strategies may be commenced. This is not a treatment for the underlying psychological difficulties. Urgent sedation should only be used under medical supervision and when other non-pharmacological methods, such as special nurse observation or 'specialalling' as it is commonly known, enlisting support from family/whānau/support people, and attempting to establish rapport are not working. In the case where a person is refusing oral sedatives there are clear legal guidelines (Sections 110 and 110A of the Mental Health Act) about when they can be sedated against their wishes. It states that a medical practitioner may urgently sedate a person, by injection if necessary if they have "reasonable grounds for believing that the person presents a significant danger to himself or herself or any other person; and....Has reasonable grounds for believing that it is in the interests of the person to receive a sedative drug urgently".³⁵ A medical officer, when acting under this section, should make every reasonable effort to get the advice and assistance of a Duly Authorised Officer before administering the sedative.

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It should be recognised that sedation might cloud a person's mental state (making them drowsy, muddled or vague), which can make assessment more difficult. It should also be used with extreme caution if the person is already intoxicated with alcohol or other drugs.

Broadstock¹⁴[1+] reviewed 12 research papers reporting on randomized controlled trials in psychiatric and emergency room settings and found that pharmacological approaches to urgent sedation appear to be both effective and reasonably safe. No conclusive benefits were suggested for one antipsychotic over another, antipsychotics over benzodiazepines, or combination drugs over single drug regimens. (NB The main focus of this review was on people who were violent rather than suicidal per se). However, Haloperidol is contraindicated with depressed patients (unless they are established on antidepressant medication), or where there might be CNS depression (such as if they have been drinking). Haloperidol should only be used for sedation if the person shows violent or agitated behaviour, or symptoms of psychosis. There are cautions about using benzodiazepines in the longer-term with people who are suicidal that are described in Chapter 4, in the section 'prescribing issues'.

RECOMMENDATIONS	
Acute sedation with medication may be necessary if the person shows violent or agitated behaviour, or symptoms of psychosis. Consider prescribing an antipsychotic (such as haloperidol or a short to medium term benzodiazepine (such as lorazepam which has a short half-life, or clonazepam which is presently the only intra-muscular benzodiazepine available). A full assessment must then be resumed.	C
Haloperidol is contraindicated where the person is depressed or has CNS depression due to drugs or alcohol	A
Haloperidol can cause painful dystonic reactions for some people, particularly among people who have never taken an antipsychotic before. In such cases, the co-prescription of an anticholinergic agent (such as benztropine) is advised. The newer antipsychotic medications have not yet been formally evaluated for use in this setting.	<input checked="" type="checkbox"/>
Benzodiazepines should only be used for sedation as a short-term measure. They must be administered under supervision.	<input checked="" type="checkbox"/>
Check for allergic reactions to some sedating drugs. Ask the person or obtain file notes.	<input checked="" type="checkbox"/>
If a person has been sedated and then needs to be transported to another place for assessment, medical support must be provided during transit. The accompanying clinician needs to be aware of potential medical complications of sedation (eg, respiratory arrest following intravenous benzodiazepine use).	<input checked="" type="checkbox"/>

ASSESSMENT OF INTOXICATED PEOPLE

There is a strong link between alcohol and drug consumption and suicidality, both as a predisposing risk factor and also a precipitating risk factor.²¹[2++]

Intoxication with alcohol or other drugs may increase suicide risk by:

- increasing the person's distress (eg, alcohol can act as a depressant)
- increasing a person's impulsivity and aggressiveness
- decreasing their ability to problem solve and find alternative solutions for their difficulties.

Despite this clear association with risk, people are less likely to be seen or properly assessed if they present to emergency departments whilst intoxicated.⁷[2-]

People at risk of suicide should be strongly advised to stop using alcohol or illicit drugs due to their potential disinhibiting effects. Whānau/family members should also be told of this.

RECOMMENDATION

People who present to emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk (whilst they are still intoxicated). Enduring risk cannot be judged until the person is sober.



People at risk of suicide should be strongly advised to stop using alcohol or illicit drugs due to their potential disinhibiting effects. Whānau/family members should also be told of this.



REFERRAL TO MENTAL HEALTH SERVICES

Some people are chronically suicidal and in ongoing treatment with a mental health service. Such people may have individual management plans held in the emergency department, which, at times, may suggest that after initial assessment the person is discharged home without further psychiatric review. In general, the psychiatric emergency team should be advised by phone of such contact and written notes should always be faxed in confirmation of this contact.

Management plans are only a guide to usual presentations. They should be over-ridden if the person has made a medically serious or potentially lethal attempt or is in acute distress. In such circumstances, consultation with specialist mental health services is essential and a brief admission may need to be considered, irrespective of directives in the management plan. The section in Chapter 5, 'Assessment and Management of Chronically Suicidal People' provides further information about working with this group.

RECOMMENDATION

Mental health services should at least be contacted (or existing management plan consulted) by the assessing emergency department clinician whenever suicidal ideation, intent, or a suicide attempt or self-harm is present.



Assessing staff in the emergency department should work through the following checklist with any person expressing suicidal ideation before they are allowed to go home. If the person is being transferred to mental health services, emergency department staff should work collaboratively with mental health services to complete the handover and ensure the checklist is completed.

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Discharge Checklist

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

DETAILED SUICIDE ASSESSMENT/ASSESSMENT BY MENTAL HEALTH SERVICES

The most statistically robust conclusion that can be drawn from the suicide literature is the association between suicide and psychiatric illness.^{14[2+]} Psychiatric autopsy studies found that 95% of the adults who died by suicide had a psychiatric illness or substance use disorder. Studies of adolescents have also found comparable prevalence, with major depression and impulsive behaviours the most common mental illnesses.^{21,36,37[2++/3]}

Therefore, it is vital to accurately identify and treat any psychiatric or substance use disorders that are present in people who have made suicide attempts. The key to diagnosis and management is a fully comprehensive psychiatric/psychosocial assessment and an evaluation of short and longer-term risk of suicide. This evaluation will consist of a clear history obtained from the person and any available relatives or other informants, as well as the perusal of any previously available information such as old case notes.

The aims of a comprehensive psychiatric/psychosocial assessment carried out by a mental health clinician are to enable the best preventive efforts to minimise risk of future suicide.

To do this, clinicians should:

- identify all acute and chronic co-morbid psychiatric conditions
- evaluate all factors and motivations associated with the attempt or threat
- identify significant interpersonal problems and conflicts
- identify social stressors and concerns such as unemployment and illness
- identify patterns of dysfunctional thinking and behaviour
- adequately consult with whānau, family and friends where possible
- assess short-term and continuing risks of suicide and deliberate self-harm
- assess for factors that contribute to long-term risk
- conduct the assessment within the context of a multidisciplinary team, under psychiatric supervision.

This process may occur over one or more contacts with the person. An integral part of any good assessment is the establishment of rapport. The accuracy and amount of information disclosed is largely a function of the trust a person has in the clinician.^{38[4]}

Mental health specialists, while better than other clinicians at recording information about risk in their suicide assessments in case notes,^{39[3]} nevertheless often overlook assessing (or at least recording) other critical information.^{39,40[3]} As mentioned under General Assessment Principles, this can be improved by augmenting case notes with structured assessments^{34[2-]} and training in suicide assessments.^{32[3]}

MENTAL STATE EXAMINATION

A key part of any assessment is a Mental State Examination. A clinician can infer a lot of clinically useful information from the appearance of a person and their account of themselves. Particular attention should be paid to factors such as an increase in their distress, an increase in feelings of self-dislike, hopelessness⁴¹[2] (nothing will change) and/or helplessness (I can't change), evidence that they are denigrating themselves or their circumstances, and evidence of an increased preoccupation with escape and suicide as the only option.⁴²[4] Appendix 3 outlines key aspects of conducting a Mental State Examination.

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INFORMATION FROM WHĀNAU/FAMILY/FRIENDS

If possible, corroborative sources should be asked about whether they have seen anything that would suggest suicidal intent, about any stressors that the person has recently been under and any changes in the way they normally act. Specific questions one might ask a whānau/family member/friend about suicidality include the following:

- Are they their usual self?
- Have they made any comments that they would be 'better off dead'?
- Have there been any statements about 'things getting better soon'?
- Have you been worried about them? Do they seem down or depressed?
- Are they drinking more than usual?

A corroborative interview also provides a chance to determine further what social supports a person has. A lack of whānau/family/friends or social supports has often been seen as a risk factor for people attempting suicide.

PHYSICAL ILLNESS

A general medical history with attention to recent diagnoses and the presence of any chronic illness should also be undertaken.

KEY COMPONENTS OF A PSYCHIATRIC/PSYCHOSOCIAL ASSESSMENT

Not everyone who is suicidal has a mental illness. Nonetheless, certain mental illnesses are typically associated with an increased risk of suicidality, especially depression.^{14,19}[2++/2+] Impulsivity associated with substance abuse may also be a risk factor while the person is intoxicated. On some occasions, the presence of hallucinations (such as, telling them to kill themselves) or delusional beliefs may place someone at increased risk.⁴³[4]

There is also a link between personality disorders and suicidal risk, especially with Borderline Personality Disorder and Antisocial Personality Disorder.

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RECOMMENDATION

When conducting an assessment of suicide risk always be mindful of the presence of concomitant mental illness, particularly the following diagnoses, which are associated with increased risk.

B

- Major depression - acute risk factors: severe anhedonia, insomnia, anxiety, substance abuse.
- Substance abuse - acute risk factors: co-morbid depression, recent interpersonal loss or disruption.
- Schizophrenia - acute risk factors: age <40, chronicity of illness with frequent exacerbations, awareness of deterioration and poor prognosis, depression.
- Borderline Personality Disorder or Antisocial Personality Disorder – acute risk factors: co-morbid Axis I disorders, particularly depression.

Appendix 4 outlines the core components of a detailed psychiatric/psychosocial assessment of a person's mental health.

USE OF SCREENING MEASURES

Screening measures may be used to supplement the information gathered in the clinical interview, or to direct further questioning. They should never be used in the place of a thorough Mental State Examination.

The measures designed to screen for suicidality have varied reliability, predictive power and utility for various populations.^{24,44} The Beck Hopelessness Scale is particularly useful, as it has robust reliability and strong positive predictive power when administered to clinical samples of adults.^{41,45,46}[2++]. There is also emerging evidence of its utility with adolescents.^{44,45} A number of researchers have shown that hopelessness and helplessness are strongly correlated with both suicidal ideation and suicidal intent.^{14,45}[2++]. Hopelessness has also been found to be associated with eventual suicide in clinically-referred adult samples.^{14,47}[2++]

A score of 9+ on the scale should be taken to mean that the person is at an elevated risk and a score of 15+ suggests that the person is at severe risk.^{41,45}[2++]

RECOMMENDATION

The Beck Hopelessness Scale has the best generic application for screening for suicide risk amongst adults, adolescents, inpatients, outpatients and people seeking assistance from emergency departments.

B

FORMULATING RISK

A key difficulty in the assessment of risk of suicide is the arbitrary nature of assigning risk as low, moderate or high. Suicidality is not a diagnosis and there is no evidence for absolute markers that predict its presence or intensity. Risk assessment requires sound clinical judgment.¹⁸[4] Even then risk varies and an assessment only provides a snapshot of a person's risk at a given time. Further, the assignation of people into categories of risk is not highly predictive of suicidal behaviour.^{15,16}[2++]. Some people who are judged to be at low to moderate risk of suicide have gone on to complete suicide, whereas other people judged as at high risk have not.¹⁵[3] It is not clear in the latter case if this is due to effective treatment or initial misattribution of risk.¹⁵[2++]

RECOMMENDATION

Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk should be re-assessed regularly, particularly if their circumstances have changed.



Basing assessments on an accumulation of risk factors alone is not realistic. Many of these are long-term factors, which increase vulnerability to various mental disorders and suicidal behaviour. Awareness of these may alert the clinician to general levels of risk, but it is the key contextual triggering factors and the person's current mental state that are most immediately important.⁴⁸[2++]

22

Assessment of risk represents an integration of the following factors:

- intent
- lethality
- means
- presence of risk factors (eg, mental illness, hopelessness, anxiety and depression, impulsivity/recklessness)
- psychosocial triggers
- lack or presence of protective factors.

The assessing clinician should seek to identify the factors that led a person to consider suicide at this time. A formulation of the suicidal behaviour takes into account long-term and immediate risk factors summarised in Table 2.

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Table 2: Risk Factors

Predisposing factors	These include long-term risk factors and demographics such as: <ul style="list-style-type: none"> • the presence of mental illness • poor socio-economic status • previous history of and lethality of attempts • history of abuse • whānau/family history of suicide • co-morbid substance abuse²¹[2++] • disrupted whānau/family upbringing etc.^{14,47}[2++/3]
Precipitating factors	What triggered the crisis? This is an essential factor when the person is experiencing adjustment difficulties, or is suicidal in the absence of mental illness. ³⁸ [4] Significant triggers include: <ul style="list-style-type: none"> • recent bereavement • relationship break up • issues around sexual identity • loss of employment • legal problems/problems with the police • increased substance abuse²¹[2++] • major changes in circumstances.¹⁴[2++]
Perpetuating factors	What is continuing the person's ongoing risk? Factors may include: <ul style="list-style-type: none"> • major life stressors • meaning of events to the individual^{21,49}[4] • mental illness, including substance abuse • access to means • suicidal intent^{14,15,16,47}[2++/2] • hopelessness.^{14,47}[2++]
Protective factors	These factors refer to aspects of a person's life that give them some reward, meaning or sense of purpose, or sense of connection with others. They include factors such as: ²⁶ [2-4] <ul style="list-style-type: none"> • relief about not completing suicide • people relying on them for ongoing care • sense of 'unfinished business' • framework for meaning eg, religious beliefs, beliefs about the need to care for children etc • good self-esteem, self-confidence • presence of close supports in community • awareness of significant others about their suicidal thoughts.

The interviewer must take care that they do not place their own values on to the person when assessing protective factors. For example, the fact that a person has children may not be seen as a deterrent for the suicidal person who may in fact think that the children would be better off without them. However, the suicidal person's perception of an absence of protective factors significantly increases the person's risk.

Thus, risk of suicide is low when the person is faced with few predisposing factors, surmountable stressors and good protective factors. Similarly, risk is high if the person has many predisposing factors, clear triggers that are of high significance (eg, the break-up of a significant relationship), and clear perpetuating factors (eg, realistic appraisal of a poor prognosis in people newly diagnosed with schizophrenia) in the absence of protective factors.

This information is critical because crisis interventions are based around strengthening and or utilising protective factors (such as whānau/family support) and minimising precipitants and perpetuants (through techniques such as structured problem-solving, assisting people to leave unsafe home environments, emergency income support etc). Moreover, if the person has high risk factors in the absence of any positive supportive elements, the clinician needs to give greater consideration to admitting the person to hospital or offering respite accommodation as the first line of intervention until the crisis can be resolved.

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CRISIS/INITIAL MANAGEMENT

By the end of the assessment, there must be a clearly documented survival plan that specifically includes a safety strategy. The key components of the treatment plan should be:

1. To ensure the safety of the person. The immediate goal of management is preventing a person in crisis from committing suicide until that crisis has passed. To that end, an early decision needs to be made on whether or not to admit to an inpatient unit.
2. To establish an effective therapeutic relationship – creating a sense of meaningful assistance.
3. To institute effective treatment of any mental illness and address whatever may have precipitated the person's distress.

A key clinical question is 'how will the person's situation be better when they leave here?' If it won't be better, then the person's suicide risk remains. Any management plan therefore should include strategies to address a person's ongoing risk factors and psychosocial stressors, taking into account safety.

The presence of a 'safety contract' does not in any way guarantee the person's actual safety. There is no evidence that it acts as a deterrent to suicide.^{50,51}

RECOMMENDATION

The presence of a 'safety contract' does not in any way guarantee the person's actual safety. There is no evidence that it acts as a deterrent to suicide.



MANAGEMENT AS AN OUTPATIENT

Many people with suicidal ideation can be treated successfully as an outpatient.^{52,53[1-]} In such circumstances, the following treatment measures should be put into place.

- Increase the frequency of outpatient visits and between-visit telephone contacts.^{13,25,54,55[4]}
- Assess the degree of risk at every contact, including evaluation of the need for hospitalisation or respite options in an ongoing way.^{13,25,54,55[4]}
- Ensure that the person has access to 24-hour emergency support (give the number for the crisis assessment and treatment team/psychiatric emergency team).^{4,32[1+]}
- Review the treatment plan regularly and revise as needed if risk level changes.^{13,25,54,55[4]}
- Consult with colleagues or multidisciplinary teams.^{26[4]}
- Consult with whānau/family/support people where appropriate.

RECOMMENDATION

Providing people with 'green cards' (24-hour access to a crisis team) is a useful but insufficient treatment strategy and other interventions should also be provided.

A

THE DECISION TO HOSPITALISE

A key factor in determining whether a person can be managed in the community or would benefit from a hospital admission is the person's safety. In general, the most acutely suicidal people are best managed as inpatients.^{22,27,56,57[4]}

Factors that strongly suggest that an admission is required include:

- the need for medical management of an attempt
- more intensive psychiatric management (eg, acute psychosis)
- psychosocial support (eg, no suitable caregivers/support people are available).^{58[2+]}

Serious consideration should also be given to the need for inpatient admission when:^{43,49}

- the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal
- the person has insufficient support to remain in the community. In this case, respite care options may provide the care needed to support the person through the immediate crisis.

It has been demonstrated that short admissions (1–4 days) do not reduce a person's risk of suicide.^{53[1-]} This suggests that 1–4 days is an insufficient length of time to treat a person's underlying mental illness. However, such short admissions may be appropriate as part of an ongoing risk management plan for a chronically suicidal person.

If the person is not admitted, appropriate arrangements must be made for timely follow-up with the relevant health provider (eg, care manager, therapist etc). For a significant proportion of people, this will need to be within 24 hours. The rationale/reasons for not admitting must be clearly documented in the person's file.

RECOMMENDATIONS

The following people with suicidal ideation should be admitted when:

- * they are acutely suicidal
- * medical management of an attempt is required
- * they require more intensive psychiatric management
- * the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal.

D

When no suitable caregivers/support people are available respite care options may be considered as an alternative to admission.

D

In order to reduce the person's risk of suicide, admission should be for more than 4 days.

A

For a chronically suicidal person short admissions (1–4 days) may be appropriate.

C

If the person is not admitted, appropriate arrangements must be made for timely follow-up with the relevant health provider (eg, care manager, therapist etc) within 24 hours.

The reasons for not admitting must be clearly documented in the person's file.

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MANAGEMENT AS AN INPATIENT

People in imminent danger of suicide require a structured environment with clinically trained staff.^{43[2+]} Although inpatient admission reduces risk, it does not provide absolute protection. Sometimes people will attempt and complete suicide despite being in inpatient care,¹² most commonly within the first week of their admission.^{43[2+]} Therefore staff need to be particularly vigilant, especially when the person is not well known. (See Appendix 6 for guidelines for supervision.) The level and frequency of support and observation should reflect the person's changing level of suicide risk. Close supervision is required for people who are assessed as being at high risk for suicide.

Underlying mental illnesses/psychological difficulties should be treated vigorously. Targeting of specific symptoms, such as anxiety, agitation and insomnia, should be considered. This may include both psychopharmacological and psychological interventions and should be introduced as early as possible in the person's admission.

RECOMMENDATIONS	
People assessed as being at high risk of suicide should be under close supervision. (See Appendix 6 for guidelines for supervision.)	
The level of support and observation should reflect the person's changing suicide risk.	
Inpatient unit staff need to be vigilant, particularly when the person is not well-known and for the first week after admission.	C
Treatment (both psychopharmacological and psychological) of underlying mental illnesses should be initiated as early as possible.	D

DISCHARGE PLANNING

The first few days and weeks following discharge from hospital are associated with increased risk of suicide particularly for people who were admitted following a suicide attempt, with suicidal ideation or depression.^{15,43[3]}

Follow-up of people who do not take up treatment post discharge significantly increases their subsequent willingness to partake in treatment.^{25,59[1+/1-]}

Consequently, when a decision is made to discharge a person, or not to admit a person with suicidal behaviour or elevated risk factors, it is recommended that the following steps occur.

1. If a person is not admitted, write detailed notes to explain why a person has not been admitted and make follow-up arrangements to ensure safety and ongoing management and care.
2. Schedule follow-up appointments in the first few days after discharge.
3. Involve whānau/family/support people (if appropriate) in discharge planning.
4. Involve the continuing care team in discharge planning and give them at least a verbal report prior to discharge.
5. Send the general practitioner full copies of the assessment/discharge information.

RECOMMENDATIONS

Follow-up should occur in the first week post-discharge, as this is the highest risk time for a person discharged from hospital. This should happen even if the person fails to attend their outpatient appointment.	A
If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm.	D
The discharge plan should be developed in consultation with the person and their key supports (including whānau/family if appropriate) and clinicians.	<input checked="" type="checkbox"/>
Before leaving the hospital the person should have a clear understanding of discharge arrangements that have been made and a written copy with information about medications, treatment plans and key contacts to call, if needed.	<input checked="" type="checkbox"/>
If appropriate, the person's whānau/family or nominated next of kin should be informed of the person's risk, told of their next appointment and invited to attend. They should also be involved in discharge planning processes.	<input checked="" type="checkbox"/>
The continuing care provider/team must get at least a verbal report prior to discharge. They should also be included in any discharge planning meetings/decision-making processes.	<input checked="" type="checkbox"/>
The person's general practitioner should also get a full copy of the discharge plan including any medication recommendations. If the general practitioner is the sole care provider, he/she should receive this prior to the person's discharge from hospital.	<input checked="" type="checkbox"/>

INTERVENTION/TREATMENT STRATEGIES

Regardless of whether the person is managed in an inpatient or community setting, treatment strategies should target the following objectives:^{*}

- maintaining safety
- identifying and treating any underlying mental illness
- identifying psychosocial stressors and developing strategies to intervene.

This should be done in collaboration with both the person at risk of suicide, and their whānau/family/support people.

There is insufficient evidence to recommend specific treatments for reducing the risk of further suicide attempts. Studies in this field are limited by small sample sizes, heterogeneous diagnostic groups and low probability outcome measures. The literature is clearer in describing the therapeutic advantage that occurs from seeing the same therapist both as an inpatient, and when discharged to outpatient service. This continuity increases their willingness to take medication and also to attend appointments.^{4[1+]} The interventions described (below) have all shown some effectiveness.

*The strategies described are those that specifically target suicidal ideation or behaviour. Discussion of the relevant treatment approaches for mental illnesses that may underlie the suicidal presentation (eg, different therapies for depression, substance abuse, Post Traumatic Stress Disorder (PTSD) etc) is outside the scope of these guidelines.

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- Longer-term therapy to treat any underlying mental illnesses (including substance abuse) is crucial.
- Both Cognitive-Behavioural Therapy and Interpersonal Psychotherapy were shown to be promising therapeutic interventions for reducing the probability of deliberate self-harm and also symptoms of depression among people who attended an emergency department for a suicide attempt.^{4,58}[1-]
- Dialectical Behavioural Therapy has also been shown to be promising for reducing suicide and self-harm attempts among people with Borderline Personality Disorder while they are in therapy.^{10,57}[1+/1]

RECOMMENDATION

Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to taking medication and to attend appointments.

A

29

PRESCRIBING ISSUES

Appropriate medication should be prescribed as part of the treatment of any underlying mental illness. When it is necessary to prescribe a medication that is potentially lethal in overdose, consider weekly (or more frequent) prescribing and/or dispensing to limit the opportunity to hoard medication. Also consider ways to assist the person to manage their risk through the supervised administration of their medication.

There is no good evidence to suggest that selective serotonin re-uptake inhibitors (SSRIs) in general and fluoxetine in particular are associated in a causal way with increased risk of suicide.⁶⁰⁻⁶²[2++]

There may be some link between suicide risk and benzodiazepine use.^{62,63}[2+] Benzodiazepine use may worsen an underlying depression, or cause a person to become disinhibited and therefore more likely to act impulsively. However, they do have some use in treating severe agitation and anxiety, which may outweigh these risks.

There has also been some suggestion that suicide risk may paradoxically increase after antidepressant treatment is initiated.⁴[2+] This may occur as people regain their motivation and drive in the absence of any alleviation of their mood and, very rarely, may reflect a direct effect of medication. Clinicians therefore need to monitor a person's suicide risk closely as they respond to medication. They should encourage those taking antidepressants and their whānau/family/support people to report any marked increase in suicidal ideation. Apparent treatment effect is not necessarily associated with decreased suicide risk.

RECOMMENDATIONS

Clinicians should be cautious when prescribing benzodiazepines (both acutely and in the medium-term), especially if the person may also be suffering from depression or have risk factors for suicide.	C
Clinicians need to monitor suicide risk closely irrespective of the antidepressant/drug used. This is essential both to rule out any paradoxical increase in suicidality and also to ensure that risk does not increase as the treatment begins to work, relieving the motor symptoms and lack of drive first, but not the mood related symptoms.	C
In general, if a person is suspected of being at risk of suicide, appropriate medications should be prescribed and dispensed in dosages and quantities that are less likely to be lethal in overdose or in combination with other drugs or alcohol.	✓

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ASSESSMENT AND CRISIS MANAGEMENT WITH SPECIAL POPULATIONS

CHILDREN AND ADOLESCENTS

The assessment of suicidal young people requires a comprehensive evaluation, ideally by a clinician who is skilled in interviewing and working with children and adolescents.^{9,27,54,64[4]}

Risk assessments should not be based on information from the young person alone. Information and input should always be drawn from several sources including the young person, their parents or guardians, school reports, school teachers/guidance counsellors and reports from other individuals close to the young person (see the earlier section on confidentiality).^{13[4]}

Clinicians should be aware which of those adolescents attempting suicide are at greater risk of subsequent suicide. Particularly at risk are:

- older males^{21,49[2+]}
- those with a current mental disorder, of either gender, regardless of age^{21,49[2+]}
- those with a disordered mental state (eg, mood disorder, particularly when complicated by substance abuse or dependency)^{14,48[2+]}
- people with issues around sexual identity^{65,66[2+]}
- those who have made prior suicide attempts^{21,49[2+]}
- those who continue to wish to die^{21,49[2+]}
- those who have used some method other than drug ingestion or superficial cutting^{21,49[2+]}
- those showing signs of instability, agitation or psychosis.^{14,48[2+]}

Self-harm among children is rare,¹² but should be treated very seriously. The child's immediate environment should be checked for safety (eg, what is happening at home? at school?) and they should be referred to appropriate services (this may include Child, Youth and Family Services (CYFS)* if there are safety issues at home and/or a child and adolescent mental health service).

RECOMMENDATIONS

The assessment of suicidal young people should be carried out by a clinician who is skilled in interviewing and working with children and adolescents whenever possible.	D
Self-harm among children is rare and should be treated very seriously.	D
Risk assessments should draw on information from multiple sources, including the young person, their teachers/guidance counsellors, parents etc.	✓

*At times, care and protection issues affect young people (16 years and younger) who are suicidal. Advice and support for these matters is available on a 24-hour basis from Child, Youth and Family Services (0508 FAMILY). This provides access to a social worker, intake processes and then links to an area social worker and the Towards Wellbeing Monitoring Programme, which is an initiative to reduce suicidal behaviour in young people.

THE ELDERLY

Although suicide rates in the elderly are relatively high,¹² their suicide risk is often overlooked. This is dangerous, as elderly who attempt suicide usually have a strong intent to die and are more likely to make attempts that are fatal.²² Elderly people who attempt suicide usually choose more lethal means and often live alone, which decreases their chances of being discovered. Because of their physical frailty, an elderly person may be less able to survive/recover from a physically serious suicide attempt.^{3,22[4]} Furthermore, it is uncommon for an older person to seek assistance after deliberately self-harming.^{3,67[4/3]} Any elderly person who is expressing suicidal ideation or has presented following a suicide attempt should be treated very seriously.

The general risk factors for suicide amongst elderly people are very similar to those experienced by younger people. Suicidal ideation is closely linked with the presence of psychiatric disorder, in particular depression and the early stages of dementia.^{3,22} In addition, there is a marked association between physical illness (particularly painful illness), depression and suicidality among older people.⁹ However, it appears that much of the increased risk associated with physical illness is mediated by depressive symptomatology. Additionally, elderly people have often experienced a number of major losses, which may act as precipitating events, such as:

- loss of health
- loss of mobility, cognitive functioning, ability for self-care
- loss of role/job (eg, retirement)
- loss of means for self-support
- loss of home or cherished possessions (eg, going into a rest home)
- loss of loved ones, including whānau/family/friends and pets.

In conducting an assessment, it is useful to consider these losses and ask about their impact on the person and their quality of life.^{6[4]} Although older people may have more illness and loss to deal with than younger adults, it is important that clinicians do not assume that depression is a normal part of ageing. An unintentional ageism may exist where clinicians assume that an older person's suicidality is part of a rational decision-making process. Most elderly people are not depressed and not suicidal. Clinicians should treat symptoms of depression in an older person as assertively as they would in a younger person.

Older people may be uncomfortable talking about their feelings, especially their psychological distress, to younger clinicians. Moreover, an older person's suicidality may also be part of a delirium or the early stages of a dementia. When conducting an assessment, and depression and/or suicidality is suspected, it is important to rule out any physical causal factors (eg, side-effects from medication, confusion from a urinary tract infection) and wherever possible, to seek collateral information.

The clinician should also maintain a high index of suspicion for symptoms that may be related to self-neglect, in case this reflects a passive death wish on the part of the older person, for example, obvious signs of poor nutrition.^{3[4]}

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RECOMMENDATIONS

Any elderly person who is expressing suicidal ideation or has presented following an attempt should be treated very seriously. The clinician should consider whether the symptoms could be related to self-neglect or reflect a passive death wish.	
Clinicians should treat symptoms of depression in an older person assertively. If depression and/or suicidality is suspected, physical causal factors need to be ruled out.	
Assessments should also draw on information from relatives or friends who can comment on whether the person is different from 'their usual self'.	

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MĀORI

The assessment of Māori people requires consideration of their cultural context and meaning associated with their identity as Māori. Modern Māori are as diverse in lifestyle and identity as any ethnic or cultural group. Clinicians cannot assume that all Māori people who are at risk of, or have attempted suicide are similar in terms of the personal meaning they associate with being Māori, nor can they assume that such personal meaning has any bearing on attempting suicide. As culture is recognised as an important determinant in the manifestation of illness,^{68,69[4]} specialist Māori input is imperative where cultural or issues of identity arise among tāngata whaiora (ie, Māori consumers). Any suggestions of breaches of cultural protocol (eg, tapu), preoccupation with a sense of personal failure on cultural grounds (ie, issues concerning loss of mana, either individual or collective) and preoccupation with deceased relatives or significant others require specialist Māori knowledge and expertise.

In attempting to make sense of suicide among Māori, general social and intergenerational disadvantage may provide partial explanation beyond the individual psychiatric risk factors often provided. Long-term predisposing risk factors such as poor socio-economic status, history of personal abuse and a disrupted whānau/family upbringing may be compounded for some Māori by a history of tribal or whānau dispossession and trauma. Traditional roles for Māori as a collective culture involved leadership or protection, and guardianship of tribal resources (particularly sites of significance) and one's social group (ie, kaitiakitanga). Elevated stress levels and reduced capacity or access to coping resources may see many Māori overwhelmed by demands of modern life without a clear personal purpose, particularly given the history of the nation where Māori have been clearly marginalised socially and politically in the land of their ancestors.

Beyond the standard clinical procedures and considerations in assessment of suicidality, issues to be considered in the assessment of tāngata whaiora Māori include:

- seeking and respecting a suicidal person's preference for presence (or otherwise) of whānau or support of significant others in assessment and developing a treatment plan
- giving Māori people an opportunity to be assessed by a qualified Māori mental health professional, as rapport and effective communication may be easier to establish for some Māori in this way
- giving Māori people the opportunity to have Māori cultural advisors present at assessment (eg, kaumātua, significant whānau members or tohunga); in some cases where cultural and/or spiritual issues are part of the presentation then consultation/clinical collaboration and/or referral may be necessary
- assessment of unresolved grief or loss of person's cultural status (mana)
- assessment of substance abuse and dependence and potential association with acts of bravado or impulsive and reckless behaviour.

Specialist Māori mental health assistance may be found among Māori staff in-service, DHB specialist Māori mental health teams, staff at Māori health units attached to hospitals, iwi health providers (eg, Māori community support workers), iwi networks and NGO Māori health and social services. If collaboration in assessment and/or treatment is to take place, roles and responsibilities for different aspects of the person's care need to be carefully negotiated between the parties involved in conjunction with the person and (where the person prefers) their whānau. Joint assessment and treatment endeavours work best when there is an existing relationship between the health care provider and Māori specialists or services as those mentioned above, preferably established before any particular people are referred.

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RECOMMENDATIONS

Assessment of Māori people requires consideration of their cultural context and meaning associated with their identity as Māori. Specialist Māori input is important when cultural issues or issues of identity arise among tāngata whaiora. Māori people who are suicidal should be offered the input of specialist Māori mental health workers.



People's preference should be sought and respected for involving whānau or support of others in assessment and developing a treatment/management plan.



PACIFIC PEOPLES

The assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Pacific peoples have their own cultural perspective on mental illness, which leads to a different formulation of the underlying causes.¹¹ Clinicians cannot assume that all Pacific peoples who are at risk of, or have attempted suicide have similar cultural values and beliefs. Pacific populations in New Zealand are heterogeneous and culturally diverse – different ethnic groups have their own language, customs, traditions and views of mental ill-health. Differences in beliefs and values can also exist among younger New Zealand-born Pacific peoples compared with those born in the Pacific Islands. Pacific peoples do, however, share a common migration and assimilation history in New Zealand.⁷⁰

Pacific peoples often have a strong sense of belonging to their families, the church and the Pacific community. An individual's identity and well-being are traditionally dependent on family heritage, family connections, roles and responsibilities. Although the closeness of mutual family obligations is weakening due to socio-economic factors and assimilation within New Zealand society, the extended family structure is still at the centre of Pacific cultures, behaviours and beliefs.⁷⁰⁻⁷¹ These social organisations (family and church) provide significant and meaningful relationships, which protect members against suicide.⁷²⁻⁷⁴

Mental illness is often believed to be a result of breaking of tapu (taboo), which usually involves offences against family, superiors, sacred symbols and places. The traditional healer is usually the first person consulted when a Pacific person becomes mentally unwell. Suicide is considered as the ultimate rejection of one's family and is very shameful to the family. There is often a lot of guilt and shame associated with the family's sense of failure to adequately care and support the victim.⁷⁵ Family members should therefore be involved throughout the assessment and treatment process. Specialist Pacific input is critical where issues of Pacific cultural beliefs present among Pacific consumers. Any suggestions of breaches of cultural protocols (tapu), preoccupation with deceased relatives or preoccupation with a sense of personal failure or loss of mana (eg, where the father or primary provider believed that he/she failed to fulfil family or social obligations), require early specialist Pacific input and expertise.⁷⁵

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Other factors that may be particularly relevant for Pacific peoples with mental health problems include:

- cycles of social and inter-generational disadvantage
- poor socio-economic status
- decline in parental support associated with disintegration of traditional family structures.

These may be compounded by urbanisation/migration and the resultant isolation, and the loss of social support mechanisms and significant interpersonal relationships.⁷⁶

Besides the standard clinical procedures, other considerations in the assessment of Pacific peoples include:

- showing a willingness to involve family and support people (and respecting the person's preference for presence of family or support people) when working with Pacific peoples
- being aware that language barriers may be an issue for some Pacific adults. It can be very difficult even for a Pacific person who speaks relatively good English to describe and articulate complex emotions and symptoms in English. Confidentiality is critical when selecting interpreters for Pacific peoples because of the stigma and shame associated with suicide and parasuicide in small Pacific communities
- giving Pacific peoples an opportunity to be assessed by a qualified Pacific mental health practitioner. This process may enhance rapport and facilitate effective communication for some Pacific peoples
- giving Pacific peoples the opportunity to have cultural support present at assessment (eg, family members, church leaders, traditional healers). Consultation and collaboration with Pacific specialists may be critical in cases where cultural and/or spiritual issues are part of the presentation. In order for effective collaboration in assessment and/or treatment to occur, clear roles and responsibilities for different aspects of the person's care need to be discussed between the parties involved, in conjunction with the Pacific person and the family.

Specialist Pacific mental health assistance may be accessed through Pacific staff at Pacific health units attached to hospitals, DHB mental health teams, Pacific health providers (Pacific community-based mental services).

RECOMMENDATIONS	
Assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Specialist Pacific input is important when cultural issues or issues of breaches of protocol are present among Pacific peoples. Pacific peoples who are suicidal should be offered the input of specialist Pacific mental health workers.	<input checked="" type="checkbox"/>
Pacific peoples' preference should be sought and respected for involving family or support of others (eg, church leaders, traditional healers) in assessment and developing a treatment/management plan.	<input checked="" type="checkbox"/>
Language barriers may be an issue for some Pacific peoples. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Pacific communities and the shame associated with suicide and attempted suicide among Pacific peoples.	<input checked="" type="checkbox"/>

PEOPLE OF INDIAN DESCENT

Working therapeutically with peoples of Indian ethnicity poses many of the same challenges faced when working with other ethnicities where the importance of the family and religion play a vital role in the individual's intrapsychic functioning and well-being.

It is important to acknowledge the considerable diversity among those people who identify as Indian (eg, those that identify being Hindu vs Sikh).⁷⁷[4] It is also very important to consider the Indian person's needs in the context of their family. The family is generally of primary importance in Indian cultures. Unlike traditional western culture, an individual is not expected to behave in a totally individuated way.⁷⁸[4] The Indian person has clearly defined roles and positions in the family based on age and gender. Men traditionally 'rule' the household and take on roles such as breadwinner and discipliner. The individual's personal actions can thus be seen to have serious repercussions on the family. For example, if the individual does not behave in a way that is expected (eg, they cannot fulfil their role as a parent or caregiver) then they may experience a great deal of shame and a sense of failure and/or pressure from the family to fulfil their unmet obligations. These factors can ultimately precipitate or exacerbate serious mental health problems.

Factors that change the structure of the Indian family (such as family life transitions, migration and acculturation issues) place considerable strain on the unit and individual members. For example, it is not uncommon to see circumstances where the father in a migrant family is unable to find work, leaving his wife to fulfil the role of the breadwinner. She might also be expected to meet her other obligations as well, such as looking after the children, running the household and caring for any other relatives that might be living with the family.

The language of personal emotions is often viewed as too self-focused by Indians, so feelings are not spoken of directly. Unpleasant emotions like anger, sadness and despair may be expressed in indirect ways, such as through somatic symptoms.⁷⁹[4] Alternatively, the Indian person might be construed as being 'resistant' or 'in denial' of their problems. The problems facing the individual may be viewed by both the person and their family as showing a 'loss of control' or 'being weak'. This can be threatening to the family by causing them to lose face, and there is the potential for the individual to be presented as a 'scapegoat'. Thus while family therapy can be highly effective in treatment, unfamiliarity with this means that the family may find it hard to see individual problems as family related. Trusted intermediaries, like close relatives, can help bridge any communication gaps. A problem-solving approach, psycho-education and use of medication can also be effective interventions.

RECOMMENDATIONS

Indian people come from many diverse cultures and assessment should acknowledge their specific cultural contexts and beliefs.



Indian people consider family roles and obligations of primary importance and assessment should acknowledge their needs within the context of their family.



Problem-solving, psycho-education and the use of trusted intermediaries can help counter some of the shame or 'loss of face' associated with mental illness.



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ASIAN POPULATIONS

Asians make up the fastest growing ethnic community in New Zealand. In 2001, 6.4% of the general population identified themselves as Asian.⁸⁰ These people come from diverse ethnic, religious and political backgrounds. The two largest population groups are Chinese and Indian.⁸⁰ These notes are specifically written from a Chinese perspective, but it should be kept in mind that while there are cultural differences between groups, there are also many commonalities.

Cultural values and beliefs vary depending on the subculture and the individual's own degree of acculturation to Western values. Therefore, each individual is unique and should be considered on his/her own merits. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others. A gap in views is often a source of significant stress.

A key issue in working with Chinese people is to understand that suicide is seen as stigmatising and shaming, both to the individual and also to the collective esteem of the family. Traditional values frown on the divulging of information that is private or shameful to people outside of the family, let alone to a person of another culture. Language barriers may further complicate assessment and even a person who speaks relatively good English may have difficulty discussing complex emotions in English. Given the relatively small Asian communities in New Zealand there can be difficulties in obtaining an interpreter who is not known to the person or their family. Care should be taken to ensure that if an interpreter is used, they are familiar with and accepting of mental health issues and will not contribute to the person's sense of shame and stigmatisation.

Suicidal ideation or behaviours often have one of at least three common symbolic meanings. It may be:

- that the person desires an end to personal suffering
- that they see that their suicide would be an act of sacrifice
- to make the life of significant others better (ie, not being a burden)
- done to make a social statement.

In the latter case, a person's suicide attempt may be driven by a desire to punish/bring social pressure on a perceived wrongdoer that the individual feels angry with and too weak to stand up to. Alternatively, it may signal helplessness and a person's efforts to get assistance. It is important when assessing suicidal intent that the meaning and underlying motives of the behaviour are uncovered carefully.

An Asian person may present with symptoms of somatisation, self-pity, sadness and anger. Males are more likely to deny suicidal ideation because it is seen as a sign of weakness. Precipitants of suicidal ideation or self-harm attempts may flow from a perception of failure to fulfil family and societal expectations, resulting in a sense of shame on the person and their family. This may be expressed as 'having no face to see their family'.

Stress-related symptoms including depression and the wish to kill oneself are perceived as socially caused. Medical help is therefore seldom perceived as appropriate unless one has strong physical symptoms. The traditional saying, 'It is only the one who hangs the bell (on my neck) who can untie it,' says it all.

If an Asian person does disclose suicidal ideation, pragmatic social approaches such as social support, direct help and problem-solving are more acceptable strategies for intervention. Further, while the family may often be a source of distress if the person has strayed from them, reconciliation often provides the opportunity for strong support.

When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways.

RECOMMENDATIONS

Cultural values and beliefs vary depending on the person's subculture and degree of acculturation to Western values. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others, as a gap in views can be a source of stress.



Language barriers may be an issue for some Asian people. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Asian communities.



When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways.



REFUGEE GROUPS

Most refugees have emerged from their experience having endured or witnessed some sort of physical or psychological trauma.^{81[4]} It is estimated that 40% of refugees have directly experienced severe trauma.^{81[4]} As a result, refugee people are at increased risk from a range of physical and psychological consequences of these experiences.

Refugees have often had experiences of multiple losses, of their family, home, identity, role, language, culture, sense of self and trust in others.^{81[4]} They may have problems of depression, anxiety, grief, Post Traumatic Stress Disorder (PTSD), psychosomatic disorders, head injuries and substance abuse.^{81[4]}

While it seems that suicide is rare among refugees in New Zealand, * self-harming behaviour through self-denial/self-neglect or not adhering to essential treatment regimes are more common. Self-sacrifice is often linked with survivor guilt, especially when family remains in conditions of extreme deprivation and risk. Energy, which goes into earning money to support offshore family, can see people working two lowly paid jobs with long hours, skimping on their own food and self-care to send maximum sums of cash to the family ('whenever I try to eat I picture my family without any food').

Issues that a clinician needs to be aware of to communicate effectively with a person who is a refugee include the fact that refugees may:^{81[4]}

- be mistrustful of the health system and feel isolated, frightened or misunderstood. Clinicians need to proceed carefully, and respectfully, and fully explain the intention behind every action
- feel shame and grief from their experiences and need to be assessed sensitively in ways that do not exacerbate these feelings of shame
- be acutely traumatised, which may be manifest by reactions such as dissociation. Clinicians should not push for accounts of trauma experiences and may need to focus assessments more fully on issues of the 'here and now'**
- need a professional interpreter. This should not be a family member. This will require the clinician to allow for extra time to conduct the interview. However, there are often issues of trust that emerge with the use of interpreters, especially if the community is small and members may know each other.

*These comments reflect the observations of the Team Leader of Refugees As Survivors in Wellington after 5 years of operation.

**There may also be a risk of misdiagnosing symptoms of severe trauma as symptoms of psychosis.

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Whenever a person comes from another culture and has been exposed to severe trauma, a careful assessment (preferably with culturally appropriate clinicians or advisors) of complex PTSD must occur. Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors.

RECOMMENDATIONS

- | | |
|--|-------------------------------------|
| Refugees are most likely to have been victims of some level of trauma. They may be distrustful of official agencies and health systems. Clinicians need to proceed respectfully and carefully, explaining the intention behind any action and potential consequences for the person. Clinicians should not push for accounts of past trauma experiences, and may need to focus more on the 'here and now'. | <input checked="" type="checkbox"/> |
| If an interpreter is needed care must be taken over confidentiality issues as many of the communities are small and people may know each other. | <input checked="" type="checkbox"/> |
| Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors. | <input checked="" type="checkbox"/> |

ASSESSMENT AND MANAGEMENT OF CHRONICALLY SUICIDAL PEOPLE

There are some people who repeatedly seek assistance from mental health or emergency services with suicidal ideation or episodes of deliberate self-harm.^{5,30,47,82}[3] These chronically suicidal people often suffer from personality disorders.¹⁹[2++]

The link between suicidality and personality disorder seems to be produced by two phenomena. People with these diagnoses are often impulsive and have difficulty managing their emotional states, including sadness and anger. They are also more likely to get into interpersonal conflicts and then lack the skills to solve these issues. These factors in turn increase the likelihood of self-harm and suicidal behaviour.

People with personality disorders are also at an elevated risk of developing a secondary Axis I disorder such as depression, or psychosis, which in turn places the person at elevated risk.³⁰[3] Furthermore, 8–10% of people with Borderline Personality Disorder die by suicide.⁸³[4] A clinician must be cautious about downplaying the seriousness of such a person's attempt at suicide, on the grounds that they are 'attention-seeking'. Although these people's suicidal crises may resolve relatively quickly, they remain at high risk and even higher risk if they have developed an Axis I disorder.⁸³[4] A careful assessment is always warranted and emergency departments should always contact mental health services whenever such a person presents.

The most appropriate means of diagnosis and management of these problems is still controversial, but there is a growing movement to try and treat these people within the community. In such cases, clinicians seek to manage continuous risk rather than responding reactively to acute crises.

For these people, it is critical that a detailed management plan is developed in conjunction with the person at risk of suicide, so that all parties know how to respond and what to reasonably expect. Management plans should include both a list of chronic symptoms and also acute symptoms. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing chronic risk. These management plans should ideally be developed when the person is relatively well, should be kept current and have an explicit expiry date.

A consistent relationship with an experienced key worker and good liaison between the helping agencies is essential for providing the support that the person needs.

Each time a person seeks assistance, they should be assessed according to their current symptoms. There is a danger of pre-emptively discharging someone who is at high risk of suicide because 'they always present like this'. When a person who is well-known to the service arrives at the emergency department it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or mental illness.

Many clinicians are of the opinion that admission to hospital of people with Borderline Personality Disorder should be avoided in all but the most extreme situations, as it can increase the person's dependency and/or exacerbate their symptoms. However, there is no empirical evidence to support the idea that this decreases suicidal ideation or saves lives in these individuals.^{30[2-4]} Inpatient management may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.

RECOMMENDATIONS

Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated.	C
Emergency departments should always contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts.	C
When a person who is well-known to the service arrives at the emergency department it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or a significant change in their mental illness(es).	D
Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.	D

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IMPLEMENTATION

GAPS AND BARRIERS TO IMPLEMENTATION

Crisis services around New Zealand are configured in different ways and offer different ranges of interventions. There are wide variations in the level of service delivery, with the number of people accessing crisis services ranging from 129 per 100,000 population per year to 1,682 per 100,000.¹ The number of people employed in crisis teams also varies widely, ranging from 3.9 FTEs to 11.5 FTEs per 100,000 population.¹ From the Mental Health Commission's Report, *Open All Hours: A Review of Crisis Mental Health Services (2001)** it is clear that while many services are working very well, nationwide a number of key gaps exist between provision of current services and best practice. Key gaps relevant to the implementation of these suicide prevention guidelines include the following:

1. **Access to services** – access can be difficult for people in rural settings. It is also limited for Māori and Pacific peoples wanting culturally specific crisis services. Specific gaps also exist in crisis services for children, youth and older people. Facilities may be unwelcoming and unhelpful for people in a state of extreme distress, such as the waiting rooms of some emergency departments. General impressions suggest that clinicians also have difficulty accessing crisis management resources such as crisis respite and inpatient beds on behalf of their clients.
2. **Crisis service integration/delivery** – there was evidence of poor co-ordination and lack of co-operation between crisis services, emergency departments and other mental health services. Also evident were breakdowns in liaison between services, often with parties having poor understanding of the services that each offered. Nearly 20% of the services did not have policies or protocols in place in regard to risk assessment.
3. **Response times** – after-hours services were characterised by long response times, lack of staff and a lack of available medical cover in some areas.
4. **Difficulties managing intoxicated people** – there is limited recognition by some crisis workers of the potentially serious risks for people in a state of intoxication.

Clinician Barriers

Gaps in best practice identified in the Mental Health Commission's (MHC) review of crisis services indicated that there are a lack of crisis training opportunities, a lack of widely agreed and implemented competencies for crisis workers, and a lack of systems and processes for supervision and external clinical review.

People working with suicidal people have a range of backgrounds and training. Even in crisis teams there is a wide variation in training and expertise. In the review conducted by the MHC (2001), five areas reported not having access to medical back-up and no routine review of crisis work with medical staff.

* This review focused on crisis mental health services, including Crisis Assessment and Treatment Teams (CATTs), inpatient units and community mental health services. They did not directly review service delivery from emergency departments.

A key effort in any implementation process must be to target clinician knowledge and attitudinal change, particularly promoting staff members' confidence in assessing and managing risk, so fewer people at risk are overlooked due to fears about asking about suicide. There is a common perception that asking about suicide increases the risk of suicide, by planting the idea in distressed but previously not suicidal individuals, but there is no evidence to support this.

Cost-Benefit Issues

Suicide and attempted suicide have both direct and indirect costs to the individual, their family and friends, and to society as a whole. These direct costs include notions of years of life lost,⁸⁴ years of living with physical consequences of a serious attempt, and the costs associated with caring for a suicidal person. Indirect costs include quality of life issues for both the individual and their social context; pain, suffering, grief and the resultant impacts on friends and family in terms of their care requirements. No data exists that quantifies these costs within the New Zealand context, which in turn makes it difficult to estimate costs for implementing these guidelines. It is also difficult to predict savings on the basis of measured outcomes as suicide is a low probability event and it is difficult to determine whether a reduction in deaths from suicide can be attributed to prevention attempts or other wider societal factors.

Implementation of these guidelines will not be cost neutral. If these guidelines are implemented effectively, flow-on costs will include paying staff to attend education and training, supervision costs, costs associated with DHBs working to develop better policies and protocols to enhance inter-service co-operation, and costs resulting from audit procedures to ensure that the crisis interventions occur in accordance with best practice. However, we can make assumptions that savings will come from reductions in repeat attempts and better therapeutic engagement. Further, it is not possible to meaningfully quantify a life saved or life prolonged. Therefore, any implementation proposal should incorporate a piloting exercise that considers the above barriers to implementation and makes explicit what the costs will be to overcome these.

KEY IMPLEMENTATION ISSUES

The key focus of implementing the guidelines should be on up-skilling the workforce to better assess and manage suicidal risk and reviewing work force configuration to better respond to risk, in accordance with the evidence-based guidelines. The key elements to implementing these guidelines are fourfold.

1. To target implementation strategies to affect individual clinicians' practice.
2. To target implementation strategies to address clinical process issues (eg, who does risk assessments? what are the referral paths and processes? how is data collected? etc).
3. To target implementation strategies at a service configuration level (eg, how do the services interface? what are the lines of clinical accountability?) This may have implications for resources, or how existing services are configured.
4. To ensure the above three components are done in accordance with key recommendations of the guidelines and evidence for effective practice.

Effective implementation needs to address the following key issues:

- access
- clinician education and up-skilling
- recruitment and retention
- improving service integration – effecting culture shift that encourages inter-agency co-operation that is client focused rather than demarcation focused. For example, key recommendations of the guidelines include increased discharge planning, risk management planning and liaison between key workers.

The key players that this guideline target are CATTs, Community Mental Health Teams (CMHTs), psychiatric inpatient units, consult-liaison psychiatry teams, emergency departments and the interface between these services. This is a specific challenge for the implementation process as they target a number of clinicians with quite disparate backgrounds, training levels, modes of working and theoretical stances. Nonetheless, clinicians in any of these services are required to assess and manage suicide risk. Therefore, implementation strategies need to be cognisant of these differences and shaped accordingly. For example, a training package for an emergency department might be quite different from one targeted at an inpatient psychiatric unit.

Other strategies to promote the use and application of these suicide prevention guidelines could include:

- developing memoranda of understanding between services treating people at risk of suicide to enhance response times and transfer between services
- developing workforce competencies in mental health and emergency department settings to increase ability to recognise and effectively care for people at risk of suicide
- adopting tools such as the RAPID Assessment tool to support appropriate clinical decision-making
- using summaries of the guidelines including resources for emergency departments, mental health service acute assessment settings, and families and consumers.

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AUDITING THE GUIDELINES

The overarching aim of these guidelines is to reduce the number of suicides by people who are currently, or have recently been, in contact with mental health services and/or emergency departments. An integral part of implementing these guidelines is the auditing process. The guideline development team recommends that the Ministry of Health should develop an auditing procedure, which could include the following assessment measures.

1. Mental health services should be asked to adopt a checklist to ensure that:
 - all staff have training in the management of risk as part of their core competency requirements
 - all people identified as at risk will have individual risk-management plans that also specify action to be taken if the person does not attend appointments
 - there is prompt access to services for people in crisis and their families
 - there is prompt follow-up for everyone discharged from hospital with serious mental illness or a history of recent self-harm or a suicide attempt.
2. Emergency departments should be asked to adopt a checklist to ensure that:
 - all staff have training in the assessment of risk and triage for suicidal people as part of their core competency requirements
 - all staff have training in crisis management and appropriate referral.
3. Procedural issues should be addressed, including the use of critical incident reviews when people have attempted suicide (eg, in the ward, or whilst a client of mental health services etc) to establish what might have been done differently. The interface between services should also be monitored. This process should facilitate problem resolution rather than contribute to a culture of blame.

APPENDICES

- 1 Rapid Assessment of Patients in Distress
- 2 Assessment of Risk of Suicide
- 3 The Mental State Examination
- 4 Comprehensive Psychiatric/Psychosocial Assessment
- 5 Guidelines for Providing a Safe Home for a Suicidal Person
- 6 Levels of Observation in Inpatient Units
- 7 Risk Factors for Suicide
- 8 Evidence and Guideline Recommendation Grading System Used for this Guideline

APPENDIX 1

RAPID ASSESSMENT OF PATIENTS IN DISTRESS

These questions are to assist in the assessment of people with potential mental health problems in the emergency department, and to consider urgency of need for mental health referral and security measures.

Name: Next of Kin:	Address: Telephone:	DOB: NHI:
Commentary Use Mental State Examination if disoriented. Consider safety issues for person and staff. Use prompts over page to assess for suicide. * May need to institute measures to prevent inappropriate self discharge prior to full assessment NOW. Is the person too sedated, sleepy or disoriented to give an adequate history? Does the person need an interpreter? Enquire about old notes/any existing mental health files. Start a problem list. Seek consent to contact whānau/family/friends. Check if they are from this area. Do you need to contact anyone immediately or can it wait until the following morning? Fax contact information.	WHAT IS THE PROBLEM? Disorientation in: <input type="checkbox"/> Time? <input type="checkbox"/> Place? <input type="checkbox"/> Person? <input type="checkbox"/> <input type="checkbox"/> Suicidal ideation* <input type="checkbox"/> Anxiety/panic attacks <input type="checkbox"/> Thoughts disordered <input type="checkbox"/> Bizarre behaviour* <input type="checkbox"/> Depressed <input type="checkbox"/> Intoxication* <input type="checkbox"/> Hallucinating <input type="checkbox"/> Aggression* <input type="checkbox"/> 'Stress' <input type="checkbox"/> Drug and alcohol withdrawal* <input type="checkbox"/> Delusional <input type="checkbox"/> Agitation*	
	WHY NOW? <input type="checkbox"/> Self-referral <input type="checkbox"/> Concern from others <input type="checkbox"/> Personal crisis <input type="checkbox"/> GP referral <input type="checkbox"/> Person won't talk <input type="checkbox"/> Mental Health Act 1992 <input type="checkbox"/> Police presentation <input type="checkbox"/> Deliberate self-harm	
	CAN I GET AN ADEQUATE HISTORY NOW? <input type="checkbox"/> Yes <input type="checkbox"/> No IS THERE A PSYCHIATRIC HISTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, working diagnosis? _____ Current medications? _____ Legal status? <input type="checkbox"/> Mental Health Act 1992 <input type="checkbox"/> Informal Is there an existing management plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	WHAT DOES THE PERSON WANT? <input type="checkbox"/> Someone to talk to <input type="checkbox"/> Accommodation <input type="checkbox"/> They don't know <input type="checkbox"/> Psychiatric input <input type="checkbox"/> Medication <input type="checkbox"/> Inpatient treatment <input type="checkbox"/> Detox <input type="checkbox"/> Outpatient treatment	
	WHERE CAN I GET INFORMATION FROM? (note contact details) <input type="checkbox"/> Whānau/family members or friends? <input type="checkbox"/> GP? <input type="checkbox"/> Community health centre? <input type="checkbox"/> Voluntary agencies? <input type="checkbox"/> Case management? <input type="checkbox"/> Therapist/counsellor? <input type="checkbox"/> NGOs? <input type="checkbox"/> Psychiatrist? <input type="checkbox"/> Psychologist?	
	IS ANYONE ELSE WITH THEM OR IN THE WAITING ROOM? Does the person have children? <input type="checkbox"/> Yes <input type="checkbox"/> No Where are they now? _____	
	CAN YOU TELL ME HOW YOU ARE FEELING AT THE MOMENT?	

Adapted from Wilhelm, Kotze, Ballard and Hudson, Consultation Liaison Psychiatry and Emergency Departments, St Vincent's Hospital, Sydney. 2001.

These questions will help determine the level of observation needed in the emergency department.

Commentary <p>Consider whether the person is safe to be alone.</p> <p>Risk factors include:</p> <ul style="list-style-type: none"> • definite plan • hopelessness • severe depression • psychotic symptoms • recent discharge from a psychiatric unit • use of alcohol, street drugs, particularly recent escalation • recent suicide attempt • single men: young, elderly • homelessness • medical illness • history of childhood abuse • recent suicide attempt by a whānau/family member or a friend. <p>IF YOU SUSPECT A PERSON IS CARRYING A WEAPON NOTIFY SECURITY NOW</p> <p>Predictors of violence include history of impulsivity and previous violence, alcohol and substance use, antisocial traits/behaviours.</p> <p>Complete a physical examination.</p> <p>Make triage decisions and decide whether to refer for a psychiatric assessment.</p> <p>Does the Mental Health (Compulsory Assessment and Treatment) Act 1992 need to be applied? Is a Duly Authorised Officer required?</p> <p>Does Child, Youth and Family Services need to be called (to offer 'care and protection' to under 17 year old)? (0508 FAMILY)</p> <p>Involve social supports in discharge planning.</p>	<p>SUICIDE ASSESSMENT</p> <p>Have you had thoughts that life isn't worth living? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you thought of harming yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you thinking of suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you tried to harm yourself in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many times? _____</p> <p>When was the most recent time? _____</p> <p>How often are you having these thoughts? _____</p> <p>Have you thought about how you would act on these (is there a plan)? (<i>Does this plan seem feasible? Are the methods available? Is it likely to be lethal?</i>)</p> <p>Have you thought about when you might act on this plan? _____</p> <p>Are there any things/reasons that stop you from acting on these thoughts? _____</p> <p>Do you know anyone who has recently tried to harm themselves? _____</p> <p>IF A SUICIDE ATTEMPT HAS BEEN MADE</p> <p>What did you hope would happen as a result of your attempt? (<i>Did they want to die, or end their pain?</i>)</p> <p>Do you still have access to the method used? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did you use alcohol or drugs before the attempt? What did you use? _____</p> <p>Do you have easy access to a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HAVE YOU THOUGHT OF HURTING ANYONE ELSE? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, have you acted on these thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been involved in any fights recently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were you using drugs or alcohol at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>DO YOU FEEL SAFE AT THE MOMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>WHO DO YOU LIVE WITH?</p> <p>Is there anyone at home right now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there anyone we need to call? _____</p> <p>HOW IS YOUR GENERAL HEALTH?</p> <p>WHAT TRIGGERED THESE THOUGHTS/ACTIONS? <i>(What are key stressors, for the person, eg, financial, relationships, employment, bereavement?)</i></p> <p>What lead you to try and take your life? _____</p> <p>What lead you to having these thoughts? _____</p> <p>What has been going on in your life lately? Are there any things that have been worrying or upsetting you? _____</p> <p>WHAT WOULD MAKE A DIFFERENCE AT THE MOMENT? <i>(Can the person see anything changing in their situation?)</i></p> <p>Can we make a list of the main problems? _____</p> <p>What can we do now? _____</p> <p>What needs to be done later? _____</p>
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ASSESSMENT OF RISK OF SUICIDE

There is no evidence to suggest that asking a person directly about suicidality increases their likelihood of making a suicidal attempt. Having said that, it is reasonable to proceed in a cautious manner when a person has sought assistance, rather than just abruptly asking, 'Have you thought about killing yourself?' or 'Is this injury self-inflicted?' especially if they are unknown to the clinician. This has two important advantages.

1. It does not alarm a person who has no suicidal ideation.
2. It 'warms up' a person who might be having such thoughts and potentially facilitates disclosure.

Questions that a clinician might consider include:

- How has your mood been lately?
- Has anything been troubling or worrying you?
- Have you had times when you have been feeling sad or 'down'?
- Have you ever felt like life is just getting on top of you?
- Do you sometimes wish you could just make it all stop, or that you could just end it?
- Have you thought about how you might do this?
- Have you ever wished you were dead?
- Have you ever thought about taking your own life?

If a person endorses any of these questions careful probing is warranted (the what, where and how of the situation). The clinician needs to go on to determine the level of intent, the presence of a plan, access to means, any underlying mental health problems and the availability of supports and protective factors. The severity and pervasiveness of current suicidal ideation also gives important information about severity and immediacy of risk (eg, are the thoughts mild and fleeting or is the person preoccupied with thoughts of suicide?).

SUICIDE INTENT

This refers to the extent that the person actually anticipated and wished to die as a result of their action. This is an important point because intent does not always correlate with bodily harm; some people may deliberately self-harm with no intent to die (eg, using their self-harm as a tension reduction strategy) but employ potentially lethal means. Others will take a relatively 'safe' overdose in the belief that it will kill them.

About a third of people who engage in deliberate self-harm will say that they actively meant to die. Another third will say that they did not care whether they lived or died. Even if the person says that they did not wish to die, the clinician still needs to check that their method of deliberate self-harm is not potentially lethal (ie, the risk of them dying by 'accident').

However, whether the person meant to die or engaged in self-harming behaviour for other reasons, both are dangerous scenarios and are associated with a high risk of death by suicide.

In assessment, the following features will help the clinician gauge the degree of intent.

- Preparation - had the person planned the act in advance? Had they written a suicide note? Had they been arranging their affairs?
- Circumstances - had they taken measures to prevent discovery or had they purposely engaged in deliberate self-harm where they were highly likely to be found and 'rescued'?

- How serious or potentially serious was the action that they took? Ask about how many pills they took, where they cut themselves etc.
- How well planned was their attempt, as opposed to being an impulsive act?
- Did alcohol or drugs play a role in the attempt?
- Why did the attempt fail? Did they seek help? Were they discovered?
- Afterwards - did they seek help? Did they express regret that they had not died? Did they believe that their act would have killed them? People who are disappointed that they did not die (rather than feeling relieved) remain at high risk of future attempts.

It is important to ask about the chronology of events leading up to the suicide attempt and then the events afterwards (questions focusing on what, where, how, who, thoughts, feelings and actions will help elicit this material). The clinician should ask the person to start at the point 'where you first began to think about suicide'.

SUICIDE PLANNING

The degree of planning gives crucial information about the person's level of intent and also the degree to which their suicidality is part of a thought-out process rather than an impulsive act. On a practical level, killing oneself is not that easy to do. People will often spend time weighing up different methods, considering the degree of pain that is tolerable, the finality of the plan, where to do it, the prevention of premature discovery, who they wanted (or did not want) to find their body, the decision about suicide notes, or the possible use of alcohol to firm their resolve etc. The more information the clinician is able to elicit about the level of forethought and planning that has gone into suicide, the better they will be able to assess the person's risk of suicide.

The following questions need to be addressed (the more questions they endorse the greater the risk of future suicide attempts).

- Have they planned how they will commit suicide?
- How plausible a plan is it ('I'm just going to lie down and not get up' vs 'I'm going to use a gun')?
- Have they been making efforts to organise their life around their plan (eg, such as making wills, saying good-bye to people)?
- Was there a note?
- Did they go to efforts to ensure that they would not be discovered?
- What do they anticipate will happen to them after they die (such as being reunited with a loved one, which might make suicide appear very compelling to the person)?

AVAILABILITY OF MEANS

Anyone who has indicated that they are considering suicide should be asked directly about the method they planned to use and the likelihood of them being able to carry this out. It should be noted that despite guns being less accessible in New Zealand than some other countries, 10% of people die by suicide using firearms.¹² Specific questions could include:

- Have you thought about how you would end your life?
- (Depending on method) how available is that to you? For example, how many pills have you stockpiled?

BARRIERS TO COMMITTING SUICIDE

Understanding what has prevented a person from acting on their suicidal impulses thus far gives the clinician insight into the immediacy of risk. A clinician also needs to assess whether the barriers that have existed still remain (eg, in the past a person has felt suicidal but would never act on it because of the distress it would cause to his wife. However, if his wife has recently died, he is at a greatly increased risk of committing suicide).

A clinician has to be careful that their own values and beliefs don't cloud their assessment, for example, a person who has two young children may not in fact see them as a reason for not committing suicide. Instead, they may endorse beliefs such as, 'They would be better off without me,' or less commonly, 'I'll kill them and then myself'.

Specific questions could include:

- You have said that in the past you have had thoughts of suicide, what has stopped you from acting on them until now?
- You have said that you have been having thoughts of harming yourself. Is there anything you can do, or people that you can be with, that makes you want to hurt yourself less? Makes you feel safer?
- You have said that in the past you didn't act on these thoughts because of X. How much does that factor into your decision-making now?

PREVIOUS SUICIDE ATTEMPTS

The major predictor of future suicidality is previous suicidality. However, the absence of previous suicide attempts cannot be taken as an indicator of diminished risk. While many people who seek help at an emergency department or mental health service following a suicide attempt will have made a previous attempt, 60–70% of people who die by suicide do so after their first attempt.⁸⁵

Given the time constraints of a session or the pressure on staff in emergency departments, clinicians should focus their initial assessment on the following key aspects of previous suicidality.

- What was the most serious past attempt (previous attempts that were potentially lethal raise greater concern than multiple non-serious attempts)?
- Are attempts escalating in potential lethality? Escalating seriousness of attempts suggests that the person is increasingly nearing the end of their resources to cope and is at greater risk of dying by suicide.
- How long ago was this previous attempt?
- In what way is the current situation similar?

THE MENTAL STATE EXAMINATION

A clinician assesses aspects of a person's mental state across the assessment process, from the initial observation of the person and while taking their history. A detailed Mental State Examination encompasses the full range of a person's expression and not just what they say. The clinician will observe a person's apparent mood, how they behave in the session, note details of their speech and how the person is responding during the interview, and in turn how the clinician is responding to the person. A thorough assessment of mental state will cover the following areas (NB Many of these overlap but have been described separately for clarity).

Appearance and general behaviour: This includes the person's facial expressions, body language, posture, gestures, manner, attire and grooming. These may give clues to the person's personality, mood, awareness of social conventions and ability to take care of themselves. A psychotic person may behave very bizarrely, or a depressed person may appear unkempt or dishevelled.

Attitude towards the interviewer: This includes whether the person was suspicious or hostile, evasive, tentative, or co-operative and whether the interviewer felt some rapport had been established. It is also important for the interviewer to consider their reaction to the person. The degree of rapport or therapeutic engagement established is directly related to how willing a person will be to disclose painful or difficult material. This is crucial in assessing for suicide risk as a disengaged or obviously reluctant person may not give a full account of their risk or intent if they do not trust the interviewer or want to be taking part in the assessment process. In such circumstances, it is particularly important to give weight to information from others and to balance this against any denials of suicidal intent during the interview that appear contradictory to these reports.

Affect/mood: Affect refers to the prevailing emotional tone of the interview, and is assessed through the person's facial expression, body posture, and tone of voice. Mood is more of a prolonged feature that is reported by the person (and others if available). A clinician should look for how emotionally responsive a person is during an interview, whether they appear flat and apathetic or at the other extreme, labile or irritable. It is also important to consider whether their reported mood matches their displayed mood (eg, someone who is speaking slowly, wringing their hands and is intermittently tearful but says they are 'fine' needs to be assessed further). Important dimensions of mood to assess for include depressed mood (eg, sad, tired etc), elated or euphoric mood, irritability and agitation. A clinician should also be aware of obvious signs of tension (eg, sweating, stammering, trembling) and reported anxiety.

Psychomotor activity: This refers to internally driven behaviours, for example, drumming of fingers that may represent feelings of anxiety. Typical behaviours that the clinician should be aware of include restlessness/agitation; slowing of movement, speech and thoughts; questions answered after prolonged delays.

Speech: A great deal of additional information can be gained from listening to how a person speaks and not just the content of their speech. The clinician should listen for the loudness and speed of speech and how effective the person is in getting their point across. For example, a person who has pressured speech may feel compelled to talk and the listener may gain the impression that their ideas flow faster than they can express them. A depressed person may demonstrate 'poverty of speech', such as responding after delays with 'I don't know', or very short or monosyllabic replies.

Thought content: Inferences about a person's thinking are made on the basis of their report of symptoms. A careful exploration of a person's presenting difficulties and history is crucial if the clinician is to gain an accurate picture of their thinking. In assessing for suicidality a clinician will pay particular attention to suicidal ideation and depressive thoughts (eg, 'I'm no good, I'd be better off dead'). The clinician should ask the person about their beliefs about themselves, others and their place in the world, and screen for the presence of delusional beliefs, anxious thinking, obsessions etc.

Thought process: Again, the clinician makes inferences about a person's thinking based upon their speech. When assessing thought processes the clinician is looking for evidence of the way the person constructs their thoughts, including sequence and speed. Marked difficulties in thought processes may include perseveration (ie, when a person seems to be stuck on one theme), tangentiality (ie, easily side-tracked without being able to return to the initial topic), or loose associations (ie, apparent absence of logical thought processes). A clinician will also be looking at the person's style of thinking (eg, do they worry or ruminate over their misfortunes, are they preoccupied with certain topics/events/ideas? For example, a person may report negative self-talk as above, but then also report that one thought triggers another related one, and another, until they feel like they can't 'shut them off').

Perceptual disturbance: In this instance the clinician is specifically screening for the presence of hallucinations. These may occur across any of the five senses. If the person is suicidal and hearing voices, care must be taken to assess whether these voices are command hallucinations (ie, telling the person to act) and how compelling these commands are. It is also important to assess for the degree of fear associated with the experience of hallucinations as this may also increase a person's suicide risk (ie, ending one's life to escape the feared hallucination).

Orientation: Briefly, this is a screen to check that the person knows where they are, who they are and why they are being interviewed. This series of questions is especially important if the person has come into the emergency department (eg, following an overdose). If the person is disoriented to place, person or time, careful examination is needed to rule out delirium, intoxication or organic complications. Disorientation in time, especially the passage of time (such as the length of the interview), is the most sensitive of these tests of orientation.

Insight and judgment: A clinician needs to judge how much the person is aware of their present circumstances, their health and the reasons for their presentation to mental health services or an emergency department. If a person is assessed as being significantly impaired in their judgment, in a way that places them at risk of harm to themselves or others, they can be compelled to have treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Intelligence/cognitive function: For the purpose of a suicide assessment a broad estimation of a person's intellectual functioning is sufficient. This can be inferred from the content of their speech, educational history and vocational background. Other aspects of cognitive functioning to screen for are attention and concentration and any memory problems. The clinician can be aided in this by using the Mini Mental State Examination.⁸⁶

COMPREHENSIVE PSYCHIATRIC/ PSYCHOSOCIAL ASSESSMENT

Assessment should include:^{9,13,18,23,83,87}[4]

- identifying data: name, gender, age, ethnicity, marital status, sources of history and reliability of historian/informants
- presenting problem(s): in the person's own words
- history of present illness/episode
- past psychiatric history
- past medical and surgical history
- current medications and recent past medications
- drug allergies/sensitivities
- medical systems review
- substance use history
- forensic history
- whānau/family history
- psychosocial history
- Mental State Examination
- physical examination
- differential diagnosis
- formulation
- working diagnosis
- treatment plan.

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PRESENTING PROBLEM(S)

Allow the person to describe in their own words their view of their problem. This will aid the establishing of rapport and avoid potential misattribution.

Seek input from the person's whānau/family/support people if appropriate. Invite them to give a description of their concerns about the person or any changes that they have noticed.

HISTORY OF PRESENT ILLNESS

It is important to obtain an account of the emergence, duration and severity of all symptoms, as well as any precipitating or aggravating factors, such as worsening of mood symptoms in relation to alcohol or substance use. As illnesses such as depression are highly associated with suicidality and suicidal attempts, one needs to be alert to symptoms of lowered mood, anhedonia, sadness, tearfulness, irritability and hopelessness. The latter is a frequent indicator of increased risk of suicide. Sleep and appetite changes such as early morning wakening, weight loss, psychomotor agitation and retardation, are all important indicators of underlying depression.⁸³

Elevated mood, elation, grandiosity, a decreased need for sleep, disinhibition, or unstable mood, may indicate the presence of a manic phase of a bipolar mood disorder. Bipolar disorders are associated with increased risk. Mixed mood states may also exist.

A history of violence or impulsivity is important as violent males, in particular, may be at increased risk, especially if depressed or intoxicated.

Anxiety disorders may also be present and may co-exist with depression. Panic attacks may cause distress and lead to suicide attempts. There is an increased risk of suicide in association with anxiety disorders and following serious trauma, such as physical or sexual abuse.

Psychotic illness may be indicated by the presence of symptoms such as delusions and hallucinations. These may be found in association with schizophrenia, manic depressive psychosis, psychotic depression and drug induced psychoses. Nihilistic delusions and delusions of guilt and sin in depressed people may engender feelings of hopelessness and lead to suicide.

Auditory command hallucinations and delusions of control may considerably increase suicide risk in a person with psychosis, particularly if the person is unable to resist these. Suicide is not just a risk when the person is acutely unwell, but may also occur after the acute phase, when the person develops insight and becomes aware of the nature and seriousness of their illness. It can also follow the demoralisation that may accompany years of chronic illness.

People with histories of disturbed interpersonal relations and personality disorder, may have made repeated attempts at deliberate self-harm and suicide. They also have an elevated risk of suicide over time.

PAST PSYCHIATRIC HISTORY

It is important to establish the history of past illness and its course, dates and duration of episodes of illness, as well as the names of hospitals and the nature of any treatment. Periods of treatment by a general practitioner should also be noted. Often the person will know the diagnosis but if not, their recall of symptoms will be helpful. Episodes should be noted in chronological order, as well as any unusual circumstances in which the illness appeared to develop. Hospital records should always be requested. Details of all past suicidal behaviour, its seriousness and outcome should be recorded.

PAST MEDICAL/SURGICAL HISTORY

Note any serious illnesses, operations or accidents, with their dates of onset, the duration and nature. Some physical illnesses and their treatment may have psychiatric sequelae. For instance, organic brain syndrome resulting from a motor vehicle accident may cause aggression and impulsivity. Endocrine disorders such as hypothyroidism may be associated with depression. Cerebral tumours and neurological conditions may have behavioural components. People with chronic neurological disorders such as epilepsy, may be at increased risk of developing a psychiatric disorder. Chronic physical conditions such as HIV/AIDS, may lead to hopelessness and depression.

CURRENT AND RECENT PAST MEDICATION

Steroids may affect mood and discontinuation may precipitate depression. Hypotensive agents and oral contraceptives may contribute to the development of depression. Stimulants may also cause mood changes and occasionally paranoid states. Anti-Parkinsonian drugs and hypnotics may cause confusional states, particularly in the elderly.

DRUG ALLERGIES/SENSITIVITIES

It is important to establish drug allergies or sensitivities before initiating any treatments.

SUBSTANCE USE HISTORY

Because of the frequent co-morbidity of substance use disorders with psychiatric disorder and their association with suicide attempts because of disinhibition, or mood changes, associated with withdrawal syndromes, it is vital to screen for these disorders.

It is important to obtain a history of all substance use (eg, alcohol, marijuana, stimulants, hallucinogens, opiates, inhalants etc), screening for indicators of abuse or dependency. One should ascertain current and past use, periods of heaviest use and note any increase in risk-taking behaviours associated with drug use. It may be useful to consult other informants on this topic as people often under-report their substance use.

FORENSIC HISTORY

It is important to establish any history of antisocial behaviour or offending. This may reveal a past history of violent offending and impulsivity, or may indicate the presence of an antisocial personality disorder. This is important to establish because of the association between impulsivity and antisocial behaviour in males, and suicide. Previous use of firearms or other weapons may indicate further serious risk of harm to self or others. There may be links between alcohol or drug taking and impending court proceedings, which may be a significant contributing factor.

WHĀNAU/FAMILY HISTORY

A positive whānau/family history of psychiatric disorder, particularly mood disorder, would indicate possible genetic vulnerability. A whānau/family history of suicide or suicidal behaviour is a significant risk factor. Loss of a parent at an early age may contribute to the later development of depression, particularly in females. Any whānau/family history of violence or drug use may also be relevant.

PSYCHOSOCIAL HISTORY

A psychosocial history should cover the person's birth and early development, a clear history of their childhood years to include any significant adverse circumstances such as disrupted attachment, physical or sexual abuse, periods in care, etc. School history should be taken to establish the presence of any learning disability or academic problems and particularly any indiscipline or truancy.

The person's occupational history should be recorded, any significant periods of unemployment, redundancy, skills, qualifications, level of employment and functioning in job, and the presence of any work difficulties.

The person's relationship history, including their ability to form and sustain relationships over time, is important and the interviewer should note any persisting or recurring conflicts or relationship difficulties. If the person is in a relationship currently it should be noted whether this is a happy and supportive, or a conflictual relationship.

Understanding the person's current situation is important. There should be an attempt to elucidate the person's support network, any friends, interests outside of work, preferred activities, overall satisfaction with life, present stressors, and previous episodes of deliberate self-harm.

DIFFERENTIAL DIAGNOSIS

A list of all relevant possible diagnoses should be made, at least with reference to the first three Axes of DSM IV-TR.⁸³

FORMULATION

The formulation synthesises the above information, drawing together an explanation of why this 'particular person has presented in this particular way at this particular time'. A formulation demonstrates a clinician's understanding of factors that predisposed the person to becoming suicidal (eg, a whānau/family and personal history of depression) and factors that precipitated their present distress (eg, grief over a relationship break up). Factors that perpetuate the person's despair are described (eg, depressive cognitions that they are 'useless') and also any protective factors, both internal (eg, intelligent, insightful) and external (eg, good and helpful social supports). The formulation should put into context the current illness in terms of their past history and social circumstances. This individual's understanding complements a specific working diagnosis or diagnoses, allowing a clear management plan to be developed for the given individual to meet their needs.

GUIDELINES FOR PROVIDING A SAFE HOME FOR A SUICIDAL PERSON

(Reproduced with permission from the *Towards Wellbeing Programme, Children, Young Persons and their Families*, 2002.)

Key points

Treat as serious any and all threats, ideas, plans or discussions of suicide.

Remove any likely methods of self-harm or suicide.

Be aware that if one method is removed the suicidal person may consider another method, so try to prevent access, or minimise the risk of the suicidal person having access, to a range of methods of suicide.

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IN THE HOME ENVIRONMENT CONSIDER THE FOLLOWING MEASURES:

Firearms

- Take actions to restrict or prevent access to weapons including, in particular, firearms, ramset guns, and air rifles. Where possible remove weapons from the house, farm or property. Give them to someone who lives on another property for safe storage. In emergencies, take the firearm to the local police station for storage. Ensure firearms and ammunition are locked in safe, separate storage as required by law.

Alcohol

- Remove alcohol from the house or store in minimum amounts only.

Cars, vehicles

- Prevent easy access to transport (eg, removed car keys) so that an individual's movements and access to means of self-harm are limited.

Medications and poisons

- Ensure that all medications are accounted for and that medications (including paracetamol) are locked away after they have been used. In an emergency, medications can be locked in the car boot if there is no lockable storage place in the house.
- Any prescription medications should be for a minimum amount.
- Where possible supervise the taking of medications.
- Clean out the medicine cabinet and dispose of all unused, out-of-date medications. Don't hoard old medicines. Take them to your local pharmacy for disposal.

- Ensure poisons and pesticides are locked away, as far away from the house as possible. Dispose of old poisons and pesticides. This is particularly important on farms and lifestyle properties.

Other means of suicide

- Remove cords, ropes, sharp knives (including craft knives) and any other obvious means of self-harm in the environment. Consider removing the vacuum cleaner hose and the garden hose from your house. Ask a neighbour to store them.

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In your contact and interactions with the suicidal person:

- When the risk of suicide is high, check regularly, know their whereabouts and do not leave them alone for extended periods of time. Consider taking the person with you if you go out or asking a friend or neighbour to sit with them if you have to go out and they cannot or do not want to go with you.
- Include the person in treatment planning and safety issues where possible.
- Encourage the person to talk to you about their suicidal thoughts/impulses.
- Provide safe alternatives to self-harm and expression of despair/anger/hurt etc (eg, physical activity, art and writing, self-soothing activities, contact with positive people, etc.)
- Be aware of high-risk periods for that individual (eg, a court appearance, transitions in care, counsellor absent or on holiday, anniversaries, etc), and be extra vigilant at these times.

LEVELS OF OBSERVATION IN INPATIENT UNITS

There are three special levels of observation over and above the basic level required for all psychiatric inpatients.

Within reach

This is for the person at extremely high risk of suicide who is expressing active suicidal intent. He/she may have recently carried out an act of deliberate self-harm, have unpredictable psychotic states and/or be impulsive and aggressive. This requires observation within reach of the person for safety purposes. On some occasions, more than one nurse may be required.

Same room and in sight

This is for the person at high risk of suicide who is expressing active suicidal intent but where there is less concern about impulsive self-destructive behaviour. The person may have recently carried out an act of deliberate self-harm or have unpredictable psychotic states. This requires constant visual observation on a 1:1 basis, with the nurse in the same room and in sight of the person.

Frequent observations (specify maximum interval in range of 10–20 minutes)

This is required for the person who is considered to be at a significantly increased suicide risk compared with the average psychiatric inpatient, or where the extent of risk is uncertain. It is recommended that the timing of observations be varied to ensure the person cannot predict the exact time of the next observation.

If a person is assessed as requiring one of the above levels of observation, details of this must be carefully and systematically documented. People who commit suicide while engaged in mental health services are likely to have had their level of care reduced before they commit suicide (ie, to have been judged as being at decreased risk).¹⁶[2++]

RECOMMENDATIONS

It is vital to review regularly the mental state of the individuals under such close observation. This should be done formally at the nursing handover at the end of each shift. Senior nursing and psychiatric staff should review the level of observation at least daily when the overall management plan is reviewed.



The levels of observation and changes to this should be documented separately in the clinical notes, with counter-signatures from senior staff and the responsible clinician. The documentation will include date, time and signature, level of observation, stop date and role of each person signing.



Changes to closer levels of observation may be initiated by any senior clinical team member.



Reduction of the level of observation must be approved by two senior members of the clinical team.



RISK FACTORS FOR SUICIDE

This mnemonic 'Sad Person's Escape' can act as an aide memoir to assist the clinician to cover the key factors in assessing for suicide risk. It has proven useful as a teaching tool. It provides a composite of predisposing risk factors and population-based risk factors (such as being male). It should be used in conjunction with a detailed assessment of the precipitants of the person's suicidal crisis, exploration of factors maintaining their distress and their current mental state. (Appendix 2 and 3, and the section on formulation in the main text describes these processes in detail.)

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Sex: While more males die by suicide, many more females attempt suicide.²²[2++]

Age: Highest risk groups are those aged 15–24 years and those over 60 years.¹²[2++]

Depression: Present in as many as 70% completed suicides; this risk is greater with symptoms of anhedonia and more severe depressions.^{14,19,83}[2++]

Previous attempt: Of those who have previously made a suicide attempt, 10–20% will eventually die by suicide.²²[2++]

Ethanol and drug abuse: Substance abuse and intoxication are also strong risk factors for suicidal behaviour.^{19,20}[2++]. Of people who die by suicide, 25–50% consume alcohol before taking their lives²¹[2++] and suicide risk is substantially enhanced among people with co-morbid substance abuse, and depression and hopelessness.^{14,19,22}[2++]

Rational thinking is impaired: Of people with schizophrenia, 10–15% die by suicide. The risk of dying by suicide is especially elevated in people with psychotic depression.^{14,19,22}[2++]

Support networks: Isolation, loneliness or a disrupted whānau/family of origin have been associated with increased risk of suicide. A whānau/family history of suicide has also been shown to increase a person's risk of suicide.¹⁴[2++]

Organised plan: The presence of an organised plan with available means increases the risk that a person will attempt suicide.

No spouse: People who live alone, are divorced or separated, or recently bereaved are at greater risk of suicide.^{14,22}[2++]

Sickness: Of people who died by suicide, 25–70% had a debilitating medical illness present at the time of their death. However, the important mediating factor for their suicide appeared to be a concurrent psychiatric illness, usually depression.²²[2++]

Experiences of adversity: These also place a person at risk of suicide. Such experiences include experiences of humiliation, social and educational disadvantage, a whānau/family history of psychiatric illness, poor relationships with parents, and being in trouble with the law.¹⁴[2++]

Sexual abuse: People who have experienced all forms of abuse and neglect are at greater risk of attempting suicide.²²[2++]

Co-morbidity: The majority of both adolescents and adults who die by suicide (over 90%) suffered from an associated psychiatric disorder at the time of their death.^{14,19}[2++]. People who meet the criteria for more than one disorder at a time are at an even greater risk.

Anxiety disorders (particularly panic disorders): People with anxiety disorders co-occurring with depression have an increased risk of suicide.

Personality disorders: Diagnoses of Antisocial and Borderline Personality Disorders with and without co-occurring Axis I disorders are associated with an increased risk of suicide. Diagnoses of Conduct Disorder and Oppositional Defiant Disorder among youth are also risk factors.^{14,19,22}[2++]

Event: In youth, an identifiable stressful event preceded 70–97% of suicides.¹⁴[2++]

EVIDENCE AND GUIDELINE RECOMMENDATION GRADING SYSTEM USED FOR THIS GUIDELINE

The guideline development team ranked the evidence according to the revised system of the Scottish Intercollegiate Guidelines Network (SIGN).⁸⁸ The SIGN Grading System for Recommendations in Evidence-based Clinical Guidelines is a revised version of the system developed by the US Agency for Health Care Policy and Research (AHCPR).⁸⁹ Evidence statements relating to interventions have been assigned a grading according to the 'strength' of the supporting evidence where 1 is the best quality evidence and 4 is expert opinion.

Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence.

LEVELS OF EVIDENCE

1++	High quality meta-analyses/systematic reviews of randomised controlled clinical trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses/systematic reviews, or RCTs with a low risk of bias
1-	Meta-analyses/systematic reviews, or RCTs with a high risk of bias
2++	High quality systematic reviews of case-control or cohort studies
	High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies eg, case reports. Case series
	Expert opinion
4	Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence.

GLOSSARY

Adjustment disorder: A psychological response to an identifiable stressor of greater than generally expected intensity but not meeting criteria for specific depressive or anxiety disorders. It is characterised by symptoms of depressed mood and/or anxiety symptoms.

Affect: Observed emotional state, as identified by facial expressions, gestures and tone of voice, which are outwardly observable to others.

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 (eg, 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 (eg, agoraphobia) or ritualistic behaviour (found in obsessive compulsive disorder).

Bipolar mood disorders: Mood disorders characterised by the occurrence of both symptoms of mania and other periods of depressed mood, at different times, or 'mixed episodes' (where both the symptoms of mania and depression occur nearly everyday, experienced by rapid shifts in mood). Both mania and depression are separately defined.

Co-morbidity: Co-existence of any two or more illnesses. Commonly used to refer to co-existing mental illness and substance abuse, but can also refer to physical illness concurrent with a psychiatric disorder.

Conduct disorder: Persistent pattern of behaviour in children/adolescents characterised by rule (and law) breaking, disregard of others, deceitfulness, and aggression to people and animals.

Crisis intervention: Brief interventions aimed at helping the person deal with acute distress.

Deliberate self-harm: Deliberately hurting oneself without an intention to die. Motivations for self-harm include tension reduction, or to reduce feelings of unreality or to punish oneself. A person may, for example, cut himself or herself superficially without any intention of dying.

Delirium: A disturbance of consciousness and change in cognition that develop over a short period of time, occurring as a result of a general medical condition, substance intoxication or withdrawal, use of medication or exposure to toxins.

Delusion: A fixed false belief, which is inconsistent with social and cultural norms. The belief in a delusion is sustained despite evidence that it is false. Delusions are not amenable to problem-solving or persuasion.

Delusion of control: The belief that one's thoughts, feelings, impulses or behaviours are not one's own but are controlled by an external force or agent.

Dementia: A brain disorder that results in a progressive deterioration of mental faculties; memory, judgment, abstract thought, intellectual ability, control of impulses, and personality, that eventually impairs all aspects of functioning.

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.

Empathy: Awareness and understanding of the feelings, behaviour and motives of another person, combined with concern for that person, without self-identification with those experiences.

Flashback: A recurrence of a memory, feeling or perceptual experience from the past, resulting in fear or distress.

Hallucinations: Perceptual experiences in the absence of an actual external stimulus. Hallucinations can occur in any of the senses but most commonly are auditory (hearing voices or other noises), and visual (visions). The presence of other forms of hallucination tends to be indicative of organic processes or to be related to substance abuse.

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.

Incidence: The rate at which new cases of a disorder appear in the general population.

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).

Mania: An emotional state of intense but unfounded elation, shown by talkativeness, flight of ideas, distractibility, grandiose ideas, increased energy, agitation and sometimes irritability.

Mental disorder: Clinically significant clusters of behavioural and/or psychological symptoms, which cause distress and disability and are not merely an expected response to a particular event.

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.

Negative symptoms: Symptoms of a mental disorder that result in deficits in behaviour, cognitions or mood, such as flat affect and apathy (common to depression and schizophrenia).

Obsession: An intrusive and recurring thought that seems irrational and intrusive to the person experiencing it. It is a symptom of obsessive-compulsive disorder, which may result in the person feeling compelled to repeat certain acts again and again to reduce the distress associated with the obsession.

Oppositional defiant disorder: A recurrent pattern of defiant, disobedient, disruptive and hostile behaviour toward authority figures. This disorder is typically diagnosed among children and adolescents, and the oppositional behaviour must be substantially more frequent and severe than that which is age appropriate.

Panic attacks: Discrete periods of a sudden onset of intense apprehension, and fearfulness, with co-occurring physical symptoms of physiological arousal (shortness of breath, dizziness, chest pain). Panic attacks may be seemingly 'out of the blue' or triggered by exposure to or anticipation of a particular feared cue.

Perseveration: The persistent repetition of words and ideas, it may be found in people with schizophrenia, or head injury.

Personality disorder: A group of disorders characterised by long-standing, inflexible and maladaptive personality traits, which impair interpersonal functioning and may cause extreme distress.

- **Antisocial Personality Disorder:** A pervasive pattern of disregard for and violation of the rights of others, that begins in childhood and continues through adolescence into adult life.
- **Borderline Personality Disorder:** A pervasive pattern of instability in interpersonal relationships, self-image, and affect, with marked impulsivity.

Poverty of speech: Reduced amount of talking or self-expression – a negative symptom that can occur in schizophrenia and also in more severe major depression.

Pressured speech: Increased amount, rate, and volume of speech. People with pressured speech are difficult to interrupt, and may talk with little prompting and even if no one is listening.

Psychosis: A disorder characterised by the presence of delusions and/or hallucinations, and impaired reality testing. The most common form of psychosis is schizophrenia, but it also includes drug-induced psychosis and psychosis seen in severe depression or mania.

Schizophrenia: Mental illness characterised by withdrawal, apathy, thought disorder, general emotional disturbance, and delusions and hallucinations.

Somatisation: Physical symptoms which are suggestive of a medical condition (eg, pain), which cannot be/are not fully explained by the presence of any general medical condition.

Specialling: Brief intensive 1:1 crisis intervention provided to mentally unwell people in their own home/in the community/in an inpatient ward. It usually involves at least one trained nurse working full time with the person and their whānau/family/support people, whilst the acute suicide risk/mental illness remains.

Substance abuse: The use of a drug (including alcohol) for at least one month to such an extent that the person fails to meet important obligations as a result of the drug use (eg, missing work due to a hang over), but where there is no physiological dependence on the drug.

Substance dependence: The abuse of a drug (including alcohol) accompanied by physiological dependence (addiction). Signs of dependence include increased tolerance to the substance (needing more to get the desired effect), and withdrawal symptoms if the person tries to stop the drug.

Substance use disorders: Where drugs such as alcohol or marijuana are abused to such an extent that it significantly impacts on social and occupational functioning, and control or abstinence is impossible for the person. Reliance on the drug may be both psychological (I can't cope without it) and physiological.

Suicide: Deliberately bringing about one's own death.

- **Ideation:** Thoughts about dying by suicide.

- **Intent:** The degree to which a person plans and intends to act to take their own life.
- **Lethal means:** Implements, substances, weapons or actions capable of causing death.
- **Intervention:** Taking steps to prevent a person taking their life or to reduce their risk of attempting suicide.

Tangentiality: When a person replies to questions with oblique/irrelevant responses. They may go 'off on tangents' and fail to return to the original topic at hand. It may be difficult for the listener to follow where the conversation is heading or to understand connections between the topic areas.

Thought blocking: When a person loses track of a train of thought. May be evidenced by them suddenly stopping mid-sentence. They may appear perplexed and unable to talk, or begin a new and unrelated thought/stream of ideas.

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