Suicide Prevention Australia

Foundations Paper:
Improvements and Alternatives to Emergency Departments for Young People who have Attempted Suicide or Self-harmed

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The *Foundations* papers are series of reports each providing background information for a program of work conducted by Suicide Prevention Australia. The reports are produced by volunteers and students on placement at Suicide Prevention Australia under the supervision of staff. Suicide Prevention Australia would like to thank Lilliana Clark for her work producing this paper.

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Summary

Young people are at elevated risk for suicide and often present to emergency departments when experiencing significant suicidal ideation or following a suicide attempt.[1] Research shows that young people often have negative experiences in emergency departments and those that do, are less likely to return.[2] This is an area of concern given that those with previous visits to emergency departments for suicide-related behaviours are far more likely to die by suicide.[3]

One of the most commonly highlighted issues is the lack of alternatives to emergency departments for those experiencing suicide-related distress.[4] While there are currently no widespread alternatives available to young Australians, there are several services that provide a good foundation for how such services should operate and their role. Safe spaces provide a safe environment for those experiencing significant distress and are mainly staffed by peer support workers who can provide comfort and assist individuals in accessing other community services.[5] Crisis Assessment and Treatment Teams are made up of mental health professionals and provide an alternative point of contact for mental health and suicide related crisis in hospitals.[6] For those who require a higher level of care, the Intensive Outpatient Program sees individuals undergoing a variety of cognitive behavioural therapy sessions.[7] Another service model that has been implemented in the US, is the Crisis Now model, which consists of a crisis call centre, a 24/7 mobile crisis response team and crisis stabilisation sites.[8]

Young people have also expressed the need for changes within emergency departments to reduce further distress and improve the overall experience.[9] Changes to the emergency department environment such as alternative waiting areas, increased privacy and sensory tools or rooms, could potentially address some of these issues by providing young people with a secure and calm environment.[10] Emergency departments could also improve staff training, introduce peer support workers and establish suicide response teams to ensure they are equipped and capable of responding to young

[1] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm.* International Journal of Environmental Research and Public Health, 18(6), p.2892.

[2] Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F., 2021. *Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation.*

[3] Crandall, C., Fullerton-Gleason, L., Aguero, R. and LaValley, J., 2006. Subsequent Suicide Mortality among Emergency Department Patients Seen for Suicidal Behavior. Academic Emergency Medicine, 13(4), pp.435-442.

[4] Freeman, J., Strauss, P., Hamilton, S., Pugh, C., Browne, K., Caren, S., Harris, C., Millett, L., Smith, W. and Lin, A., 2022. They Told Me "This Isn't a Hotel": Young People's Experiences and Perceptions of Care When Presenting to the Emergency Department with Suicide-Related Behaviour. International Journal of Environmental Research and Public Health, 19(3), p.1377.

[5] NSW Health. 2021. Safe Haven Opens Doors for People Experiencing Suicidal Distress in NSW - Towards Zero Suicide news. [online] Available at: <https://www.health.nsw.gov.au/towardszerosuicides/news/Pages/dec-2021-safe-haven.aspx>

[6] Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.

[7] Kennard, B., Mayes, T., King, J., Moorehead, A., Wolfe, K., Hughes, J., Castillo, B., Smith, M., Matney, J., Oscarson, B., Stewart, S., Nakonezny, P., Foxwell, A. and Emslie, G., 2019. The Development and Feasibility Outcomes of a Youth Suicide Prevention Intensive Outpatient Program. Journal of Adolescent Health, 64(3), pp.362-369.

[8] Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.

[9] Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.; Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F., 2021. Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation; Liddicoat, S., 2019. Designing a supportive emergency department environment for people with self harm and suicidal ideation: A scoping review. Australasian Emergency Care, 22(3), pp.139-148.

[10] Consumers of Mental Health WA, 2019. Alternatives to Emergency Departments Project Report. Cannington; West, M., Melvin, G., McNamara, F. and Gordon, M., 2017. An evaluation of the use and efficacy of a sensory room within an adolescent psychiatric inpatient unit. Australian Occupational Therapy Journal, 64(3), pp.253-263.

people in suicide-related distress. Young people have also expressed the need for improvement in follow-up and aftercare.[11] Other improvements include involving support persons and harm minimisation. There are some existing guidelines for emergency departments that in-part address some of these issues, however they are often too general and do not look at the needs of young people specifically.

Introduction

Suicide is currently the leading cause of death for young people aged 15-24 with over one third of deaths of young people being as a result of suicide in 2020.[12] There has also been a consistent growth in the number of self-harm or suicidal ideation emergency department presentations by young people in recent years.[13] Although self-harm is not always intended to be a deliberate attempt to end one's life, there is an elevated risk of suicide in individuals who self-harm.[14] Data has also shown overall elevated levels of distress among young people, especially during the pandemic, with Kids Helpline reporting a 264% rise in cases between March 2020 and December 2021.[15] Kids Helpline also reported that of 2,783 duty of care interventions in 2020 (in which emergency services are contacted), 37% were related to a suicide attempt.[16]

It is evident that emergency departments provide a critical opportunity for support, intervention and potential referral to other relevant supports to assist in suicide prevention.[17] The quality and consistency of this support is crucial, with evidence showing that those in suicidal distress who have poor experiences in an emergency department are less likely to return to the emergency department or attend follow-up appointments.[18] Despite the number of people presenting to emergency departments for suicide-related distress, staff can feel unequipped to deal with self-harm or suicidal behaviour beyond providing immediate physical care.[19] There is also a need for youth specific interventions and services as the risk factors and motives for suicide attempts are often different for young people compared to adults.[20] This is particularly important considering the recent and ongoing impact of the Covid-19

[11] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health, 18(6), p.2892.

[12] Australian Institute of Health and Welfare, 2021. *Suicide & self-harm monitoring: Intentional self-harm hospitalisations*, available online at <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations>.

[13] Sara, G., Wu, J., Uesi, J., Jong, N., Perkes, I., Knight, K., O'Leary, F., Trudgett, C. and Bowden, M., 2022. Growth in emergency department self-harm or suicidal ideation presentations in young people: Comparing trends before and since the COVID-19 first wave in New South Wales, Australia. New Zealand Journal of Psychiatry; Australian Institute of Health and Welfare, 2021. Suicide & Self-harm Monitoring.

[14] Carroll, R., Metcalfe, C. and Gunnell, D., 2014. Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis. PLoS ONE, 9(2), p.e89944.

[15] Yourtown. 2021. New Kids Helpline data reveals spike in duty of care interventions. [online] Available at: https://www.yourtown.com.au/media-centre/new-kids-helpline-data-reveals-spike-duty-care-interventions.

[16] Ibid.

[17] Larkin, G. L., & Beautrais, A. L. (2010). *Emergency departments are underutilized sites for suicide prevention*. Crisis, 31(1), 1–6.

[18] Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F., 2021. *Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation.*

[19] Lee, J., Bang, Y., Min, S., Ahn, J., Kim, H., Cha, Y., Park, I. and Kim, M., 2019. *Characteristics of adolescents who visit the emergency department following suicide attempts: comparison study between adolescents and adults*. BMC Psychiatry, 19(1).

[20] Kwan, Y., Choi, S., Min, S., Ahn, J., Kim, H., Kim, M. and Lee, J., 2021. *Does personality problems increase youth suicide risk?: A characteristic analysis study of youth who visit the emergency department following suicide attempt*. Journal of Affective Disorders, 282, pp.539-544; Lee, J., Bang, Y., Min, S., Ahn, J., Kim, H., Cha, Y., Park, I. and Kim, M., 2019. *Characteristics of adolescents who visit the emergency department following suicide attempts: comparison study between adolescents and adults*. BMC Psychiatry, 19(1).

pandemic on the lives of young people. The pandemic has resulted in significant disruption and distress such as missing key milestones, disruption to schooling and social isolation.[21]

Emergency departments are also often the first point of contact for young people seeking help in relation to suicide ideation, suicide attempts or self-harm.[22] One study found that up to 50% of young people who died by suicide presented to an emergency department within the year leading up to their death.[23]

However, young people's experiences with emergency departments following a suicide attempt or when experiencing suicidal ideation, are overwhelmingly negative.[24] Interviews with young people have highlighted the need for improved staff training, a better emergency department environment and management protocol, and alternatives to emergency departments.[25] There is also a lack of follow-up and a disconnect between discharge from emergency and further care, with studies showing as little as 43% of people discharged receiving follow-up care.[26] This leaves a significant amount of people without care and thus at risk for further self-harm and suicidal thoughts and behaviours.[27]

This paper will explore and discuss some of the issues faced by young people when experiencing suicidal ideation or intent in relation to emergency departments. It will begin by outlining the need for alternatives to emergency departments as well as presenting some existing services that exist to fill this need. The paper will then go on to highlight some of the identified issues within emergency departments and what changes could be made to address these. This section will include an analysis of some existing guidelines for emergency department responses to people presenting due to self-harm, suicidal ideation or suicide attempt.

Alternatives to Emergency Departments

Emergency departments are very clinical and often extremely busy environments, making them less than ideal environments for young people in cases of suicide related distress and behaviour.[28] Research has highlighted the crucial need for alternatives to emergency departments for people experiencing suicidal distress or ideation. Currently there are some services offering an alternative to emergency departments that are being trialled and rolled out on a small scale, however the need for widespread available alternatives to emergency departments as part of a national network remains. Where alternatives do

[21] Li, S., Beames, J., Newby, J., Maston, K., Christensen, H. and Werner-Seidler, A., 2021. The impact of COVID-19 on the lives and mental health of Australian adolescents. European Child and Adolescent Psychiatry,.

[22] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm.* International Journal of Environmental Research and Public Health, 18(6), p.2892.

[23] Rhodes, A., Khan, S., Boyle, M., Tonmyr, L., Wekerle, C., Goodman, D., Bethell, J., Leslie, B., Lu, H. and Manion, I., 2013. *Sex Differences in Suicides among Children and Youth: The Potential Impact of Help-Seeking Behaviour.* The Canadian Journal of Psychiatry, 58(5), pp.274-282.

[24] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health*, 18(6), p.2892.

[25] Freeman, J., Strauss, P., Hamilton, S., Pugh, C., Browne, K., Caren, S., Harris, C., Millett, L., Smith, W. and Lin, A., 2022. *They Told Me "This Isn't a Hotel": Young People's Experiences and Perceptions of Care When Presenting to the Emergency Department with Suicide-Related Behaviour*. International Journal of Environmental Research and Public Health, 19(3), p.1377; Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F., 2021. *Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation.*

[26] Bridge, J., Marcus, S. and Olfson, M., 2012. Outpatient Care of Young People After Emergency Treatment of Deliberate Self-Harm. Journal of the American Academy of Child & Adolescent Psychiatry, 51(2), pp.213-222.e1.

[27] Ibid.

[28] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm*. International Journal of Environmental Research and Public Health, 18(6), p.2892.

exist, they are often not youth specific. However, several of these programs and services could function as models to be adapted to a youth specific alternative, examples of programs that could be adapted are described below.

SAFE Havens

Safe Havens are described as a non-clinical, peer-based services for anyone experiencing a mental health or suicide related crisis.[29] The Safe Haven Café in Melbourne is an example of this. The Safe Haven Café is connected to St Vincent's Hospital and can be accessed by anyone through walk-in or through an emergency department-based peer worker.[30] Not only have individuals and the community identified this service as beneficial, but it has also shown to be cost effective, with estimated savings to the emergency department being $225 400, while operating costs were estimated at $191 540.[31]

Currently there are now Safe Havens or Safe Spaces available in all states and territories across Australia. In NSW specifically, fourteen Safe Haven services have been rolled out across Greater Sydney which are available to all ages.[32] These Safe Havens are mostly staffed by peer support workers with lived experience but also some health and allied health professionals.[33] They aim to provide a safe and calming environment, one-on-one or group peer support and link individuals to other relevant support services.[34] These services are also co-designed with people with lived experience to tailor them to the needs of the community.[35] The Safe Haven model could be adapted and co-designed with young people to develop a similar service catered specifically to young people's needs. This could include extended operating hours, as operating hours for current Safe Haven sites are limited.

Crisis Assessment and Treatment Teams

Crisis Assessment and Treatment Teams (CATT), sometimes referred to as Psychiatric Emergency Teams are made up of mental health professionals such as social workers and psychologists and are based in hospitals.[36] The purpose of CATTs is to provide an alternative point of contact for mental health and suicide related crisis that is available 24/7.[37] When contacted the team will assess the individual to determine the next step. This will usually involve a referral to other relevant health and support services to provide more long-term care.[38] CATTs are referred to by different names across Australia - CATT in Tasmania, ACT and NT; Acute Care Teams in Queensland and NSW; Acute Community Intervention Service in Victoria; Mental Health Triage Service in SA; and the Mental Health Emergency Response Line in WA.[39] Currently CATTs and similar crisis management teams are not catered to youth specifically and may not be accessible for everyone such as those in rural or remote areas.

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[29] Consumers of Mental Health WA, 2019. Alternatives to Emergency Departments Project Report. Consumers of Mental Health WA.
[30] Ibid.
[31] Consumers of Mental Health WA, 2019. Alternatives to Emergency Departments Project Report. Consumers of Mental Health WA.
[32] NSW Health. 2021. Safe Haven Opens Doors for People Experiencing Suicidal Distress in NSW - Towards Zero Suicide news. [online] Available at: <https://www.health.nsw.gov.au/towardszerosuicides/news/Pages/dec-2021-safe-haven.aspx>
[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.
[37] Ibid.
[38] Ibid.
[39] Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.

Intensive Outpatient Program

The Intensive Outpatient Program (IOP) is designed as an alternative to both emergency departments and other more low-intensity outpatient services.[40] Individuals can be referred through the emergency department, outpatient or inpatient services.[41] The IOPs intervention approach is mainly Cognitive Behavioural Therapy but has also incorporated aspects of other approaches such as Dialectical Behaviour Therapy.[42] Participants would undergo group, family and individual therapy sessions. A study examining the feasibility and effectiveness of the IOP found that 99% of parents and 96% of young people reported being mostly or very satisfied with the program.[43] They also reported a significant decrease in depressive symptoms and suicidal ideation and behaviour.[44] This trial and evaluation was conducted in the United States but does not appear to have been implemented elsewhere thus far.

Crisis Now

Crisis Now is a US model that focuses on 3 components to increase availability of support for anyone in crisis. The 3 components are: a crisis call centre, a 24/7 mobile crisis response team, and crisis stabilisation sites. All 3 components are available 24/7 and the model is designed to provide a suitable alternative to emergency departments and reduce incidents of police responding to people experiencing a mental health or suicide related crisis.[45] This model has not yet been adopted outside of the US; however, it does combine many aspects of other existing services and could be adopted to guide the development of similar service for young people.

Crisis Stabilisation Unit

Recently, Gold Coast Health opened Queensland's first Crisis Stabilisation Unit located at Robina Hospital.[46] The purpose of the unit is to provide a safe, comfortable and therapeutic environment for those presenting to emergency departments in acute mental health crisis.[47] The unit was co-designed with clinicians and people with lived experience to ensure the environment was calm, safe and non-clinical.[48] The centres are mainly staffed by peer support workers and some health and allied health professionals.[49] At the moment admissions to the unit are coordinated between the QLD ambulance service, QLD police service and the hospital emergency department, but they do not currently allow self-admissions.[50]

Urgent Care Clinics

While none have been trialled yet, the Labor government has announced that if elected, they will establish at least 50 Medicare Urgent Care Clinics with the aim of reducing pressure on emergency departments.[51] It was found that in 2020-21, 47% of emergency department presentations were

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[40] Kennard, B., Mayes, T., King, J., Moorehead, A., Wolfe, K., Hughes, J., Castillo, B., Smith, M., Matney, J., Oscarson, B., Stewart, S., Nakonezny, P., Foxwell, A. and Emslie, G., 2019. The Development and Feasibility Outcomes of a Youth Suicide Prevention Intensive Outpatient Program. Journal of Adolescent Health, 64(3), pp.362-369.

[41] Ibid.

[42] Kennard, B., Mayes, T., King, J., Moorehead, A., Wolfe, K., Hughes, J., Castillo, B., Smith, M., Matney, J., Oscarson, B., Stewart, S., Nakonezny, P., Foxwell, A. and Emslie, G., 2019. The Development and Feasibility Outcomes of a Youth Suicide Prevention Intensive Outpatient Program. Journal of Adolescent Health, 64(3), pp.362-369.

[43] Ibid.

[44] Ibid.

[45] National Action Alliance for Suicide Prevention: Crisis Services Task Force. 2016. Crisis now: Transforming services is within our reach. Washington, DC: Education Development Centre

[46] Gold Coast Health. 2021. Queensland's first Crisis Stabilisation Unit opens at Robina Hospital. [online] Available at: https://www.goldcoast.health.qld.gov.au/about-us/news/queenslands-first-crisis-stabilisation-unit-opens-robina-hospital.

[47] Ibid.

[48] Ibid.

[49] Ibid.

[50] Ibid.

[51] Australian Labor Party. 2022. Medicare Urgent Care Clinics. [online] Available at: https://www.alp.org.au/policies/medicare-urgent-care-clinics.

classified as semi-urgent or non-urgent meaning it could have been seen to by a doctor or nurse outside of hospital.[52] The lack of alternative services in cases like this results in significant pressure and strain on emergency departments and hospitals. The proposed Urgent Care Clinics will be covered by Medicare and located close to community health centres and emergency departments.[53] While at this stage it does not appear these services will be equipped to deal with mental health and suicide related crisis, they could be resourced to undertake this role.

Urgent Mental Health Care Centre

A service similar to the Safe Havens discussed above is the Urgent Mental Health Care Centre (UMHCC) in Adelaide. The UMHCC is located nearby St Andrew's hospital and provides an alternative to emergency departments for those experiencing mental health crisis.[54] The centre is available through walk-in or referral and is open 24 hours a day, 7 days a week.[55] The UMHCC aims to provide a safe, welcoming and inclusive environment and provides both peer-led and clinical support to aid in recovery.[56] Staff work closely with individuals to reduce immediate distress, develop care plans, and connect people to relevant service to provide more long-term support.[57]

Improvements to Emergency Departments

There has also been substantial research on changing various aspects of emergency departments to ensure they are equipped and capable to respond to the needs of young people in suicide-related distress. Some commonly discussed improvements include:

- Alternative waiting areas
- Sensory tools/sensory rooms
- Increased privacy
- Introducing peer support workers in emergency departments
- Suicide specific staff training
- Introducing and establishing Suicide Response Teams
- Involvement of support persons
- Improved follow-up and aftercare

Emergency Department Environment/Alternative Waiting Areas

The emergency department is known to be busy, loud and very open, which provides a set of challenges in effectively managing anyone who presents due to a mental health or suicide related crisis.[58] Available qualitative data into the experiences of young people presenting to emergency departments with suicidal thoughts or behaviours highlights the need for alternative waiting areas with environments designed to

[52] Ibid.
[53] Martin, S., 2022. Labor to commit $135m to trial 50 urgent care clinics intended to ease pressure on hospitals. [online] The Guardian. Available at: <https://www.theguardian.com/australia-news/2022/apr/13/labor-to-commit-135m-to-trial-50-urgent-care-clinics-intended-to-ease-pressure-on-hospitals>.
[54] Neami National. 2022. Urgent Mental Health Care Centre (UMHCC). [online] Available at: <https://www.neaminational.org.au/find-services/umhcc/>.
[55] Ibid.
[56] Urgent Mental Health Care Centre. 2022. A welcoming place for people experiencing a mental health crisis. [online] Available at: <https://www.umhcc.org.au/>.
[57] Ibid.
[58] Asarnow, J., Babeva, K. and Horstmann, E., 2017. *The Emergency Department*. Child and Adolescent Psychiatric Clinics of North America, 26(4), pp.771-783.

minimise additional distress.[59] Health and allied health workers including nurses, social workers and emergency department staff have also identified this as an area to be addressed.[60]

One of the most common suggestions is providing a separate waiting area to provide young people experiencing significant psychological and suicide related distress with a calm and safe space.[61] Suggested features of these rooms include less harsh lighting, less noise, supervision and having means of self-harm and suicide removed.[62] There is also the emerging field of evidence-based design which looks at the link between the physical and structural design of environments and healthcare outcomes.[63] There is some existing research that has collated and discussed some architectural changes that could potentially address some existing issues and improve emergency department environments for people experiencing mental health or suicide related distress. Some of the features include:

- Ceiling to floor partitions
- Private consultation rooms
- Solid core wood doors on consultation rooms
- Open layouts to improve ability to navigate
- Direct lines of sight for security and staff
- Video monitoring
- Decrease distance between waiting area and consultation rooms
- Remove physical obstructions or potentially harmful physical features[64]

However, very few studies have been conducted to determine the relationship between healthcare outcomes and the listed features. More evidence-based research is required to determine the extent to which specific design features in hospitals impact on outcomes, specifically for patients in suicide-related distress. Also, while the issues these studies address are ones identified by young people, the suggested changes are drawn from research and guidelines that are not youth specific and may need to be adapted or trialled to determine their suitability for young people.

Sensory Tools/Rooms

There is also some research into the use of sensory tools to help reduce psychological distress in young people. One study based at the Child and Adolescent Inpatient Unit at Princess Margert Hospital in New Zealand found that the introduction of a sensory modulation room showed improved patient energy and arousal.[65] Another study reported that 94% of adolescents that engaged with the sensory rooms reported a reduction in distress.[66] This study utilised a variety of sensory tools and equipment including: a rocking chair, weighted blankets, fidget toys, scented oils, music, projected images and teas.[67]

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[59] Asarnow, J., Babeva, K. and Horstmann, E., 2017. *The Emergency Department*. Child and Adolescent Psychiatric Clinics of North America, 26(4), pp.771-783.; Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F., 2021. *Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation.;* Liddicoat, S., 2019. *Designing a supportive emergency department environment for people with self harm and suicidal ideation: A scoping review*. Australasian Emergency Care, 22(3), pp.139-148.

[60] True, G., Pollock, M., Bowden, C., Cullen, S., Ross, A., Doupnik, S., Caterino, J., Olfson, M. and Marcus, S., 2021. *Strategies to Care for Patients Being Treated in the Emergency Department After Self-harm: Perspectives of Frontline Staff.* Journal of Emergency Nursing, 47(3), pp.426-436.e5.

[61] Consumers of Mental Health WA, 2019. *Alternatives to Emergency Departments Project Report*. Cannington.

[62] Hill, N.T.M, Halliday, L, Reavley, N.J 2017. *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings*. Sydney, Black Dog Institute.

[63] Liddicoat, S., 2019. *Designing a supportive emergency department environment for people with self harm and suicidal ideation: A scoping review*. Australasian Emergency Care, 22(3), pp.139-148.

[64] Ibid.

[65] Bobier, C., Boon, T., Downward, M., Loomes, B., Mountford, H. and Swadi, H., 2015. *Pilot Investigation of the Use and Usefulness of a Sensory Modulation Room in a Child and Adolescent Psychiatric Inpatient Unit.* Occupational Therapy in Mental Health, 31(4), pp.385-401.

[66] West, M., Melvin, G., McNamara, F. and Gordon, M., 2017. *An evaluation of the use and efficacy of a sensory room within an adolescent psychiatric inpatient unit.* Australian Occupational Therapy Journal, 64(3), pp.253-263.

[67] Ibid.

However, available research is mostly based in psychiatric care settings and there is little to no research available on the use of sensory tools or rooms in emergency departments. The studies found also focused on young people experiencing severe mental illness and not those experiencing suicide related distress specifically. Further research is required to determine the potential benefits and feasibility of sensory modulation for young people presenting to an emergency department following a suicide attempt.

Increased Privacy

Another issue identified by young people was the lack of privacy when having to disclose the nature of their presentation to the emergency department. Young people recounted experiences in which staff would openly and loudly discuss details regarding their suicide attempt or suicidal ideation which contributed to their overall negative emergency department experiences.[68]

This issue is one that can be also addressed by the usage of alternative triage waiting areas as discussed above. Increased staff awareness of this issue could also be helpful to improve the care taken to ensure information provided is treated sensitively and discretely. In a study where young people with lived experience were interviewed, one participant stated that having to verbally disclose details within earshot of other patients and staff, affected the amount of information they provided.[69] Suggested solutions from young people included providing the option to complete an online questionnaire as an alternative.[70]

Peer Support Workers

Despite the known benefits of peer support workers in the mental health and suicide prevention sector, peer support worker roles have not been implemented in emergency departments. Having peer support workers with lived or living experience of suicide available in emergency departments is an area of particular focus in studies and in the development of suicide management guidelines for emergency department settings. Some of the tasks of peer support workers in emergency department settings could include:

- Advocating for the patient/client
- Offering comfort
- De-escalation
- Accompanying and supervising
- Help communicate with staff
- Help navigate the emergency department
- Liaise with support person/s[71]

Furthermore, being able to connect with someone who has a similar experience can be extremely beneficial. In one study a young person stated that “being able to connect with other people who have

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[68] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O’Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People’s Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health*, 18(6), p.2892.

[69] Ibid.

[70] Ibid.

[71] Hill, N., Halliday, L. and Reavly, N., 2017. *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*. Sydney: Black Dog Institute.; Brasier, C., Roennfeldt, H., Hamilton, B., Martel, A., Hill, N., Stratford, A., Buchanan-Hagen, S., Byrne, L., Castle, D., Cocks, N., Davidson, L. and Brophy, L., 2021. *Peer support work for people experiencing mental distress attending the emergency department: Exploring the potential.* Emergency Medicine Australasia, 34(1), pp.78-84.

lived experience was the really life changing thing" highlighting the potential benefits of peer support workers for young people in emergency departments following a suicide attempt.[72]

Suicide Specific staff training

Another area requiring attention is the training of staff in emergency departments to effectively and appropriately respond and provide care to young people following a suicide attempt. Young people have reported staff often seem disinterested and lack empathy which contributes to feelings of guilt and shame and can increase distress.[73] Training should also be provided to all staff that may come into contact with someone in suicide related distress to improve the quality, consistency and efficiency of care. Providing appropriate training would not only improve the quality of care provided but may also help to decrease stigma.[74] Increasing the number of staff trained in managing patients experiencing suicidality and conducting assessments can also help to decrease initial waiting times.[75] Specific recommendations for training include:

- Increase awareness, empathy and sensitivity[76]
- Increase capacity to build a therapeutic alliance and rapport with a client[77]
- Increase knowledge and skills required to appropriately conduct risk and psychosocial assessments[78]
- Increase knowledge on risk and protective factors[79]
- Improve knowledge on available services[80]
- Knowledge to perform culturally appropriate and sensitive assessments[81]

Suicide Response Teams

In addition to universal staff training, some research and guidelines also suggest having a designated team to respond and provide support to individuals experiencing suicide-related distress. The Blackdog Institutes 'Guidelines for integrated suicide-related crisis and follow-up in Emergency Departments' provides a detailed outline of the duties of a 'Suicide Response Team' and how it would operate in the emergency department setting. The guidelines stipulate that the team should be an interdisciplinary team trained in crisis intervention, conducting assessments, discharge and follow-up care planning and referral to in-patient or out-patient services.[82] Suicide Response Team staff should have the following:

- Extensive knowledge of hospital operates and protocol, suicide risk factors/behaviours and available services
- Skills to perform evaluations, assessments and develop care plans
- Skills to practice person-centred care e.g. active listening

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[72] Glowacki, K., Whyte, M., Weinstein, J., Marchand, K., Barbic, D., Scheuermeyer, F., Mathias, S. and Barbic, S., 2022. *Exploring How to Enhance Care and Pathways Between the Emergency Department and Integrated Youth Services for Young People with Mental Health and Substance Use Concerns.*

[73] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm.* International Journal of Environmental Research and Public Health, 18(6), p.2892.

[74] McCann, T., Clark, E., McConnachie, S. and Harvey, I., 2006. *Accident and emergency nurses' attitudes towards patients who self-harm.* Accident and Emergency Nursing, 14(1), pp.4-10.

[75] Asarnow, J., Babeva, K. and Horstmann, E., 2017. *The Emergency Department Challenges and Opportunities for Suicide Prevention*. Child and Adolescent Psychiatric Clinics of North America, 26(4), pp.771-783.

[76] Hill, N., Halliday, L. and Reavly, N., 2017. *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*. Sydney: Black Dog Institute.

[77] Queensland Centre for Mental Health Learning. 2022. QC25 Suicide Risk Assessment and Management in Emergency Department settings. [ebook] Available at: <https://www.qcmhl.qld.edu.au/course/handouts/QC25_course_handout.pdf>.

[78] Hill, N., Halliday, L. and Reavly, N., 2017. *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*. Sydney: Black Dog Institute.

[79] Ibid.

[80] Queensland Centre for Mental Health Learning. 2022. QC25 Suicide Risk Assessment and Management in Emergency Department settings. [ebook] Available at: <https://www.qcmhl.qld.edu.au/course/handouts/QC25_course_handout.pdf>.

[81] Hill, N., Halliday, L. and Reavly, N., 2017. *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*. Sydney: Black Dog Institute.

[82] Ibid.

- Skills to facilitate communication and collaboration with relevant services and staff
- Skills to evaluate the service delivery including information/data recording[83]

To ensure Suicide Response Teams are equipped to provide support to young people specifically, training should also include youth specific information on things such as risk and protective factors, interventions and services catered to young people. These specialised suicide response teams do not currently exist in emergency departments, however other crisis response teams such as the Sexual Assault Response Team in the Royal Brisbane and Women's Hospital may be able to provide a broad framework for the implementation of Suicide Response Teams in emergency departments.[84]

Interacting with Support Persons

Another important aspect to consider is the involvement of support people that accompany young people to the emergency department following a suicide attempt. Young people presenting to emergency departments following a suicide attempt may not want to provide extensive information or they may not be capable of doing so at the time. Where available, staff should look to gather information from family, friends and carers regarding things such as: behaviour, family history, drug or alcohol use and significant life events.[85]

The involvement of support people should also extend beyond this with family and friends being involved in care planning and interventions where possible. Motivations and risk factors for suicide amongst young people has found to be more related to interpersonal and family problems than for adults, further highlighting the need for targeted interventions.[86]

The Family Intervention for Suicide Prevention (FISP) is an example of family-based intervention. The intervention is made up of 3 components: emergency department staff training, youth and family crisis therapy session, and follow-up phone contacts.[87] FISP utilises cognitive-behavioural therapy techniques and has 5 main goals:

1. Increase safety
2. Highlight and reinforce strengths/protective factors
3. Build skills for client and family to identify suicide related thoughts, emotions and behaviours
4. Develop a safety plan
5. Build coping strategies and available areas of support[88]

One study found that 92% of young people that received family-based cognitive-behavioural therapy intervention attended outpatient treatment versus only 76% of young people who received treatment as

[83] Ibid.

[84] Sexual Assault Response Teams are made up of a variety of health and allied health professionals including nurses, medical examiners, mental health workers and social workers. The team is available 24 hours a day, 7 days a week for people aged 14 and above. The team/service provides continued care which consists of follow-up support, individual counselling, counselling for support persons, referral/service coordination, education and training. Best practice elements of this model include: multi-agency approach, person-centred approach, specialised services for diverse groups, and appropriate follow-up care. See: Royal Brisbane and Women's Hospital. 2018. *Social Work*. [online] Available at: <https://metronorth.health.qld.gov.au/rbwh/healthcare-services/social-work> and KPMG, 2009. Review of Queensland Health Responses to Adult Victims of Sexual Assault. Queensland Health.

[85] Betz, M. and Boudreaux, E., 2016. *Managing Suicidal Patients in the Emergency Department*. Annals of Emergency Medicine, 67(2), pp.276-282.

[86] Lee, J., Bang, Y., Min, S., Ahn, J., Kim, H., Cha, Y., Park, I. and Kim, M., 2019. *Characteristics of adolescents who visit the emergency department following suicide attempts: comparison study between adolescents and adults.* BMC Psychiatry, 19(1).

[87] Hughes, J. and Asarnow, J., 2013. *Enhanced Mental Health Interventions in the Emergency Department: Suicide and Suicide Attempt Prevention*. Clinical Pediatric Emergency Medicine, 14(1), pp.28-34.

[88] Ibid.

usual.[89] Similar family-based interventions have seen comparable success. For example, a study trialling attachment-based family therapy saw a significant improvement in self-reported suicidal ideation.[90]

While family-based interventions appear to be effective, for young people to be eligible they must present to the emergency department with one or both parents or guardians and this is not often the case. It is unknown the proportion of young people that present to emergency department with friends instead of with family, however data on help seeking behaviour shows that a higher percentage of young people in suicidal crisis seek help from friends rather than family.[91] Emergency department-based interventions for young people should consider these help seeking behaviours and adapt to suit the needs of young people.

Improved and Youth Specific Follow-up and Aftercare

There is a higher risk of a suicide in the period following a suicide attempt, extending up to twelve months.[92] To prevent further suicide attempts, those discharged from hospital following a suicide attempt should be provided with adequate aftercare and follow-up support.

The Productivity Commission's Mental Health Inquiry Report stated that providing adequate aftercare could prevent up to 35 people dying from suicide and another 6,100 people from attempting suicide per year.[93] Another study found that providing follow-up intervention and safety planning resources to patients in the emergency department following a suicide attempt, reduced the odds of repeated suicidal behaviour over six months by around half.[94] Despite this, research shows that the majority of young people discharged from hospital following a suicide attempt do not receive follow-up or aftercare.[95]

The 2021-22 Federal Budget made an important step to address this by announcing $158.6 million to go towards delivering universal aftercare.[96] However, this has not yet been implemented, and so in the interim there are a number of actions that emergency departments can implement to improve and increase access to support after self-harm or suicide attempt, including:

- Improve communication and collaboration between emergency departments and other services to ensure a careful transition[97]
- Provide details of the emergency department presentation, assessment and care plans to individuals primary health provider such as their doctor and psychologist[98]
- Making information regarding available services, support groups and emergency department alternatives available to individuals and support people[99]

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[89] Asarnow, J., Baraff, L., Berk, M., Grob, C., Devich-Navarro, M., Suddath, R., Piacentini, J., Rotheram-Borus, M., Cohen, D. and Tang, L., 2011. *An Emergency Department Intervention for Linking Pediatric Suicidal Patients to Follow-Up Mental Health Treatment.* Psychiatric Services, 62(11), pp.1303-1309.

[90] Diamond, G., Wintersteen, M., Brown, G., Diamond, G., Gallop, R., Shelef, K. and Levy, S., 2010. *Attachment-Based Family Therapy for Adolescents with Suicidal Ideation: A Randomized Controlled Trial.* Journal of the American Academy of Child & Adolescent Psychiatry, 49(2), pp.122-131.

[91] Terhaag, S., 2020. *Suicidality and Help Seeking in Australian Young People.* Child Family Community Australia.

[92] Christiansen, E. and Frank Jensen, B., 2007. Risk of Repetition of Suicide Attempt, Suicide or all Deaths after an Episode of Attempted Suicide: A Register-Based Survival Analysis. Australian & New Zealand Journal of Psychiatry, 41(3), pp.257-265.

[93] Productivity Commission, 2020, *Mental Health*, Report no.95, Canberra.

[94] Stanley, B., Brown, G., Brenner, L., Galfalvy, H., Currier, G., Knox, K., Chaudhury, S., Bush, A. and Green, K., 2018. *Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department*. JAMA Psychiatry, 75(9), p.894.

[95] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm*. International Journal of Environmental Research and Public Health, 18(6), p.2892.

[96] The Commonwealth of Australia, 2021. Budget 2021-22. The Commonwealth of Australia.

[97] Hill, N., Shand, F., Torok, M., Halliday, L. and Reavley, N., 2019. Development of best practice guidelines for suicide-related crisis response and aftercare in the emergency department or other acute settings: a Delphi expert consensus study. BMC Psychiatry, 19(1).

[98] SQUARE. 2007. SQUARE Suicide Questions Answers Resources: Emergency Department Setting.

[99] Hill, N.T.M, Halliday, L, Reavley, N.J 2017. *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings*. Sydney, Black Dog Institute.

- Follow-up appointments should be arranged by hospital staff and services should be contacted to ensure follow-up appointment can occur within at least 72 hours from discharge[100]
- Follow-up contact/support to be arranged with the individual[101]
- Consistent and assertive follow-up to ensure adherence to aftercare[102]
- Where possible, involve support people in decision making and planning[103]

Such actions may also continue to be important once universal aftercare is implemented.

Although aftercare is not universal, there are a number of programs and services that provide follow-up and aftercare to young people. In particular, the below are examples of programs that have strong evidence of efficacy:

Hospital Outreach Post-Suicidal Engagement (HOPE) program
The HOPE program is a follow-up and aftercare service for individuals presenting to the emergency department following a suicide attempt or in suicide-related distress. HOPE provides both the individual and any support persons with clinical and social support. Currently the HOPE program is available in some areas of Victoria through emergency department referral, however the Royal Commission into Victoria's Mental Health System has recommended the program be expanded and provide access through other services.[104] The HOPE program could be expanded or act as a model for a similar, youth-specific service, that is more accessible to young people. For example, operating under extended opening hours and providing access through schools. A program such as this one also has the potential to act as an alternative to emergency departments.

The Way Back Support Service
The Way Back Support Service is a non-clinical aftercare service for those who are discharged from hospital following a suicide attempt and aims to support individuals for up to 3-months following discharge.[105] Support workers are responsible for keeping in contact with the individual and providing support either face-to-face or via phone.[106] Support may include referral to other services, motivation, comfort and support network building.[107] Referral to the Way Back Support Service can come through hospitals, GPs and other relevant health services.[108]

The Youth Aftercare Pilot Service (i.am)
A similar aftercare service based on the Way Back service is the Youth Aftercare Pilot service, also known as "i.am". This is a psychosocial aftercare support service for children and young people experiencing suicidality.[109] The service is currently available at a number of locations in NSW and anyone can make a referral on behalf of another person or for themselves.[110] The service is run by youth

[100] Ibid.
[101] National Action Alliance for Suicide Prevention, n.d. *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care.* [online] Available at: https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf.
[102] Ibid.
[103] Ibid.
[104] Victorian Government, 2021. *Volume 2: Collaboration to Support Good Mental Health and Wellbeing*. Melbourne: Royal Commission into Victoria's Mental Health System.
[105] Wellways.org. 2022. The Way Back Support Service. [online] Available at: <https://www.wellways.org/our-services/the-way-back-support-service>.
[106] Neami National. n.d. The Way Back Support Service – Sydney. [online] Available at: <https://www.neaminational.org.au/find-services/the-way-back-support-service-sydney/>.
[107] Wellways.org. 2022. The Way Back Support Service. [online] Available at: <https://www.wellways.org/our-services/the-way-back-support-service>.
[108] Ibid.
[109] i.am. 2022. i.am human complex authentic safe me. [online] Available at: https://iam.liveshere.org.au/.
[110] Ibid.

and peer support workers who aim to provide individualised support.[111] Support includes: developing coping skills and building resilience, providing psychosocial interventions, finding housing, and strengthening family, social and community connections.[112] The i.am service was co-developed with young people with lived experience of suicide as well as mental health professionals, to ensure the service was accessible and catering to the needs of young people in the community.[113]

Eclipse Aftercare Model

Another aftercare model currently being trialled and evaluated by Lifeline Australia is the Eclipse aftercare program. The Eclipse program is based on the Survivors of Suicide Attempts program in the United States which saw significant reductions in suicidal ideation and intent.[114] The program runs for 8 weeks and aims to help participants reduce distress, develop skills and promote resilience and help-seeking to reduce suicidality.[115] The service is also non-clinical and mainly peer-led, and does not require a referral.[116] The Eclipse program is currently available at Lifeline Macarthur, Mid Coast, Harbour to Hawksbury, New England, Hunter and WA.[117]

The SAFETY Program

The SAFETY Program is a youth-specific intervention designed for integration with emergency services and settings.[118] The SAFETY Program recruited participants through an emergency department in the US and underwent a 12-week trial which saw significant improvements on measures including: suicidal behaviour, hopelessness, depression and social adjustment.[119] The program involves therapy sessions for young people and parents (individually and together) and focuses on building the knowledge and skills and necessary to prevent further suicide attempts. However, this program does require parent involvement which may not always be viable.

Brief Intervention and Contact

Brief intervention and contact usually involves a short intervention or information session prior to discharge and follow-up contacts either in-person or via phone calls. A study across 5 different countries (Brazil, Chennai, India, Colombo, Sri Lanka and Iran) utilising this intervention type saw significantly fewer deaths from suicide compared to those who received usual care.[120] This style of intervention has also been shown to improve follow-up treatment attendance so a combination of brief contact intervention alongside other aftercare may further reduce suicide risk.[121] While brief emergency department interventions and follow-up contacts have seen to be effective in decreasing suicide attempts and ideation, more research is required to determine their effectiveness for young people specifically.

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[111] NSW Department of Health. 2022. Youth Aftercare Pilot. [online] Available at: <https://www.health.nsw.gov.au/towardszerosuicides/Pages/youth-suicide-aftercare-pilot.aspx>

[112] Ibid.

[113] Ibid.

[114] Life in Mind Australia. 2022. Lifeline trialling evidence-based Eclipse aftercare program. [online] Available at: <https://lifeinmind.org.au/news/lifeline-trialling-evidence-based-eclipse-aftercare-program>.

[115] Ibid.

[116] Ibid.

[117] Ibid.

[118] Asarnow, J., Berk, M., Hughes, J. and Anderson, N., 2014. *The SAFETY Program: A Treatment-Development Trial of a Cognitive-Behavioral Family Treatment for Adolescent Suicide Attempters*. Journal of Clinical Child & Adolescent Psychology, 44(1), pp.194-203.

[119] Asarnow, J., Berk, M., Hughes, J. and Anderson, N., 2014. *The SAFETY Program: A Treatment-Development Trial of a Cognitive-Behavioral Family Treatment for Adolescent Suicide Attempters*. Journal of Clinical Child & Adolescent Psychology, 44(1), pp.194-203.

[120] Fleischmann, A., 2008. *Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries*. Bulletin of the World Health Organization, 86(9), pp.703-709.

[121] Stanley, B., Brown, G., Currier, G., Lyons, C., Chesin, M. and Knox, K., 2015. *Brief Intervention and Follow-Up for Suicidal Patients With Repeat Emergency Department Visits Enhances Treatment Engagement.* American Journal of Public Health, 105(8), pp.1570-1572.

Reconnecting After a Suicide Attempt (RAFT) service

There has also been recent focus into whether or not digital interventions are effective in reducing suicidal thoughts and behaviours and improving mental health and wellbeing. The RAFT service is an example of a text-message based intervention.[122] The RAFT service was developed in partnership with the Blackdog Institute to address the lack of follow-up care received by those discharged from hospital following self-harm or a suicide attempt.[123] RAFT sends out supportive messages and links to additional support services in the weeks following discharge.[124] This service has seen to be effective with the pilot study reporting a significant reduction in suicidal ideation and self-harm among participants.[125] Research has been conducted on the efficacy of digital interventions such as RAFT and has found that interventions that directly target suicide rather than related issues such as depression, can reduce suicidal ideation.[126] While there is not a large body of evidence to show that digital interventions can reduce suicide and improve wellbeing, digital interventions such as RAFT allow a larger level of scale and reach.[127]

Other Follow-up Supports

A range of other services exist, that are not formal aftercare programs, but can provide psychosocial and other supports that have been demonstrated to aid young people who have self-harmed. For example, a study involving young people admitted to hospital as a result of self-harm found significantly less cases of repeated self-harm among those who received brief cognitive-behavioural therapy intervention.[128] In particular, youth-specific services such as Headspace can provide support for a range of issues including mental health, sexual health and drug and alcohol services in person, over the phone and also through both one-on-one and group online support and counselling sessions.[129]

Guidelines

A range of potential improvement to emergency departments have been discussed above, one potential way to introduce and implement such changes is through developing comprehensive guidelines for responding to young people experiencing suicide-related distress in emergency departments. While guidelines are not always followed, they can provide a standard of practice and protocol to assist in working towards improving the quality and consistency of care.[130]

There are several existing papers outlining detailed guidelines for managing those presenting to emergency departments due to suicide related thoughts and behaviours:

- *NSW Health Staff guidelines*[131]

[122] Larsen, M., Shand, F., Morley, K., Batterham, P., Petrie, K., Reda, B., Berrouiguet, S., Haber, P., Carter, G. and Christensen, H., 2017. A Mobile Text Message Intervention to Reduce Repeat Suicidal Episodes: Design and Development of Reconnecting After a Suicide Attempt (RAFT). JMIR Mental Health, 4(4), p.e56.

[123] Black Dog Institute. 2022. RAFT: Reconnecting After Self-Harm. [online] Available at: <https://www.blackdoginstitute.org.au/research-projects/raft/>.

[124] Ibid.

[125] Larsen, M., Shand, F., Morley, K., Batterham, P., Petrie, K., Reda, B., Berrouiguet, S., Haber, P., Carter, G. and Christensen, H., 2017. A Mobile Text Message Intervention to Reduce Repeat Suicidal Episodes: Design and Development of Reconnecting After a Suicide Attempt (RAFT). JMIR Mental Health, 4(4), p.e56.

[126] Riley, J., Mok., K., Larsen, M., Boydell, K., Christensen, H. and Shand, F., 2020. What can be done to decrease suicidal behaviour in Australia? A call to action. White paper.. Sydney: Black Dog Institute, pp.1-12.

[127] Ibid.

[128] Sinyor, M., Williams, M., Mitchell, R., Zaheer, R., Bryan, C., Schaffer, A., Westreich, N., Ellis, J., Goldstein, B., Cheung, A., Selchen, S., Kiss, A. and Tien, H., 2020. *Cognitive behavioral therapy for suicide prevention in youth admitted to hospital following an episode of self-harm: A pilot randomized controlled trial*. Journal of Affective Disorders, 266, pp.686-694.

[129] Ibid.

[130] Woolf, S., Grol, R., Hutchinson, A., Eccles, M. and Grimshaw, J., 1999. Clinical guidelines: Potential benefits, limitations, and harms of clinical guidelines. BMJ, 318(7182), pp.527-530.

[131] NSW Department of Health. 2004. Framework for Suicide Risk Assessment and Management. North Sydney.

- Blackdog Institute's *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings* (*Blackdog Institute guidelines*)[132]
- National Action Alliance for Suicide Prevention Best Practices in Care Transitions for Individuals with Suicide Risk (*NAASP guidelines*)[133]
- *Suicide Questions Answers Resources: Emergency Department Setting* (*SQUARE guidelines*)[134]

Research has also been conducted with young people to explore their experiences and highlight areas that need to be improved. Comparing the guidelines with each other and with the research on what young people have said is needed in emergency departments will enable the identification of how issues are being addressed and recognise areas that require further attention.

The most current *NSW Health staff guidelines* outlines the protocol for managing patients that are experiencing suicide or mental health related distress. In terms of triage, waiting room and the initial emergency department assessment, the NSW guidelines provides some direction by stating that patients should be checked for means of self-harm and left in a secure, supervised area. Furthermore, we know that young people have communicated a need for privacy and a calmer environment when presenting to emergency departments following a suicide attempt.[135] The *Blackdog Institute guidelines* somewhat addresses these needs by recommending a safe and supervised alternative waiting area be made available. However, in environments where alternative waiting or consultation rooms are not an option, there are no visible measures to ensure privacy when patients are communicating with emergency department staff.

The *NSW Health staff guidelines* also outlines the need for additional staff to act as a calm support person for patients where required. The guidelines do not however go into detail as to who should step into this role, unlike other guidelines such as the *Blackdog Institute guidelines* which outline how peer support workers can be introduced into emergency departments alongside ensuring access to a crisis response team. The *NAASP guidelines* do not include protocols for a specialised crisis response team, but also emphasise utilising peer workers with lived experience of suicide to support people in emergency departments.

As discussed above an important area that should be focused on is staff training which should ensure staff are capable in identifying risk factors, conducting assessments, being sensitive and empathetic and are culturally competent and respectful to avoid further distress and negative experiences in emergency departments.[136] The *NSW Health staff guidelines* do outline the areas that should be covered in a risk or psychosocial assessment but unfortunately do not provide much direction or detail into how to conduct these assessments appropriately or provide information regarding different cultural factors to consider. All three other guidelines analysed address the need for staff to be compassionate, empathetic, competent in suicide prevention and to communicate effectively. The *SQUARE guidelines* go one step further and recommends that in addition to having knowledge of cultural differences, cultural supports may also be involved in care plans.

Available guidelines also look at the protocol for discharging a patient and the required courses of action needed before this can occur. The *NSW Health staff guidelines* contain a detailed list of requirements

[132] Hill, N.T.M, Halliday, L, Reavley, N.J (2017). *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings*. Sydney, Black Dog Institute.
[133] National Action Alliance for Suicide Prevention, n.d. *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care.* [online] Available at: https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf.
[134] SQUARE. 2007. SQUARE Suicide Questions Answers Resources: Emergency Department Setting.
[135] Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J., 2021. *A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm.* International Journal of Environmental Research and Public Health, 18(6), p.2892.
[136] Ibid.

before a person is to be discharged including arranging follow-up care and contacting support people. It also states that if a person is high risk, they are to be discharged to an in-patient facility. The *Blackdog Institute guidelines* and the NAASP guidelines both outline that a care plan be developed with the patient and communicated to relevant support people and primary health care providers prior to discharge. The *SQUARE guidelines* go into even more detail and outline what should be included in a discharge plan such as: safety, support options, protective factors, medications and referrals.

As previously discussed, follow-up interventions and services should also be arranged for patients prior to discharge. The *NSW Health staff guidelines* stipulates that staff should communicate with other relevant services and arrange referrals and appointments where possible. The *NAASP guidelines* provides the most detailed outline for referral and follow-up. This includes providing information to out-patient care provider, involving support peoples, ongoing contact and follow-up with both the out-patient care provider and the patient, and following up on missed appointments. One aspect these guidelines do not include is a timeframe in which follow-up appointments should occur. The *Blackdog Institute guidelines* aims to ensure a timely aftercare response by stating that appointments be arranged, and agencies be contacted by hospital staff to ensure the appointments can take place within 24-72 hrs of discharge.

Unfortunately, a limitation of all four of these guidelines is that they are not youth specific. While certain guidelines include some youth specific options such as informing and involving school counsellors in care plans,[137] most of the information and protocol are generalised and do not include or address youth specific circumstances, risk factors, behaviours or needs. The development of a similar management guideline that is developed alongside young people may help to enhance young people's experiences when presenting to emergency departments following a suicide attempt, and potentially reduce the risk of repeat attempts and deaths by suicide.

Conclusion

It is evident that young people need services that can provide accessible, high quality and consistent support for those experiencing suicide-related crisis. Currently, young people view emergency departments as one of, if not the only, viable option when experiencing suicide-related distress or following a suicide attempt.[138] Given the largely unavoidable fact that emergency departments are often extremely crowded, busy and loud places, they are limited in the extent to which they can provide adequate support and minimise distress.[139] As a result, priority should be placed on developing a youth specific alternative to emergency departments similar to Safe Havens or Intensive Outpatient Programs, to provide more targeted support for those experiencing suicidal ideation or behaviours.

However, alternative services can not entirely replace the need for emergency departments to be able to manage and respond to young people presenting as a result of self-harm, suicidal ideation, or suicide attempts. Emergency departments are often the first point of contact in these situations and so provide a critical opportunity for support and intervention.[140] As a result of this, emphasis should also be placed on improving emergency departments to improve the experiences and health care outcomes of young people at risk of suicide. Improvements are required in key areas such as staff availability, staff training,

[137] National Action Alliance for Suicide Prevention, n.d. *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care.* [online] Available at: <https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf>.

[138] Freeman, J., Strauss, P., Hamilton, S., Pugh, C., Browne, K., Caren, S., Harris, C., Millett, L., Smith, W. and Lin, A., 2022. They Told Me "This Isn't a Hotel": Young People's Experiences and Perceptions of Care When Presenting to the Emergency Department with Suicide-Related Behaviour. International Journal of Environmental Research and Public Health, 19(3), p.1377.

[139] Ibid.

[140] Larkin, G. L., & Beautrais, A. L. 2010. Emergency departments are underutilized sites for suicide prevention. Crisis, 31(1), 1–6.

waiting areas, privacy and follow-up and aftercare.[141] Guidelines for emergency department management of those experiencing suicidal ideation or behaviour should be comprehensive in their practice guidelines and aim to address these areas to ensure consistency in care. Furthermore, it may be useful to develop youth specific guidelines, considering the various issues, factors and needs of young people.

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Advice from young people help determine the topic explored in this report.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our reports. Suicide Prevention Australia thanks all involved in the development of this report.

[141] Ibid.