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## Suicide Assessment and Disposition

### Introduction

During the past 20 years, suicide has become recognized as a major public health concern. The death toll has increased by 30% and suicide remains the 10th leading cause of death overall in the United States.<sup>1</sup> To put this in context, suicide now claims more lives than traffic accidents<sup>2</sup> and more than double the deaths due to homicide.<sup>3</sup> More than 45,000 deaths were attributed to suicide in 2016.<sup>4</sup> Suicide is the second leading cause of death among individuals 10-34 years of age. In the United States, indigenous people are 50% more likely to die from suicide than white Americans.<sup>5</sup> In a recent analysis, the Department of Veterans Affairs (VA) determined that the risk for suicide is 22% higher among veterans than nonveterans in the United States.<sup>6</sup>

The rising rate of suicide can be attributed to numerous causes, including a fragmented mental healthcare system, the opioid addiction epidemic, unregulated handgun ownership, and post-traumatic stress disorder (PTSD) and other mental illnesses experienced by the general public and veterans in particular.<sup>5,6</sup> Moreover, research suggests that almost 90% of those who die from suicide experience serious mental illness (SMI), such as bipolar disorder, major depression, schizophrenia, or substance use disorders.<sup>5,6,7</sup> Thus, psychiatric disorders and previous suicide attempts are intertwined and increase suicide risk.<sup>8</sup> However, the rates of completed suicides reveal only part of the picture. Statistics from the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey<sup>9</sup> demonstrate that 8,500 out of every 100,000 adolescents attempt suicide. In the United States, this amounts to 2 million young people attempting suicide annually. Among youth, 90% of suicide attempts are unknown to parents. Additionally, it is estimated that 1.5 million adolescents rely on the emergency department (ED) as their usual source of medical care.<sup>10</sup> Therefore, point-of-care screening for suicide may be a key prevention strategy. However, in the ED, medical providers often do not detect suicide ideation in their patients (including children and adolescents) who eventually die by suicide, despite the fact that most of them received healthcare services in the year preceding death, usually for complaints not related to suicide or mental health.<sup>11</sup>

Approximately 8% of all adult ED patients have had suicidal thoughts or behaviors recently,<sup>12,13</sup> but the majority of them will not tell providers unless asked. Much of what is known about suicide has logistical limitations. For example, The Joint Commission's Sentinel Event database exists as a voluntary registry, but it only reflects a small proportion of actual events. The database contains reports of 1,089 suicides that occurred from 2010 to 2014 among

## EXECUTIVE SUMMARY

- Since 2010, suicide has been the 10th leading overall cause of death in the United States and one of the five leading causes of death among children, adolescents, and adults 10-54 years of age.
- The rates of suicide attempts and deaths vary by sex, age, and race or ethnicity.
- Factors such as psychiatric disorders and previous suicide attempts increase the risk of suicide.
- Emergency physicians play a crucial role in detecting suicide ideation using a three-step process: obtain an inventory of suicide risk factors, screen for suicidal ideation, and review screening questionnaires prior to discharge.
- The Joint Commission requires emergency physicians to screen all patients who present for a chief complaint that is behavioral for suicide ideation using a brief, standardized, evidence-based screening tool.
- Asking patients about plans or thoughts of suicide does not incite or encourage suicidal behavior.
- Individual risk factors are limited in the ability to predict suicide in a person at a specific time. A large proportion of Americans have one of these suicide risk factors, but only a small proportion of them will attempt suicide, and less will die from it.
- Most of the evidence regarding treatment effectiveness is among high-risk populations who were not identified with screening, such as people who presented to an emergency department (ED) because of a suicide attempt.
- ED-based interventions that provide enhanced support to patients with suicide risk after they are discharged have demonstrated a reduction in the risk of future suicidal behavior.

patients who received treatment and services in a staffed 24-hour setting or within 72 hours of discharge, including from an ED.<sup>14</sup> Notably, the most common deficiency noted in the care of patients who committed suicide within the time frame was an insufficient assessment or lack of psychiatric assessment.

More research about the epidemiology and history of suicide risk is needed. The populations of people who survive suicide attempts and those who die by suicide overlap. Some people may die from their first suicide attempt and may not be seen in the ED, while other people may repeat attempts or may die after multiple suicide attempts.<sup>15</sup> More research also is needed to better understand these groups and to determine who accesses the ED, who seeks care through their primary care provider or mental health system, and who never seeks care.

### Identifying Suicidal Patients

Currently, The Joint Commission requires ED providers to screen for suicidal ideation all patients who present with a behavioral health chief complaint using a brief, standardized screening tool that is backed by evidence.<sup>14</sup>

Studies in primary care settings suggest that there is insufficient evidence to conclude that screening adolescents, adults, and the elderly adequately identifies patients at risk for suicide who would not otherwise be identified based

on an existing mental health disorder, emotional distress, or previous suicide attempt. In addition, there is inadequate evidence about whether such screening is harmful (increases in suicide attempts, ideation, or emotional distress) because of the lack of data and study limitations. Thus, the balance of benefits and harms cannot be determined for universal screening of patients to identify those at risk for suicide.<sup>16</sup>

Moreover, there is evidence that current treatment is not 100% effective. One of the times of highest risk for suicide is just after discharge from a psychiatric facility.<sup>8,17</sup> Furthermore, assessing actual risk (as opposed to ideation) is important, as some patients have persistent suicidal ideation without harming themselves, while others act impulsively without preceding suicidal thoughts. Finally “appropriate” treatment is not yet defined. Some patients improve after talking on a suicide prevention hotline, while others respond to postcards with caring messages.<sup>18</sup> Others will need professional outpatient management, and a smaller number will require hospitalization.

Nonetheless, management and disposition hinge on suicidal risk assessment, regardless of how suicidal ED patients are identified. These serial steps occur after ED providers review each patient's personal and family medical history for suicide risk factors. Taking note of risk factors is important because patients may not tell clinicians about suicidal ideation voluntarily. Risk factors for

suicide include (*see Table 1*):

- SMI or emotional disorder;<sup>5,6,7</sup>
- Previous attempts at suicide or self-inflicted injuries (The risk of suicide is twice as high as the general suicide rate for one year after a suicide attempt.<sup>19</sup> Patients evaluated in the ED for a suicide attempt and dispositioned home are at very high risk for another attempt in the first few weeks after discharge.<sup>20,21</sup>);
- A history of trauma or loss, including child abuse or a family history of suicide,<sup>22</sup> bereavement, or economic loss;<sup>16</sup>
- Physical illness, chronic pain, or functional impairment;<sup>16</sup>
- Alcohol and substance use disorder;<sup>23</sup>
- Social isolation,<sup>24</sup> aggression, or history of antisocial behavior;<sup>25</sup>
- Experience of discrimination or prejudice associated with being lesbian, gay, bisexual, or transgender;<sup>26</sup>
- Discharge from psychiatric hospitalization or after an ED visit for deliberate self-harm;<sup>8,17</sup>
- Veterans with a history of traumatic brain injury, separation from military service < 12 months, low income, PTSD, and other mental health disorders;<sup>5</sup>
- Access to lethal means paired with suicide ideation.<sup>16</sup>

However, because the previous prognostic factors for suicide are poorly defined, ED providers are left in the quandary of predicting a rare event for patients. Most people who have these

## Table 1. Populations at Higher Risk for Suicide

- People 10-34 years of age
- Veterans
- Indigenous tribes
- People with serious mental illness
- People with prior suicide attempts
- People recently released from inpatient care for suicidal ideation/attempts
- People with recent serious illness or emotional distress
- People with a history of recent trauma or loss
- People with alcohol or substance use
- Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) population

risk factors do not attempt suicide, while others without these risk factors sometimes do.

Suicidal ideation exists as a symptom of an ongoing SMI, with suicidal crisis being a sign of temporary worsening of the underlying condition. Repeat attempts, then, are not inevitable,<sup>15</sup> but when present, they are associated with future attempts. Because of the nature of SMI, participants who withdraw themselves from studies of suicide prevention may be more likely to die by suicide than people who stay in the study. This complicates the ability of the researchers to evaluate the effects of interventions and potentially could bias the results in unforeseen ways.<sup>1,21</sup>

There are many issues with universal screening. First, most screens have two parts. An initial screen identifies populations that might be at risk, along with those that have suicidal ideation. Screening at this level is easy to do with existing personnel. (See Table 2.) A secondary, more time-consuming screen then is needed, requiring more resources than are available in some settings. In addition, there need to be resources for follow-up in the community or by telepsychiatry. Although this sounds daunting, many institutions have created effective programs.<sup>27</sup>

As with universal screening for any condition, if a screening program is not designed to fit within the

ED's workflow, it may not perform adequately. Some patients also will not answer questions honestly. These factors must be considered with the early data suggesting that screening identifies people with occult suicide ideation<sup>13,17</sup> without negatively affecting ED flow.<sup>28</sup>

The strongest known risk factor for suicide is a recent suicide attempt. Approximately 1% of adults and adolescents who go to an ED because of intentional self-injury will die by suicide within three months of their index visit. Retrospectively, 15% of people who die by suicide have gone to the ED for intentional self-injury within the previous year.<sup>29</sup> In one study, about half of patients who visited an ED and were diagnosed with deliberate self-injury did not have documentation of a mental health assessment during their visit and were discharged home.<sup>30</sup> Consequently, some researchers have argued that the ED is the prism to focus on high-risk populations and potentially provide suicide prevention efforts concentrating on this period of high risk.<sup>8,30</sup>

## ED Approach

Suicidal patients and, to a lesser extent, those who engage in deliberate self-harm present with a severe mental pain or "psychache," according to Edwin Shneidman, a preeminent suicidologist. He argued that "suicide occurs when the psychache is deemed by [an individual] to be unbearable."<sup>31</sup> He also labeled suicide as a "permanent solution to a temporary problem." The goal for the emergency physician (EP) is to recognize suicidal ideation, assess the degree of danger or threat, and establish a safe discharge plan. Understanding that suicidal ideation is a pain that needs to be assessed and managed like any other pain complaint can be helpful. It is also important to engage family, friends, and other caring contacts in the process who will support the individual post-discharge. Just as patients with physical pain are treated with analgesics, patients with emotional pain must learn to develop protective insights to avoid impulsive acts when the bad confluence is only temporary and the potential consequence is irrevocable. To save lives and maintain a caring rapport between doctors and their hurting patients, a

therapeutic connection needs to be forged in conversation.

Just as EPs should make clinical decisions to exclude subarachnoid bleed from the differential for patients experiencing the worst headache of their life, they should respond similarly to patients being evaluated for psychaches with positive screens for suicide risk. This also may help providers who are skeptical about suicide prevention in the ED or who may have biases against patients with mental illness.<sup>28</sup>

Establishing rapport will enhance communication and improve the patient's ED experience. Asking a patient about suicide ideation or plans does not trigger suicidal behavior,<sup>32</sup> and certain details elicited in direct conversation with patients may be useful for risk-stratification in the ED. Gaining early insights, first responder impressions, and concerns of friends and family at the scene and during ED triage intake is particularly important for EPs managing suicidal patients. Time spent gathering collateral information as part of due diligence also may help prevent premature case closure.

Important information may get lost. Patients may feel mounting scrutiny or stigma introduced by ED safety precautions or resist psychiatry holding procedures initiated on their behalf. This may lead patients to change their stories or deny their suicide ideation to gain ED discharge. In this common scenario, EPs must remain vigilant to avoid premature discharge. Obtaining informed consent from patients for contacting appropriate collateral sources is part of a best practices approach. However, the Health Insurance Portability and Accountability Act (HIPAA) allows clinicians to gather collateral information from the appropriate contacts without the patient's express permission only when the clinician believes the patient is a danger to self or others.<sup>33</sup>

## Focused Medical Assessment

Patients who present with new psychiatric symptoms should be medically "cleared." Patients with a history of psychiatric disease consistent with their current symptoms do not require such clearance. Medical clearance implies the

**Table 2. Some Resources for Initial Suicide Ideation**

American College of Emergency Physicians ICAR <sup>2</sup> E	<a href="http://www.acep.org/icar2e">www.acep.org/icar2e</a>
ED SAFE Patient Safety Screener	<a href="http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf">http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf</a>
Suicide Prevention Resource Center Patient Safety Screener	<a href="https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk">https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk</a>

removal of active medical illness as the etiology for psychiatric decompensation in patients with SMI.<sup>34</sup> Routine diagnostic testing is not recommended in medically asymptomatic patients.<sup>34</sup> Such testing has not been demonstrated to have clinical benefit<sup>35,36,37</sup> and adds to the cost of care. However, mental health consultants often request laboratory tests (i.e., drug of abuse screening, alcohol and drug level testing, and pregnancy testing for women) to document a baseline status for inpatient hospitalization or to facilitate transfer of patient care to outpatient settings like community-based treatment programs.

## Suicide Risk Assessment

Several risk factors exist for suicide, and individual factors are limited in predicting suicide in a person at a particular time. A large proportion of Americans have one of these suicide risk factors, but only a small proportion of them will make an attempt and even fewer will die by it.<sup>21</sup> Thus, the goal of a suicide risk assessment in the ED is to identify a treatment that is appropriate for the individual with suicidal ideation. Treatment interventions include full-spectrum options from discharge with outpatient follow-up to involuntary psychiatric admission. Although assessing risk is an inexact science, the goal is to incorporate the patients' history, current mental state, and home environment in conjunction with their specific suicidal thoughts or behaviors.

A small subset of patients with suicidal ideation can be managed by ED providers and discharged home without receiving a mental health consultation.<sup>38</sup>

Here, the analogous situation some authors apply is comparable to the use of decision rule-out algorithms in formulating their clinical judgment.<sup>39</sup> For example, with chest pain patients, EPs perform a clinical evaluation including history gathering to triage and then conduct a focused physical exam and diagnostic studies to risk-stratify patients comprehensively. They use their clinical judgment in taking the next steps to manage patients with provisional diagnosis and may incorporate a cardiology consultation when indicated. The lowest-risk patients in the clinical context of suicide may be those without a serious suicidal plan, prior suicide attempt, or history of SMI or substance abuse disorder, and with a normal mental status (without high levels of emotional distress) and no access to lethal means.<sup>38</sup>

For example, a 50-year-old, employed, Catholic registered nurse and recent empty nester is experiencing an initial episode of depression with vague suicidal thoughts. She indicates she has a strong support network and attends church every Sunday where she also teaches Bible school. She says she would not kill herself because she considers it to be a mortal sin. Of note, in a recent large prospective cohort of 89,708 U.S. nurses with 1,528,538 person-years of follow-up, researchers noted a substantial inverse association between frequent attendance at religious services and suicide risk. The women in the study who attended religious services one or more times per week had a suicide risk that was more than fivefold lower than the women who never attended services

(hazard ratio, 0.05; 95% confidence interval [CI], 0.006–0.48).<sup>40</sup> Hence, this patient would not require an emergency mental health consultation.

A resource titled Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments, created with input from multidisciplinary experts, supports the decision of providers to forgo consultation in low-risk cases.<sup>38</sup> The guide contains a decision support tool of six questions that can be used to document medical decision-making and assess if a mental health consultation is indicated.<sup>38</sup> When universal screening is used, such tools may be beneficial in assessing risk among those who screen positive.

However, the majority of patients in the ED with suicidal ideation need a comprehensive risk assessment to determine decision-making about treatment and disposition. Clinical sobriety and cognitive capacity for decision-making are prerequisites for meaningful patient participation in the assessment process. A particular blood or breath alcohol level has not been correlated with the timing of a valid psychiatric evaluation in the literature. Traditionally, psychiatry often delays consultation until the patient's blood alcohol level is below 100 mg/dL. However, this practice is not evidence-based, and in some patients can precipitate withdrawal seizures. Conversations between psychiatry services and the ED staff about when patients are sober enough for evaluation, outside of the acute event, may establish appropriate guidelines for care. The lack of active intoxicants in the blood and qualitative detection of other substances from urine testing may help identify the existence of substance use disorder and/or medical nonadherence that may have treatment and disposition implications.

Patients who present with suicidal thoughts and concomitant intoxication and then recant suicidality when sober present a frustrating challenge for EPs, especially because patients with chronic alcohol or substance use may visit the ED frequently. Acute and chronic alcohol use increases the risk of suicide. More than one-third of those who die by suicide drink alcohol prior to death,<sup>41</sup> and adults with a substance use disorder

**Table 3. Some Resources for Evaluation of Suicidal Risk**

SAFE-T	<a href="https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432">https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432</a>
Columbia-Suicide Severity Rating	<a href="http://cssrs.columbia.edu/">http://cssrs.columbia.edu/</a>
Ask Suicide-Screening Questions (ASQ)	<a href="https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml">https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml</a>
Beck Scale for Suicidal Ideation	<a href="https://www.commondataelements.ninds.nih.gov/doc/noc/beck_depression_inventory_noc_link.pdf">https://www.commondataelements.ninds.nih.gov/doc/noc/beck_depression_inventory_noc_link.pdf</a>
Motto's Risk Estimator	<a href="http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Marilyn/Motto1985.pdf">http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Marilyn/Motto1985.pdf</a>

often attempt suicide after thinking seriously about it and making a plan.<sup>42</sup> Consequently, the most conservative approach is to observe patients who are intoxicated until they become sober enough for a comprehensive suicide risk assessment. More research in this area is needed.

Mental health consultants (i.e., psychiatrists, psychologists, nurse practitioners, and social workers) typically perform comprehensive assessments. These consultants typically have additional training and time to evaluate patients. However, EPs have the final say on ED disposition. The consultations may occur either in person in the ED or remotely through electronic communication (i.e., telepsychiatry).<sup>38</sup> Decisions regarding consultations may be site-specific and depend on available resources.

If mental health consultation is not readily available, the ED provider can use one of several tools designed to assess risk of suicide in patients with ideation. (*See Table 3.*) The Suicide Assessment 5-step Evaluation and Triage (SAFE-T)<sup>43</sup> is a free tool, in various formats (pocket card and mobile application),<sup>43,44</sup> that helps primary care and behavioral health providers integrate suicide prevention strategies. It also guides providers through a stepwise evaluation of a patient's risk and protective factors and the specifics of the

suicidal thoughts or plans to estimate overall risk. Even when the EP is not completing the comprehensive assessment, the SAFE-T domains provide useful reminders about specific questions to ask patients.

The Columbia-Suicide Severity Rating Scale (C-SSR) can be used for in-depth screening and assessment in adults and adolescents. A screening version is available that truncates the three-page, evidence-supported scale for use in ambulatory settings.<sup>45</sup>

Although The Joint Commission, issued a Sentinel Event Alert recommending that all medical patients be screened for suicide risk in February 2016, valid suicide risk screening tools either have not been validated or have relatively low sensitivity and specificity. Few have been tested in the emergency setting and fewer have been tested in adolescents. However, screening tools may assist clinicians to detect who is at risk and who needs further intervention.

Since 2008, the National Institute of Mental Health (NIMH) led a multisite study to develop and validate a suicide risk screening tool for youth 10-24 years of age in the medical setting. The Ask Suicide-Screening Questions (ASQ) consists of four yes/no questions and takes about 20 seconds to administer.<sup>46</sup> (*See Figure 1.*) Screening identifies individuals who require further mental health/suicide safety assessment. In an

NIMH study, a "yes" response to one or more of the four questions identified 97% of youth (age 10-21 years) at risk for suicide (sensitivity 96.9%, specificity 87.6%).<sup>47</sup> The ASQ is a validated four-item screening tool that exists in the public domain, is free of charge, and is available in multiple languages. It is recommended that suicide screening be conducted without the parent/guardian present if possible.<sup>48</sup> Parents/guardians may benefit from provider reassurance and recent evidence that shows asking youth about suicidality does not increase the likelihood of suicide.<sup>32,49</sup>

## What Happens if Patients Screen Positive?

In the ED setting, one of the most significant barriers to screening is how to manage the patients who screen positive effectively and efficiently. EDs should develop plans to manage patients who screen positive for suicide risk. The ASQ Toolkit was developed to assist with this management plan. Patients who are found to be at risk (positive screens) should receive a brief suicide safety assessment (BSSA) conducted by a trained clinician to determine if a more comprehensive mental health evaluation is needed. The BSSA should guide what happens next in the ED.<sup>46,47</sup> For any patient who screens positive, regardless of disposition, EPs should review the screening questionnaires and have final authority to determine the proper and immediate course of treatment. All patients screened and assessed comprehensively should be given suicide resources that detail suicide prevention interventions widely considered to be evidence-supported best practices.<sup>39</sup>

## Implementing Immediate Action and Safety Planning

Patients in acute suicidal crisis should be kept in sight and safe within the ED. When possible, one-to-one observation can protect patients from self-harm until the formal evaluation is complete. When feasible, keep suicidal patients awaiting psychiatry consultation in private rooms and, when available, in a dedicated psychiatric emergency area within the ED, outfitted with constant

**Figure 1. Ask Suicide-Screening Questions (ASQ)**



## Suicide Risk Screening Tool

NIMH TOOLKIT

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead?  Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  Yes  No
3. In the past week, have you been having thoughts about killing yourself?  Yes  No
4. Have you ever tried to kill yourself?  Yes  No

If yes, how? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  Yes  No
- If yes, please describe: \_\_\_\_\_

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
  - "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a **STAT** safety/full mental health evaluation.  
Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a brief **suicide safety assessment** to determine if a **full** mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)



6/13/2017

Source: National Institute of Mental Health

surveillance capability. Ensure that possible anchor points for hanging, such as IV poles and overhead room equipment, are removed. Have security staff conduct personal searches and secure street clothes (elopement risk), possessions, or materials that can be used for self-injury.<sup>50</sup> Some typical ED paraphernalia that have been used in suicides include items such as drawstrings on hospital clothing, bandages, sheets, bell cords, belts, laces, cloth restraints, plastic bags, and IV or oxygen tubing.<sup>50,51,52</sup>

Being disrobed and placed in paper scrubs may be traumatic to the patient and likely will impair rapport. Therefore, ED providers should try to de-escalate or calm agitated patients verbally first and use restraints as a last resort. Having clearly articulated protocols to limit violence toward staff caring for these individuals and to protect the patients from self-harm and loss of dignity is the best way to maintain a safe and therapeutic healthcare environment.

For patients at lower risk of suicide, make personal and direct referrals to outpatient behavioral health and other providers for follow-up care within one week of initial assessment,<sup>38</sup> when possible. Often, timely resources are not available for low-risk patients. Consider providing the National Suicide Prevention Lifeline number (1-800-273-8255 [TALK]) at a minimum.

## ED-Based Interventions/Treatment

Suicidal patients have long lengths of stay either awaiting ED evaluation or psychiatric hospitalization. From 2006 to 2013, the rate of ED visits related to suicidal ideation among adults increased by 12% on average annually. By 2013, 1% of all adult ED visits involved suicidal ideation. At-risk patients were more likely to be male, 18–64 years of age, and uninsured or covered by Medicaid.<sup>53</sup> The vast majority of ED visits (78.6%) related to suicidal ideation resulted in either admission to the same hospital or transfer to another hospital or facility. One-fourth of ED visits (26.9%) related to suicidal ideation resulted in routine discharge.<sup>53</sup>

Brief ED interventions may be helpful in preventing future self-harm, particularly for patients being discharged

home. Recommended interventions center on helping patients develop skills to recognize and cope with suicidal thoughts, including action plans for making their home environments safer and for identifying sources of help and emotional support. Templatized materials and other resources exist for each of the example interventions discussed.<sup>39</sup>

ED patient education and joint safety planning should include customized plans with warning signs, follow-up, and emergency contacts.<sup>38,54</sup> Safety planning is not to be confused with “contracting for safety,” which is a discredited concept and no longer is recommended.<sup>55</sup> Safety planning uses a graduated approach to help patients identify mechanisms for coping and taking the initiative with seeking help during crises. The plan initially completed on paper then can be stored in a free mobile application (e.g., MY3 or Suicide Safe).

Discharged suicidal patients need rapid referral for outpatient follow-up care because the days following discharge from the ED are a high-risk period for them.<sup>6</sup> During this period, it can be especially difficult to provide continuity of care.<sup>56,57</sup> Research has shown in the majority (60–90%) of cases, individuals referred to community-based resources do not access them.<sup>54</sup> However, making an appointment before the patient leaves the ED and enlisting help from friends and family to follow up may ensure compliance.<sup>58</sup>

Patients with suicidal ideation should not have easy access to means that may be used in suicide attempts, such as firearms or other weapons, household chemicals or poisons, or materials that can be used for hanging or suffocation.<sup>59</sup> There is evidence that counseling by providers to reduce home access to lethal means can affect home storage behaviors<sup>60</sup> and is acceptable to patients.<sup>61</sup> Suicidal acts often are impulsive<sup>62</sup> and evolve during transitory crises.<sup>63</sup> The lethality of the chosen method becomes the independent variable on which survival depends.<sup>64</sup> Guns have the highest suicide case-fatality rate (greater than 90%),<sup>65</sup> and many studies have shown both an association between gun access and suicide risk.<sup>66</sup> Safe gun storage (i.e., locked, unloaded, and

ammunition inaccessible) can mitigate this risk.<sup>67,68</sup> State “gag laws” do not prohibit physicians from asking suicidal patients about gun access.<sup>69,70,71</sup>

While mass shootings grab headlines, they account for only a small fraction of the 30,000 gun deaths each year in the United States. More than two-thirds are suicides.<sup>71</sup> Yet since 1996, a budget amendment law has restricted how much the CDC can focus on gun ownership as the risk factor in suicides and mandates that “none of the funds made available for injury prevention and control at the CDC may be used to advocate or promote gun control.”<sup>70</sup> Notwithstanding, ED providers should counsel all suicidal patients and get patient commitment to store firearms out of harm’s way (e.g., at a gun shop, police department, relative’s home gun safe) during a crisis. Gun cabinets or lock boxes at home may be reasonable alternatives only if the patient does not have access.

Since there is no biological marker for suicide risk, clinicians cannot exclude the diagnosis of acute suicidality in the ED in most patients. Providers also cannot admit all the non-low-risk suicide patients identified during various decision instruments for risk stratification. Strictly adhering to tight follow-up (less than one week), counseling to reduce home access to lethal means (e.g., firearms, toxic medications), and prioritizing family participation to secure the safest environment for the patient in the interim period cannot be overemphasized.

Psychotherapy is one of the most effective treatments to reduce the risk of attempting suicide. The most commonly studied psychotherapy intervention is cognitive behavioral therapy<sup>72</sup> and related approaches, including problem-solving therapy and developmental group therapy. Although most of these treatments are not administered by providers in the ED customarily, patients can be referred to behavioral health providers, possibly collaborating in the active care and dispositional planning of the at-risk ED patient.<sup>72</sup>

## Disposition

Patients in acute crisis with moderate to high suicide risk routinely are

admitted for psychiatric inpatient hospitalization. In this instance, voluntary admissions is preferred when possible. But involuntary hospitalization ("emergency commitment") may be required. EPs should adhere to their state laws, which vary substantially in definitions, length of commitment, and other requirements that apply beyond EMTALA mandates.

Often, there is a wait for an inpatient bed. Emergency Medical Treatment and Labor Act (EMTALA) violations and subsequent fines can stem from the care of psychiatric or behavioral health patients in the ED. In June 2017, the Office of Inspector General (OIG) imposed the largest monetary penalty in EMTALA history on a South Carolina hospital for allegedly failing to appropriately stabilize psychiatric patients presenting to the hospital's ED.<sup>73,74</sup> In this case, the hospital provided inpatient psychiatric care with psychiatrists but did not accept involuntary patients. Those patients were kept in the ED for days to weeks, waiting for an inpatient bed. During that time, the inpatient psychiatrists did not provide consultation to the ED, and the ED did not initiate treatment. Because the patients were held involuntarily, they were presumed not to be stabilized. Under EMTALA, the OIG determined that the hospital was obligated to provide care to those psychiatric patients held for long periods of time because they had those services available.

Some interpreted this as a statement that EPs could not stabilize a patient with mental illness. However, the OIG asserted that no treatment was given to the patients who waited up to 38 days in the ED. And, since they were waiting to be admitted, they were "unstable." Therefore, the hospital was under obligation to provide what services they could to those patients.

This ruling should not be interpreted as requiring EPs to initiate treatment if they do not feel adequately trained to provide such care. However, given the growing problem of mental health in the ED, coupled with new fast-acting medications on the horizon, EPs should consider improving their mental health diagnostic and therapeutic skills.<sup>74</sup> If

psychiatric services are available, they should be used.

Most patients identified as being at low current risk of suicide can be managed as outpatients, depending on available ED and outpatient resources. These patients should be discharged to supportive, safe environments without access to guns or lethal medications. Multiple methods of engaging patients after discharge from the ED have been shown to reduce subsequent suicidal behaviors. Caring contacts<sup>39</sup> (which include phone calls, letters, or email messages to facilitate brief supportive conversations), case management contacts, and protocols that combine different services appear to decrease suicide attempts and deaths.<sup>75</sup> Overall, the existing literature is insufficient to recommend widespread adoption of any individual strategy or protocol. However, providing psychosocial and emotional support to patients with an identified suicide risk after they are discharged from the ED is feasible and may reduce suicidal behaviors. Templates for providing supportive outreach using different modalities now exist, and these may help guide the ongoing development and widespread adoption of more effective and less costly solutions.<sup>39</sup> All patients should be given the number for the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) a nationwide, free telephone and online chat resource with crisis guidance, connection to local resources, and special services for veterans.

## Conclusion

ED providers can help prevent future injury and death in suicidal patients. Focused medical assessment and suicide risk assessment help determine whether a mental health consultation is required and whether patients need hospitalization. Brief ED interventions — including counseling about reducing access to firearms and toxic medications — are beneficial and feasible, particularly when additional staff are available. Understanding how ED-based interventions can provide enhanced support and reduce suicidal behavior in at-risk, discharged patients is an important area of ongoing research.

Although several organizations have established initiatives to achieve a zero suicide rate, the concept is controversial and likely not achievable. Various clinical decision support tools have been identified to assess for suicide risk. However, no tool can reliably predict future behavior for all patients. The ultimate responsibility for the assessment and disposition of a patient with suicidal ideation lies with the treating provider. This responsibility and, therefore, liability, may be shared with the EP and a consulting psychiatrist, both of whom share expertise in assessment and disposition of patients with mental illness. Beyond the clinical assessment, safe discharge planning also involves assessment of non-clinical factors, such as social support from family and friends, housing, transportation, safeguarding lethal means, and facilitating access to appropriate outpatient resources. The lack of any of these factors could contribute to the risk of suicide. Given that suicidal patients have long lengths of stay, clinicians should consider the use of assessment tools and deploy ED-based interventions while documenting carefully to mitigate medicolegal risks.

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- c. There are structural changes in the brain that underlie suicide risk.  
d. All patients with suicidal thoughts require emergency hospitalization.
4. Which of the following is a positive modulator for preventing suicide?
    - a. Perceived immediate support network
    - b. Planning for the future
    - c. Participating in weekly religious services
    - d. All of the above
  5. Who is more likely to die by suicide?
    - a. 20-year-old men
    - b. 20-year-old women
    - c. 50-year-old women churchgoers
    - d. 40-year-old married men
  6. What is the term for the preventive method of limiting access to lethal means?
    - a. Cognitive therapy
    - b. Limited liability
    - c. Community action initiative
    - d. Controlling the environment
  7. Which of the following causes more deaths in the world today?
    - a. Suicide
    - b. Homicide
    - c. AIDS
    - d. Traffic accidents
  8. Which of the following is *not necessarily* a suicide warning sign?
    - a. Having a plan for suicide
    - b. Having the means available for a stated suicide plan
    - c. Self-cutting behaviors
    - d. Saying, "I'm going to kill myself"

## CME/CE Questions

1. In which age group is suicide most prevalent?
  - a. 5-10 years of age
  - b. 16-30 years of age
  - c. 40-50 years of age
  - d. 50-65 years of age
2. Which of the following statements is true?
  - a. Nearly 90% of suicide attempts among youth are unknown to parents.
  - b. Guns have the lowest suicide case-fatality rate (< 10%).
  - c. State "gag laws" prohibit doctors from asking suicidal patients about gun access.
3. Which of the following statements is *false*?
  - a. Asking patients about suicidality increases the likelihood of suicide.
  - b. A previous suicide attempt is the best marker of a future attempt.



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# EMERGENCY MEDICINE **REPORTS**

## Suicide Assessment and Disposition

### **Populations at Higher Risk for Suicide**

- People 10-34 years of age
- Veterans
- Indigenous tribes
- People with serious mental illness
- People with prior suicide attempts
- People recently released from inpatient care for suicidal ideation/attempts
- People with recent serious illness or emotional distress
- People with a history of recent trauma or loss
- People with alcohol or substance use
- Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) population

### **Some Resources for Initial Suicide Ideation**

American College of Emergency Physicians ICAR <sup>2</sup> E	<a href="http://www.acep.org/icar2e">www.acep.org/icar2e</a>
ED SAFE Patient Safety Screener	<a href="http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf">http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf</a>
Suicide Prevention Resource Center Patient Safety Screener	<a href="https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk">https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk</a>

### **Some Resources for Evaluation of Suicidal Risk**

SAFE-T	<a href="https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432">https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432</a>
Columbia-Suicide Severity Rating	<a href="http://cssrs.columbia.edu/">http://cssrs.columbia.edu/</a>
Ask Suicide-Screening Questions (ASQ)	<a href="https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml">https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml</a>
Beck Scale for Suicidal Ideation	<a href="https://www.commondataelements.ninds.nih.gov/doc/noc/beck_depression_inventory_noc_link.pdf">https://www.commondataelements.ninds.nih.gov/doc/noc/beck_depression_inventory_noc_link.pdf</a>
Motto's Risk Estimator	<a href="http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Marilyn/Motto1985.pdf">http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Marilyn/Motto1985.pdf</a>

## Figure. Ask Suicide-Screening Questions (ASQ)



Ask the patient:

1. In the past few weeks, have you wished you were dead?  Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  Yes  No
3. In the past week, have you been having thoughts about killing yourself?  Yes  No
4. Have you ever tried to kill yourself?  Yes  No

If yes, how? \_\_\_\_\_

When? \_\_\_\_\_

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  Yes  No

If yes, please describe: \_\_\_\_\_

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - "Yes" to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a **STAT safety/full mental health evaluation**.  
Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - "No" to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)



6/13/2017

Source: National Institute of Mental Health

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