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AHC Media

Practical Management of the Suicidal Patient in the Emergency Department

Many of us have known someone, a relative, a colleague perhaps, who has attempted or died by suicide. Most of the time these tragedies come as a surprise. There are often few indicators that the person was contemplating taking his or her life.

It is often difficult to determine which patients are suicidal, especially if they are really intent on dying, and those who are simply making statements to attract attention. The new Joint Commission standard calls for extended if not universal screening for suicide ideology. Their intention is well-meaning; the literature suggests that many patients who later attempt suicide come to the emergency department (ED). However, many of these patients come to the ED for non-mental health reasons. Further, with more than 100 million visits per year, the ED simply sees a lot of patients and could theoretically be used to screen for anything.

Screening is one thing, but there then needs to be a plan for patients who screen positive. Current mental health resources are completely overwhelmed in most communities, particularly for the uninsured and those without adequate coverage. Adding more patients to a system that is already overflowing into our emergency departments will jeopardize care for many.

Finally, mental health procedures are legally more complex than physical health issues. Clearly there are legal implications if we discharge a patient who later harms himself. There are also implications, legally and emotionally, if we detain a patient against his or her will. Further, the rules regarding detention vary by state and may even mandate release of a patient who is not transferred to an inpatient facility within a set timeframe.

— Sandra M. Schneider, MD, Editor

Introduction

Although rarely discussed as a major mortality factor such as cancer and heart disease, suicide is nonetheless one of the top 10 causes of death in the United States.¹ Further, those with elevated suicidal risk may comprise a significant percentage of individuals presenting to emergency departments; thus, to increase detection, prevention, and treatment of suicidality, emergency departments would appear to be an ideal location for enhanced assessment of dangerousness to self.² Recognizing this, The Joint Commission created National Patient Safety Goal (NPSG) 15.01.01 in 2010, which requires “behavioral health care organizations, psychiatric hospitals, and general hospitals treating individuals for emotional or behavioral disorders to identify patients at risk for suicide.”³

This NPSG has raised controversy in numerous EDs for several reasons. First, it is unknown how many patients visit an ED as opposed to their primary care clinic before suicide.⁴ Second, there are legitimate concerns among emergency clinicians that the detention of a subset of patients for additional mental health

Executive Summary

- Recently The Joint Commission created a new standard, which calls for the identification of ED patients who are suicidal. This is based, in part, on the fact that a significant proportion of patients who die by suicide are seen in the ED in the months prior to their suicide. However, many of these patients are seen for non-mental health reasons.
- When a patient presents with suicidal ideation, attention to the patient's safety, as well as to their acquaintances and the ED staff, is paramount. Patients should be searched for weapons and placed in a prepared room without potential weapons.
- The initial evaluation should attempt to identify high-risk factors, such as substance abuse, feelings of hopelessness or purposelessness, and a plan.
- Use of a contract to prevent suicide has not been 100% effective. It is suggested that discharged patients should develop a "safe plan" of action should they have suicide ideation in the future.

evaluations, solely due to the results of universal screening, could potentially escalate overcrowding and delays in emergency departments. Finally, there has been no research showing reduced mortality from universal screening in the ED.⁵

The fact that a majority of patients visit a primary care provider before suicide has been well documented. A meta-analysis of 40 such studies concluded that the vast majority of patients had visited a primary care provider within one year of suicide, and 20% had contact with mental health services in the month before their suicide.⁶ Although practice patterns for suicide evaluation can vary widely in U.S. emergency departments, there is reason to believe that the ED has been an important identification point for patients, albeit with varying levels of sensitivity and specificity.⁷ One study indicated that 39% of patients who died by suicide in Leeds, England, from 1994-1999 had presented to an emergency department within 12 months.⁸ Another study by Kemball and colleagues indicated that only 25% of patients who disclosed suicidal ideation when asked had any mention of this noted on the chart, and only 10% were admitted or transferred to psychiatric services after their ED visit.⁹

Rationale for Knowledge of Suicide Assessment by Emergency Clinicians

Although the ED may have a pivotal role for patients with thoughts

of self-harm, training for emergency clinicians in this area has been scant. In part, this is because specialized training on behavioral crises is a relatively new concept; indeed, training in any behavioral emergencies was almost non-existent before the 19th century.¹⁰ Prior to this, individuals with mental illness, when treated by physicians at all, were typically cared for by general practitioners with little expertise in psychiatry.

Unfortunately, the situation has not improved much in modern times, with most emergency physicians also receiving little or no formal training in behavioral emergencies, despite the increasing numbers of psychiatric patients who present to a typical general emergency department.¹¹⁻¹³ This suggests an imbalance between patient demand and expert availability for treatment, and also suggests a possible explanation for the low concordance rates between emergency medicine clinicians and psychiatrists about the appropriate disposition for patients with behavioral emergencies.¹⁴

Despite the lack of formal residency training in suicide assessment, emergency clinicians now should add these skills for at least two reasons. First, despite the increasing number of psychiatric patients, not all EDs have consistent access to mental health specialists. In one study by Baraff et al (2006), 23% of emergency department directors stated that suicidal patients in their ED were occasionally discharged without an evaluation by a mental health

professional, and 8.5% reported that this was done 10% of the time or more.⁷ Second, even if emergency clinicians are fortunate enough to have 24-hour access to mental health professionals, many of these are not physicians, and emergency clinicians must be able to judge the soundness of consultant recommendations before admitting or discharging a patient in their care.

The following manuscript, therefore, written in cooperation with experts from the American Association for Emergency Psychiatry, will present the fundamentals of suicide assessment. The focus of this review is for the benefit of the emergency clinician. No formal training in suicide or mental health assessment is assumed.

Initial Approach to the Patient with Suicidal Ideation

Proper planning for suicidal patients in the ED starts prior to any patient arrival. The ED has been termed the "de facto option for initial identification and treatment of suicidal patients," and so it should have a system in place to identify these patients early, preferably at triage.¹⁵ Once patients are identified as being at risk for self-harm, they should not be returned to the waiting room unsupervised; instead, they should be placed in a specially prepared patient room within the emergency department. This space should be free of the normal array of sharp

medically oriented tools found in the average ED room, and should allow for easy visualization of patients at all times. Ideally, this room should also be readied in advance so as to save patients the humiliation of watching staff “prepare their area” by removing all objects.

Clinicians or safety staff should ask patients about any weapons or medications that they may have on their person. Even though the suicidal patient is in a more controlled environment, there still may be significant risk for the patient who is firmly set on dying; unfortunately, suicides completed by patients within the ED are far too common.¹⁶ If the patient does have medications from home, these should be secured prior to leaving the patient alone in the room.

Next, the emergency clinician should make a rapid assessment of provider safety. Although many suicidal patients are withdrawn or quiet, patients who are suffering from hallucinations, mania, alcohol intoxication, or drug intoxication may be agitated and aggressive. Patients who are agitated and who have a history of violence may become dangerous; in fact, a history of violence is the best predictor for future violence. Staff should be cautious with any such patients, particularly if they have ever been violent in health care settings.¹⁷ If the patient has not already been through a screening process, providers should rapidly ascertain if the patient brought any weapons (or objects that could be used as weapons) to the emergency department, and ensure any that are discovered are removed. Some facilities routinely ask such patients to pass through a metal detector or wand them for metallic objects.

During the initial screening, patients should be asked about thoughts of harming others, which can often accompany suicidal ideation. If a patient is determined to be a danger to others as well as self, the patient should be isolated from individuals to whom they might cause harm.

After ensuring provider safety, emergency clinicians next should

perform a rapid but thorough medical assessment. If the patient has already attempted to end his or her life, resuscitative measures take priority. The ABCs (airway, breathing, circulation) should be managed first, bleeding controlled, and life-threatening toxidromes treated immediately. Sometimes, a patient wishing to end his or her life may not be forthcoming about an ingestion. Careful attention will need to be paid if overdose is suspected.

Unfortunately, a tension often exists between emergency clinicians who wish to expedite these steps of triage, medical assessment, and resuscitative measures and patients who may be frightened by the large numbers of ED staff who are suddenly assessing them. If the patient suddenly decides to leave, the emergency clinician may be called upon to perform a quick assessment of the patient’s capacity for decision-making and whether some other form of hold is required (see “Discharging the Patient with Suicidal Ideation”). In general, although slightly more time-consuming, it is best to use finesse instead of force in these situations: Introduce the clinicians by name, reassure the patients that they are safe and no harm will come to them, explain why additional staff is needed, and let the patient know what will be happening.

Restraints and Involuntary Holds for Patients with Suicidal Ideation

Most suicidal patients who present to the ED have come voluntarily and will not need to be restrained if they try to leave. In most cases, these patients will stay with some reassurance about the process. Occasionally, patients who are violent toward others, imminently violent toward themselves, or are unable to make decisions may require some form of restraint. Most ED clinicians are quite familiar with the concept of restraining patients, and the benefits of doing so often might seem obvious.¹⁸ However, many ED clinicians

may not be so familiar with the controversy surrounding the use of restraints.¹⁸⁻²⁰

The use of restraints has been discouraged by most medical and professional societies. Although the complication rate of restraints in one prospective study was low, restraint-related injuries were the seventh most frequently reported event to The Joint Commission.²⁰⁻²¹ In addition, although there are no studies that support the use of restraints, there are by now a number of studies documenting the harm of this practice.²²⁻²⁵ Finally, patients who have had a history of traumatic assault, especially rape, have noted that being restrained caused feelings of re-victimization.²⁶ As a result, many nursing organizations, most psychiatry organizations, and a recent expert consensus panel from the American Association for Emergency Psychiatry have called for limiting the use of restraints to exceptional circumstances, and only as a last resort.²⁷⁻²⁹

If restraints are used, they are acceptable only in an emergency situation in which there is an immediate danger to self or others. Emergency clinicians have been successfully sued for restraining patients when only a minor probability of harm exists and for not documenting that less restrictive interventions were tried first.³⁰ Restraints cannot be used on patients who are merely loud or disruptive, who refuse medication, or simply to aid in undressing patients who refuse to get unclothed.^{18,31} Patients who are restrained must be observed according to applicable regulations and hospital protocol, with frequent reassessments.

Emergency clinicians may also sometimes be asked to place suicidal patients on an involuntary mental health hold. Although state statutes for mental health holds vary, most courts have held that adults who are not under conservatorship have a fundamental right to refuse even needed treatment, as long as they do not pose a serious risk of harm to themselves or others in the near future.³¹ If a patient is placed on an

Table 1: Warning Signs of Imminent Suicide³⁸

IS PATH WARM?

- Ideation
- Substance abuse
- Purposelessness
- Anxiety
- Trapped
- Hopelessness
- Withdrawal
- Anger
- Recklessness
- Mood changes
- ? You must ask

involuntary hold, the clinician should know and follow all local and state regulations regarding this practice. Although emergency physicians have occasionally been sued for involuntary detention of patients, this is rarely successful unless the clinician fails to follow appropriate laws or does not document the case well.³⁰ In most cases, courts have found that safety, related to the imminent danger the patient posed, outweighed the liberty interest set forth in the Constitution.

Initial Psychiatric Assessment

Although it has been fairly consistent that approximately 11.3 United States citizens per 100,000 will die by suicide, it has proven extremely difficult to accurately predict which individuals will do so.³² For every suicide death, the United States Centers for Disease Control and Prevention reports that approximately 11 more suicide attempts have occurred, although some sources cite much higher numbers in the range of 10-20 attempts per suicide death.^{1,33} In part, the complexity of suicide prediction is increased by the necessity of assessing a large number of potential risk factors (suicide risk assessment), as well as the ambiguity of compiling these data into a general opinion about the degree of suicidal risk (suicide risk formulation). For mental health clinicians, the exact art of suicide risk assessment and formulation is honed over the course of training and

experience in the specialty. As noted above, most emergency medicine physicians do not have this training and experience as part of their residency. Even if they have been able to acquire such a skill set, there is rarely enough time for an attending to conduct a thorough suicide assessment in a busy ED. Consequently, emergency clinicians should mostly err on the side of caution by obtaining expert consultation for all but the lowest risk patients (see “Who Is a Low-risk Patient?”).

Although the exact method of establishing suicide risk may vary from provider to provider, most mental health clinicians believe this is best determined by performing a structured evaluation of three domains: assessment of current suicidal thoughts, assessment of risk factors, and assessment of protective factors.³⁴ These three domains are then combined, using professional judgment, into a final formulation of risk.

Of note, several major organizations have sponsored a risk-assessment tool that takes the clinician through this process and aids in the formulation and disposition. The tool is called the Suicide Assessment Five-step Evaluation and Triage (“SAFE-T”). It was specifically designed for mental health professionals, but may be helpful to have as a resource. This pocket-card resource reminds the busy clinician of the major risks and protective factors and questions to use in the suicide inquiry.³⁵ (*For more information, see reference 35.*)

New standards by The Joint Commission recommend the identification of patients at risk for suicide among the patients who seek care in the ED. While many patients who later attempt suicide are seen in the ED prior to their act, many of them are not seen for a mental health issue.

The first step after identifying a patient at risk for self-harm is to place the patient in a “safe” room away from potential weapons and rapidly screen for safety concerns for the patient, staff, and other individuals. Restraints are used only when necessary and then documentation should be adequate.

Patients should be asked about feelings of hopelessness, suicidality, past suicide attempts, substance abuse, and whether they have a plan for completing their suicide.

Contracts with patients regarding future suicide attempts have not been 100% effective. Instead, patients who are discharged should have a written “safe” plan, which outlines what they can do if they start to feel suicidal.

Notably, not all mental health professionals agree with this model. Some argue that clinical assessment, focusing solely on the treatment needs of patients, is more important than perceived risk formulations.³⁶ Some providers also incorporate more information than that contained in a traditional risk assessment. Depending on the mental health provider, this assessment may involve various unique factors, such as intuition, experience, and familiarity with the patient.³⁷ In a system with mental health clinicians who rely solely on a clinical assessment for evaluation, emergency clinicians may find it difficult to accurately predict what their mental health colleagues would have done for a particular patient. Thus, more rather than less expert consultation may be required, and emergency clinicians should defer to the practice standard at their institution.

If patients are evaluated with a traditional structured assessment, this typically begins by asking about

Table 2: Important Selected Risk Factors for Suicide

- Presence or absence of a plan
- Lethality of the plan
- Presence of a weapon at home
- Psychosocial stressors
- Previous attempts and their lethality
- Presence of hopelessness
- Presence of psychosis
- Family history of suicide or mental illness
- Physical illness
- Demographics: older than the age of 65 years, males, Caucasian
- Current psychiatric diagnosis
- Previous psychiatric history: depression or a personality disorder

Table 3: Important Selected Protective Factors

- Religious beliefs around suicide
- Life satisfaction
- Good social/family support
- Ability to cope with stress
- Responsibility to children or pets
- Future planning/goals

current suicidal thoughts. Effective, targeted questions to ask include “Have you ever felt that life was not worth living?” or “Have things reached the point where you’ve thought of harming yourself?”³⁸ If the patient answers yes, clinicians should inquire about a plan and ask about the availability of weapons. Subsequent questions to ask include “Have you made a specific plan to harm or kill yourself? What does the plan include?”³⁸

Patients may have suicidal thoughts that involve a plan, but do not include any real intent to act on the plan. It is important to understand the patient’s intent to act, such as by asking “I hear that you wish you were not alive and can imagine overdosing on pills; how likely are you to do this?” Clinicians should ask about precipitating factors by asking “What led up to these thoughts? What happened afterward?” It is also very important to ask about previous self-harm behaviors and attempts. The clinician should specifically focus on lethality of previous suicide attempts, which have been found to be a strong indicator of future lethality.³⁸

Next, clinicians should evaluate risk factors. These are typically divided into chronic (also called baseline or non-modifiable) and acute (or potentially modifiable) factors. This method of appraisal has been likened to the assessment of myocardial infarction.³⁹ Not every elderly male with a past medical history of diabetes and hypertension will have a myocardial infarction, for instance, but an individual male with this past medical history (baseline risk factors) who presents to the ED with chest pain and shortness of breath (acute signs) should be carefully assessed, even if his symptoms initially are somewhat atypical.

Perhaps by training, emergency clinicians often focus on acute factors instead of chronic or baseline risk factors.⁴⁰ Along these lines, the American Association for Suicidology has put a high priority on recognizing particularly concerning acute factors, termed warning signs. Warning signs have been defined as a “detectable observation that is associated with, hence suggests, heightened risk for suicide in the near-time (i.e., within hours or days).”⁴¹ Patients displaying any of these warning signs

in Table 1 should be considered to be at significant risk.

Hopelessness is a particularly concerning sign, typically assessed by the question “Do you think that things are ever going to get better?”³⁸

The complete list of risk factors for suicide includes numerous factors, with the last American Psychiatric Association guideline on suicide risk assessment listing several dozen. Many of the important risk factors for suicide that are often ascertained during a standard ED history and physical examination are listed in Table 2.

In psychological studies of patients who have died by suicide (the so-called “psychological autopsy”), a vast majority met criteria for a mental disorder.⁴² Studies have shown that approximately 90% of suicide completers have a psychiatric diagnosis at the time death.⁴³⁻⁴⁴ In particular, a psychiatric diagnosis of depression is an important risk factor.⁴⁵ Mood disorders,⁴⁶ substance-use disorders,⁴⁷⁻⁴⁹ psychotic disorders,^{46,48} and borderline personality disorder⁴⁹⁻⁵⁰ all elevate risk. Anxiety disorders also increase risk of suicide, particularly if occurring with depression.⁵¹⁻⁵² Incidentally, one underappreciated risk factor may simply be seeking treatment at an emergency department. Crandall et al noted that the suicide rate for patients seen in the emergency department for suicidal ideation, self-harm, or overdose were 5.8 times as likely to die by suicide as other patients.⁵³

One other important and frequently noted acute risk factor in the ED is substance abuse. Most ED clinicians are quite familiar with alcohol-intoxicated patients who present with thoughts of self-harm. Complicating their assessment, it is often difficult to obtain a good history from intoxicated patients. Consequently, emergency clinicians should wait until the patient is sober enough to provide a good history before assessing suicidal intent. The exact definition of “sober enough” is frequently a matter of contention between psychiatry and emergency clinicians. However, the American

Table 4: The Modified SAD PERSONS Score

Factors	Points
S Sex: male	1
A Age: < 19 or > 45 years	1
D Depression or hopelessness	2
P Previous attempts or psychiatric care	1
E Excessive alcohol or drug use	1
R Rational thinking loss	2
S Separated/divorced/widowed	1
O Organized or serious attempt	2
N No social supports	1
S Stated future intent	2

Table 5: The Manchester Self-Harm Rule

- Any history of self-harm
- Previous psychiatric treatment
- Benzodiazepine use in attempt
- Any current psychiatric treatment

College of Emergency Physicians' clinical policy on assessment of psychiatric patients in the ED recommends that "the patient's cognitive abilities, rather than a specific alcohol level, should be the basis on which clinicians begin the psychiatric assessment."⁵⁴

Alcohol use elevates the risk of self-harm, particularly when the patient's thinking process is impaired, or if the patient becomes more impulsive while drinking. However, studies have indicated that alcohol use also elevates the risk of self-harm even when patients are not intoxicated.⁴ In one study of 298 patients with alcohol-use disorder, 19% had a history of at least one suicide attempt.⁵⁵

As the patient sobers, thoughts of self-harm often abate. However, even though these patients may be sober and completely denying suicidal thoughts, it is important to refer patients for substance-abuse treatment and counseling upon discharge, especially if the clinician thinks that the patient is likely to resume drinking.

Many patients with thoughts of self-harm may be poor historians, even if their thinking process is not impaired by alcohol or other drugs.

As such, collateral information from family, friends, outpatient providers, and/or past medical records should be used, and are considered an important part of suicide risk assessment. Close family members or other loved ones may provide a distinctly different history than that provided by the individuals themselves, especially if a patient still wishes to die by suicide. The suicidal patient may minimize past treatment, attempts, and current symptoms. Emergency clinicians, therefore, should use all available sources of information, as well as asking a patient for the phone numbers of close friends or relatives, before discharging a patient with suicidal ideation. Reluctance of a patient to give out contact information for any family or friends should be of concern. (See "Discharging the Patient with Suicidal Ideation.")

Some factors may decrease the risk of suicide.⁵⁶⁻⁵⁷ As the third step of the suicidality evaluation, clinicians should assess the presence of protective factors, some of which are noted in Table 3. There should be caution around the idea that being "religious" is, in and of itself, a protective factor. In fact, it is the belief system around suicide that is the important aspect. Some beliefs include hell or

purgatory for those who die by suicide, while others believe that God is understanding and forgiving about the act. This second interpretation, as might be imagined, does not deter suicide, while the former can be a compelling mitigating factor preventing suicide.

After assessment of the factors in Tables 2 and 3, the formulation of risk is undertaken by weighing the balance of factors. Risk and protective factors should not be considered one-to-one, or "balancing each other out." Instead, the clinician will need to weigh the importance of each in making a safety formulation.⁵⁶⁻⁵⁷ Based on the perceived level of risk, the clinician will also need to weigh several factors when determining whether to admit the patient, especially if the admission is involuntary. If the patient is deemed to be imminently dangerous to self, admission or further observation is clearly necessary. It is much more of a difficult situation when the patient has vague or moderate suicidal thoughts, a plan but no current intent, and mixed risk and protective factors. Specialists in mental health should be brought in for these cases to assist in making the final decision on disposition.

Other factors to weigh in determining need for hospitalization include judging whether the inpatient stay would be beneficial in reducing the patient's risk of suicide (especially if the patient is chronically suicidal), or whether it would be more harmful in terms of such things as lost pay at work, expensive hospital bills, social stigma, and the coercion involved in involuntary hospitalization.

Use of Screening Tools

Given the large numbers of potential risk factors and the observation that some variables (such as hopelessness and ideation with specific lethal means) are weighted more heavily in risk assessment, much research effort has attempted to develop simplified scoring systems for suicide prediction. In general, these efforts have failed to produce a scoring instrument that is perfectly predictive of

imminent suicide. Most current scoring systems indicate heightened risk of suicide, but are not sensitive enough to detect which particular individual high-risk patients will attempt suicide.⁵⁸

Some ED researchers have taken the opposite approach, namely the development of scoring systems that identify patients at lowest risk of suicide (see “Who Is a Low-risk Patient?”). Although this approach has generally been more successful, existing scoring systems have not been developed for this purpose. Although multiple screening tools exist, two current systems, the modified SAD PERSONS score (see *Table 4*) and the Manchester Self-Harm Rule (see *Table 5*), have been proposed specifically for use in the emergency department. The modified SAD PERSONS score incorporates 10 criteria for assessment of potential suicidal patients with differential weighting for each factor. Both the modified SAD PERSONS and the original SAD PERSONS scale on which it is based have shown poor predictive value for future suicide attempts.⁵⁹

In a 1988 article, however, Hockberger and Rothstein showed that patients with suicidal ideation who had a score of 6 or more were consistently hospitalized by the UCLA Department of Psychiatry.⁶⁰ This rule, although limited by the practice of a single center, correctly categorized patients with a sensitivity of 94% and a specificity of 71%. This may indicate that the rule performs better on categorizing low-risk patients for ED discharge than it does for predicting suicide in higher-risk patients. However, it remains to be seen through further research if this scale can be generalized to other types of patients or institutions.

The Manchester Self-Harm Rule, comprised of four questions, was designed to determine the risk of suicide within six months in patients presenting after self-harm.⁶¹ In the validation cohort, the rule performed impressively well, with a sensitivity of 94% and a specificity of 25%. However, like the modified

SAD PERSONS score, the rule may have limited generalizability. In the Manchester derivation cohort, benzodiazepine overdose was a significant predictor of eventual suicide. This is not true of other localities, such as the United States, where firearms are the most common method of suicide. Further, in cities like San Diego, only a small number of individuals who have died by suicide test positive for benzodiazepines at autopsy.⁶² In addition, the Manchester Self-Harm Rule does not include other important risk factors such as those in *Table 1* or most in *Table 2*.

At the current time, clinical risk scores such as these cannot predict suicide in an individual, and a particular score should not be used to justify admission to the hospital.⁵⁸ There are several groups investigating better assessment tools. There is also some early work on biomarkers.⁶³

Who Is a Low-risk Patient?

If the definition of a high-risk patient depends on the formulation of risk after careful assessment of a number of variables, which factors predict a low-risk patient? In other words, are there any patients whom emergency clinicians can discharge without a time-consuming wait for a mental health consultation?

Although the exact answer to this is controversial, with some clinicians advocating for a full risk assessment in all mental-health patients, some guidelines for the discharge of extremely low-risk patients can be proposed for the emergency department. In general, an extremely low-risk patient has either no desire or very vague desire for self-harm, does not have a lethal plan for self-harm, has no weapons at home, is not hopeless, is optimistic and making future plans, has not made previous suicide attempts, and is able to engage with the interviewer. Conversely, patients who attempt to conceal information from the interviewer or who have impaired thinking because of psychosis or substance

use should be presumed to be at higher risk. Of course, consultation should be obtained for all patients in whom the ED clinician cannot effectively establish that the risk is very low, or if the clinician feels any degree of uncertainty.

Who Gets Hospitalized?

The exact method of combining variables obtained in a suicide risk assessment into a suicide risk formulation is complex, and can vary by practitioner (see “Initial Psychiatric Assessment”). In general, patients hospitalized for suicidality are the opposite of low-risk patients, and are individuals who are at near-term risk for self-harm. This of course leaves a large continuum of patients in the middle. These patients may have some risk factors or may have a chronic waxing and waning level of suicidal ideation. Mental health consultants are particularly useful for these patients, and may be able to offer many types of support other than hospitalization, such as brief interventions, crisis housing, acute diversion units, or expedited mental health appointments.⁵⁷

Discharging the Patient with Suicidal Ideation

Discharge of the patient with suicidal ideation can sometimes be ethically challenging. For instance, when is it appropriate to allow a patient with thoughts of self-harm to make decisions about his or her own care? When can these patients be trusted to leave against medical advice without further structured care for their thoughts of self-harm? Should suicidal patients be restrained or placed on involuntary holds to prevent their leaving the emergency department?

In general, when deciding whether a suicidal patient is able to leave the ED, the same standards as for other patients should be applied. Although competency is a legal determination, capacity is a clinical concept that refers to the patient’s ability to make decisions about their medical care. In order to be considered capable, patients must have a factual

understanding of the nature of the proposed treatment, the risks of that treatment, and alternatives to treatment.

Informed refusal implies that the patient understands the consequences of refusing that treatment, and is able to rationally weigh the risks and benefits of rejecting care. Unless there is a clear reason to believe that the patient's decision-making capacity is impaired in some way, patients should be allowed to make choices about their situation. Simply put, is the patient capable of understanding the benefits of, and the risks of refusing, the proposed treatment? If so, the patient has capacity to refuse, just as any non-psychiatric patient has the ability to decline even what might be considered necessary treatment.³¹

Patients who are deemed to have decisional capacity may not be restrained or placed on involuntary holds for refusing treatment unless they are determined to be at imminent risk of harming themselves or others (see "Restraints and Involuntary Holds for Patients with Suicidal Ideation").

There is sometimes a temptation upon discharge to "contract a patient for safety," i.e., have patients sign a written contract stating that they will not harm themselves. In general, contracts for safety are neither safe nor good contracts. Many patients have attempted suicide after signing safety contracts, and such contracts have been dismissed by both courts and legal analysts.⁶⁴

Instead, providers should help a patient formulate a good safety plan prior to discharge. Safety plans should be written by the patient and attempt to identify coping strategies that the patient can use when starting to feel unsafe. This plan could include listening to music, watching television, taking a walk, calling a family member or friend, or calling a support line. The American Association of Suicidology recommends specific, clear discharge information to include education about suicide, including warning signs, increased risks of suicide following

discharge, the need for medication and taking this as directed, the need for stopping intoxicating substances, and the risks of having weapons available.⁶⁵ This information should be provided in written form if possible. Phone numbers to support lines or suicide hotlines should be given with discharge instructions as further support. The patient should also be told to return to the ED with return or worsening of symptoms, especially if there is a safety concern.

Finally, the individual should be assessed for the potential of harm to others. If the patient is dangerous to a particular individual, then clinicians have a duty to warn the person or persons involved. As with other laws, various states have interpreted this mandate differently, and the clinician should have an understanding of local statutes.⁶⁶

Conclusions

Given the increasing numbers of mental health patients coming to emergency departments, and the common lack of access to mental health professionals, emergency clinicians need to understand the basics of suicide assessment. In the ED, identification of patients at risk for suicide should begin early, preferentially at triage. This requires institutional support so that once identified, patients can be promptly diverted into "safe" rooms that do not contain objects that could be used as weapons, nor access to medications nor poisons.

Providers should rapidly make an assessment of safety as part of, or before commencing, medical evaluation. It should be recognized that most suicidal patients are not imminently dangerous, do not require restraint or locked seclusion, and are capable of making decisions about their own treatment.

Once medical evaluation is complete, clinicians should perform a basic psychiatric assessment. This assessment, using collateral information from family and others if possible, should include the presence of suicidal ideation, the nature of any plans for suicide, the lethality of that

plan, level of intent to act on the plan, and delineation of precipitating factors that led to suicidality. In general, emergency clinicians should err on the side of caution by obtaining mental health consultation for all patients who are not definitively low risk.

Discharge of patients with suicidal ideation from the ED should involve a good patient safety plan. Contracts for safety may not be appropriate, but emergency clinicians should involve family or friends in the discharge process to further support the patient and the safety/discharge plan. Patients should always feel welcome to return to the ED as necessary.

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CME Questions

1. Which of the following statements is true?
 - A. A majority of patients visit a physician before suicide.
 - B. About half of the patients visit a physician before suicide.
 - C. Less than half of the patients visit a physician before suicide.
 - D. Very few patients visit a physician before suicide.
2. Which of the following statements is most true?
 - A. Proper assessment of a suicidal patient often takes intensive staff resources so that it can be done quickly.
 - B. Proper planning for a suicidal patient should start before the patient even arrives.
 - C. Suicidal patients always disclose thoughts of self-harm, usually to nursing staff, if they are being seen in the ED.
 - D. Physicians should avoid asking friends or family for information about the patient.
3. Which of the following statements is most true?
 - A. In general, medications are often required for suicidal patients in the ED.
 - B. In general, restraints are often required for suicidal patients who attempt to leave the ED without completing a full psychiatric assessment.
 - C. In general, involuntary mental health holds are always required for suicidal patients who attempt to leave the ED without completing a full psychiatric assessment.
 - D. A suicidal patient should be mostly sober before completing a psychiatric assessment.
4. One good way to approach the topic of suicide with patients is by asking which of the following questions?
 - A. "Have you reached the point where you've thought of harming yourself?"
 - B. "Have you thought about suicide?"
 - C. "Have you thought about death?"
 - D. "Why did you come to the ED today?"
5. Warning signs of imminent suicide include which of the following?
 - A. psychosis
 - B. presence of a weapon at home
 - C. hopelessness
 - D. physical illness
6. Risk factors for suicide include which of the following?
 - A. age older than 50 years for women, age older than 65 years for men
 - B. responsibility to pets
 - C. life dissatisfaction
 - D. previous serious attempts
7. Protective factors for suicide include which of the following?
 - A. age older than 50 years for women, age older than 65 years for men
 - B. responsibility to pets
 - C. life dissatisfaction
 - D. previous serious attempts
8. Which of the following is true?
 - A. Suicide risk assessment and suicide risk formulation are an exact science.
 - B. When performing a traditional risk assessment, clinicians often count the number of risk factors and the number of protective factors. If there are more protective factors than risk factors, the patient is safe for discharge (and vice versa).
 - C. When performing a traditional risk assessment, clinicians often weigh risk factors and protective factors. If protective factors outweigh risk factors or if protective factors outweigh the harm caused by psychiatric hospitalization, the patient will likely be discharged.
 - D. When performing a traditional risk assessment, clinicians often ask questions in four domains.

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CME Objectives

Upon completion of this educational activity, participants should be able to:

- recognize specific conditions in patients presenting to the emergency department;
- apply state-of-the-art diagnostic and therapeutic techniques to patients with the particular medical problems discussed in the publication;
- discuss the differential diagnosis of the particular medical problems discussed in the publication;
- explain both the likely and rare complications that may be associated with the particular medical problems discussed in the publication.

9. Which of the following is most true?
- A. Screening tools are recommended to help the clinician remember to ask all of the important questions in suicide assessment.
 - B. Screening tools may be useful in identifying patients at higher or lower risk of suicide, but cannot be used to justify hospital admission.
 - C. Screening tools have been shown to reduce mortality by catching patients at the earliest stage of self-harm thoughts.
 - D. Several selected screening tools have been shown to have excellent predictive value when identifying individual patients who will commit suicide.
10. Which of the following is most true?
- A. Informed refusal involves the following elements: factual understanding of the procedure or treatment; risks of the procedure or treatment; and alternatives to the procedure or treatment.
 - B. Courts often defer to decisions by emergency clinicians regarding competency.
 - C. Suicidal patients may be restrained if they do not wish to comply with needed treatment to prevent self-harm.
 - D. Mental health patients, by virtue of their disease, are often presumed not to have clear decision-making capacity.

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