Assessing depression and suicidality in the A&E department

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Abstract

10% of all mental health attendances to accident and emergency (A&E) departments are due to suicide attempts or suicidal ideation (1), with many of these being related to depression (2). Accurate judgement of risk is of crucial importance as it dictates management. This article recommends a practical approach to risk assessment and management of the suicidal patient in A&E. We also discuss the 'next steps' for the patient beyond the A&E.

Keywords: suicide, suicidality, risk, depression, A&E assessment

Background

Suicidal behaviour or ideation are common features in A&E attendances; 10% of all patients presenting to the emergency department have recently experienced suicidal ideation or exhibited suicidal behaviour (1, 3, 4). Given the fact that a suicide attempt is a strong predictor of future completed suicide, steps must be taken to ensure the short-term and long-term safety of these patients (5).

Although some suicide attempts or acts of self-harm are unrelated to mental illness, around 90% of those who die by suicide have a mental illness, ranging from depression to psychosis and personality disorder (6-8). A major depressive disorder is present in 20% to 35% of deaths by suicide (2). One study suggested that around 1 in 5 patients in A&E may suffer from depression (9), yet it is underdiagnosed by A&E doctors, especially in older patients (10, 11). Psychiatric assessment of suicidality in A&E can help identify treatable mental illness, such as depression.

Once a patient has presented to A&E with suicidal thoughts or actions the psychiatric assessment should occur alongside the physical assessment, unless the patient requires life-saving medical or surgical treatment that excludes this, for example if the patient is unconscious or needs emergency surgery (12). The patient needs to be appropriately medically managed, whilst avoiding unnecessary delays in psychiatric assessment. No patient with a suicide attempt should be discharged without both a psychiatric and a physical assessment.

Despite the time pressures of A&E, the safety of the patient must always be a primary concern. Beyond the patient's medical needs, the plan for supervision/observation and future management is guided by an assessment of the current degree of suicidality. While a psychiatric diagnosis will assist in the formulation of a safe management plan, it is acceptable to make a working diagnosis, and perform a more detailed assessment of the precise diagnosis once the emergency is over.

Psychiatry assessment and mental state examination

There are numerous guides available regarding suicide risk assessment in A&E. We have used the following two as a basis for this article: the Centre for Suicide Research 'Assessment of suicide risk: clinical guide' (13) and the BMJ Best Practice 'Suicide risk management' (14).

Environment

The psychiatric assessment should take place in a private, quiet room to minimise disturbance. It is often beneficial to see the patient alone but their preference and any risk to others should be considered. It is

critical to use non-judgemental, empathetic communication skills, and care should be taken to establish rapport.

Collateral Information

Information from the patient's friends and family, GP, or notes from previous admissions can provide a more rounded view of the patient and their suicide attempt or ideation. When practical and consensual, family, close friends and carers should be informed, especially with high-risk patients.

Mental State Examination (MSE)

An MSE, which includes the patient's behaviours, will provide essential information about current mental health and is an integral part of the assessment. It is carried out in conjunction with the history taking process.

Broaching the subject of suicide

There is no definitive way to enquire about suicide. Indeed, some patients may raise the topic themselves without prompting; others may be too embarrassed or ashamed to acknowledge suicidal ideation, let alone an attempt, verbally. One option is to broach suicidal thoughts indirectly. Questions about recent mood or negative thoughts can be useful, or an alternative, more oblique, approach would be for the doctor to reflect upon the patient's non-verbal communication (for example: "You seem very down to me"). The line of questioning must be considered and sensitive, although it should be emphasised that there is no evidence that enquiring about suicidal thoughts causes suicidal ideation (15).

Suicide risk assessment

There are four suggested steps a clinician should cover:

Step 1: Information gathering and assessment of the five components

The five components which need to be explored in the history are suicidal ideation, intent, plan, access to lethal means and history of past suicide attempts. Please see boxes for some examples of questions that could be used.

Table 1: Information gathering and assessment of the five components

Asking about suicidal ideation	It must be difficult to feel that way - is there ever a time when it feels so difficult that you've thought about death, or even that you might be better off dead?
	Have you thought that your life is not worth living?
	Have you thought about ending your life?
	Do you feel that your reasons for living outweigh your reasons for dying?
	If you had a way, would you try to take your own life?
	If you thought you were going to die, would you take steps to save yourself?
	How often do you think about dying?
	How long does it usually take for the thoughts to go away?
	Are thoughts about dying or taking your life overpowering to you?

Asking about suicidal intent and plan	How do you feel when you start thinking about taking your own life? Have you ever thought of ways to take your own life? Have you ever had specific thoughts or plans about taking your own life? Have you set a time or date? What are those plans? Do you have access to (method e.g. pills, poisons, medication, weapon)? Do you think you could get (method) if you needed to? Do you think you would die if you used (method)? Have you done anything or taken steps to prepare to take your own life (e.g. writing suicide note or will, arranging method, giving away possessions)? Do you think that you could take your own life? Do you feel ready to die?

Step 2: Risk factors for suicide

NICE recommends that risk assessment 'should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent' (12). Although various local risk assessment tools exist, there is not sufficient evidence for their effectiveness and NICE do not recommend their use (16). The following table highlights some identifiable risk factors that could be explored in the history. Static risk factors are those that are historical and not now modifiable. Dynamic risk factors are open to some degree of modification and could be addressed in a risk management plan

Table 2: Possible risk factors (12-14, 16)

	Static factors	Dynamic factors
Presenting complaint	Serious attempt with violent method Evidence of careful planning	Suicidal ideation/plan Presence of mental illness (e.g. a personality disorder, depression or anxiety) Hopelessness, guilt, worthlessness (i.e. active psychological symptoms) Psychological stress (e.g. bereavement, unemployment)

	Static factors	Dynamic factors
Psychiatric history	History of self-harm and previous suicide attempts History of mental disorder Recent psychiatry inpatient admission	Poorly optimised treatment of mental health condition (e.g. not taking prescribed medications)
Medical history		Concurrent physical illness, especially if recently diagnosed, terminal, chronic or painful. Functional impairment, cognitive impairment, loss of sight/hearing, disfigurement, loss of independence
Drugs and alcohol		Alcohol or drug abuse
Family history	Family history of self-harm, suicide and mental disorder	
Social/personal history	Gender (male) Age (elderly) Separation or divorce, legal troubles Physical or sexual abuse	Marital difficulties Access to a method of suicide (e.g. firearms) Family conflict, abuse Living alone with poor social support Exposure to suicidal behaviour of others, either directly or via the media

Step 3: Evaluation of the patient's experience

The patient's perception and evaluation of their suicidal ideation and any acts is important for establishing ongoing risk. The following questions could be asked to help explore these issues:

- Why is the patient considering suicide as an option?
- Why now? Has anything changed in the patient's environment?
- What exactly is happening now? How is it affecting the patient?

Regret for a suicide attempt and future plans for a further attempt are important aspects of the patient's experience which should not be forgotten.

The psychosocial facet of the history establishes the patient's broad lifestyle, the stressors to which they are exposed, as well as the extent and manner with which the patient copes with them. It sets the patient's experience into context. NICE guidance is for a 'psychosocial assessment and assessment of needs' including 'social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment (12).

Step 4: Identification of targets for intervention

Information already gathered earlier in the assessment can be used to identify dynamic risk factors for suicide, including mental illness, adverse living situations or personality issues. These can then be fixed upon as opportunities for intervention in the management plan. Protective factors should be emphasised and enhanced if possible.

Management from A&E

Following the assessment a management plan needs to be formulated. It is best practice to try and work together with the patient to support them in making an informed decision in their best interest rather than treating against their will. Thus at all points the patient's capacity should be considered and optimised when possible. The Mental Capacity Act (2005) and the Mental Health Act (1983) may, however, be needed if the patient does not accept treatment that is thought to be necessary; in particular life-saving medical treatment or hospital admission for further assessment or treatment of suspected mental illness.

Admission to a medical ward

It is important to note that most psychiatric wards have limited capacity for medical therapies, such as intravenous fluids, so patients requiring both ongoing medical and psychiatric input may need to remain on a medical ward until stable enough for discharge. If the necessity for a medical admission is clear from the outset, then assessment of risk and the need for 1:1 nursing on the ward is most important. This, in part, will depend on the risk of further acts of self-harm or absconding.

1:1 nursing observation may be used to help contain risk, to offer therapeutic interaction, to continue to assess mental state and risk, especially if there is an unpredictable or changeable component to a patient's presentation, and also to aid engagement. Disclosed or apparent drug or alcohol use should be made clear to the medical team and considered as part of the management plan - particularly if alcohol withdrawal is likely to complicate the management.

The psychiatry liaison team covering the medical wards can offer ongoing review of the patient; they can also consider further management and plans when the patient is ready for medical discharge. Very short admissions, such as for N-acetylcysteine treatment following paracetamol overdose, can occasionally allow for discharge planning from the medical ward at the initial review, but this is not the norm.

Admission to a psychiatry ward and ongoing community support

Decisions about psychiatric admissions should be made on the basis of clinical need. Admission to a psychiatric ward can be considered when management in the community presents ongoing risks. Such risks may include the following:

- To the patient's health, for example when medication compliance is unlikely if unsupervised or if community management is unacceptable to the patient who is then unlikely to engage.
- To the patient's safety, for example ongoing suicidal plans and/or lack of social support.
- To the safety of others.

Using a multi-disciplinary approach with senior support helps to ensure that the patient can be treated in the least restrictive manner. Local services may offer varying degrees of community support and so any management plan must be made with local knowledge.

Discharge to community

With patients who do not require admission to a psychiatric hospital, the A&E management plan should involve referral or sign-posting to relevant local services which can provide longer-term support for the needs identified in the assessment. This also represents an opportunity to review the usefulness of the elements of any care plan already in place.

A hierarchy of interventions below the threshold of a hospital admission might be as follows, in descending order.

1. Home Treatment Team or Crisis Team referral for intensive support at home. These teams tend to be expert in risk management. Local referral guidelines vary and discussion with these teams prior to referral is recommended.
2. Community Mental Health Team referral or re-engagement. The referral should clearly state the necessity and mechanism of support required e.g. increased care co-ordinator support or medication review.

3. GP referral. This may be when primary care management of the mental illness, including monitoring is considered to be sufficient.
4. Recommendation for locally available voluntary services, such as befriending services or the Samaritans.

If the patient misuses alcohol or illicit drugs, consider referral to local drug and alcohol services alongside the above interventions.

Special Cases

Patients under the age of 16 should always have a review by Child and Adolescent Mental Health Services (CAMHS) and this may require admission overnight in a medical hospital. The clinician should be particularly alert to any safeguarding concerns, adverse family situations that may require investigation of the child's living arrangements, or significant mental illness (12).

Those over 65 years of age who present with suicidal ideation or attempts are more likely to have a subsequent suicide attempt, and careful consideration should be given to their physical health, social circumstances and the possibility of cognitive impairment (12).

Summary

Patients who present in the A&E department following suicidal ideation or suicide attempt need to be assessed sensitively but effectively. Establishment of an accurate risk assessment and a working diagnosis will enable appropriate planning for further management of the patient. In addition to addressing and acknowledging the suicide attempt or ideation, presentation to A&E offers an opportunity for the prevention of future suicide attempts through the diagnosis of mental disorders such as depression.

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