



Commonwealth of Massachusetts  
Board of Registration in Medicine  
**Quality and Patient Safety Division**

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**SUICIDE RISK ASSESSMENT IN THE EMERGENCY DEPARTMENT**

May, 2014

**Background**

The Quality and Patient Safety Division (QPSD) has received a number of Safety and Quality Review (SQR) reports of patient events associated with suicidal ideation and self-harm during and after hospital emergency department (ED) visits. This Advisory is issued to support health care facilities in the review and development of their protocols for assessing patients for suicide risk and initiating appropriate behavioral health (BH) referrals. While some references are provided, this Advisory does not include a comprehensive review of the literature; nor is it intended to provide specific recommendations for evidence-based practice.

Publication of this Advisory does not constitute an endorsement by the Board of any studies or practices described in the Advisory and none should be inferred.

**Overview**

Approximately 5 million patients with behavioral or psychiatric emergencies present to U.S. EDs annually, with roughly 590,000 visits for intentional self-harm.<sup>1</sup> Suicide is one of the most frequently reported hospital events to The Joint Commission, with 8% occurring in the ED.<sup>2</sup> Furthermore, 40% of people committing suicide have had ED visits within the last year, often for non-psychiatric complaints.<sup>3</sup>

Timely identification of at-risk patients in the ED requires appropriate screening of patients for suicide risk, and subsequent actions and protocols to keep patients safe. Barriers include busy EDs, limited BH resources, inadequate staff education, and complex patients with subtle or absent signs or symptoms of suicidal ideation. Boarding of ED patients for hours or days while waiting for appropriate transfer to inpatient psychiatric facilities frustrates patients and staff and may increase the risks for self-harm. A multidisciplinary, multifaceted approach to screening, patient safety and timely BH consultation should reduce the risk for patient self-harm in the ED or after discharge.

**Case Example and Lessons Learned**

A patient was brought to the ED for suicidal ideation. The ED nurse did not assess the patient as at risk or needing observation, and left the room to give report. In her absence, the patient attempted suicide using a cord that was in the room.

The hospital's internal review identified several gaps, including: staffing patterns; lack of a safe room; hand-off of care; and assessment of risk of self-harm. An algorithm for assessment and precautions for

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<sup>1</sup> Caterino, JM et al. Evaluating Current Patterns of Assessment for Self-harm in Emergency Departments: A Multicenter Study. *Acad Emerg Med* 2013; 20:807-815.

<sup>2</sup> The Joint Commission. A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department. *The Joint Commission Sentinel Event Alert*, 2010; 46.

<sup>3</sup> Caterino, op. cit.

BH patients was developed, as well as a plan for expediting medical clearance for BH patients. A sitter pool for ED patients was established to ensure observation until cleared by the BH service.

### **Areas for Health Care Facility Systems Review**

The areas described below provide topics and references as support for internal discussion and review of health care facility Emergency Department suicide risk protocols.

- 1. Risk Assessment/Screening:** Consistent suicide risk assessment/screening protocols and practices are key to a comprehensive approach to keeping patients safe during and after ED visits. Given the typically low rates of outpatient follow up, the identification of and intervention with high-risk patients while in the ED is important.<sup>4</sup> Recognizing and addressing barriers to screening will help to improve staff compliance and detection of at-risk patients.
  - Medical providers may avoid the topics of self-harm and suicidal ideation due to biases such as the associated stigma, prior clinical experiences, lack of time and/or resources, or skepticism regarding the preventability of suicide.<sup>5</sup> Many providers report comfort in screening patients for suicidality, but fewer feel confident in their skills to assess suicide risk, create a safety plan, or provide brief counseling.<sup>6</sup>
  - Only 0.6% of ED adult visits are for overt suicidal ideation and self-harm attempts, yet studies have shown that rates of suicidal ideation in adult ED patients range from approximately 3–12%.<sup>7</sup>
  - The stigma of mental health disorders and suicide in various cultural groups may make eliciting information about suicidal ideation and past attempts more challenging.<sup>8</sup>

**How Best to Screen?** While limitations have been found in the effectiveness of triage screening,<sup>9</sup> safety/suicidality screening in the setting and format most appropriate for each facility will offer the opportunity for help to all patients.

There are a number of screening tools that can provide valuable clinical information and context, but cannot reliably predict suicide in the individual patient (variable positive predictive values).<sup>10</sup> Electronic Health Record (EHR) systems often include standard templates that should be evaluated and modified as needed. (References for screening tools are included at the end of this Advisory.)

**High Risk Patient Characteristics:** Awareness of the characteristics of patients at higher risk for suicide can help ED staff screen more effectively and initiate independent action to keep patients safe. Many patients who commit suicide in general inpatient units do not have a personal history of suicide

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<sup>4</sup> Horowitz, LM et al. Suicide Screening in Schools, Primary Care and Emergency Departments. *Curr Opin Pediatr*. 2009 October ; 21(5): 620–627.

<sup>5</sup> Betz, ME et al. Knowledge, Attitudes, and Practices of Emergency Department Providers in the Care of Suicidal Patients. *Depression and Anxiety*, 2013; 30:1005-1012.

<sup>6</sup> Ibid.

<sup>7</sup> Allen, MH et al. Screening for Suicidal Ideation and Attempts among Emergency Department Medical Patients: Instrument and results from the Psychiatric Emergency Research Collaboration. *Suicide and Life-Threatening Behavior* 2013; 43(3):313-323.

<sup>8</sup> Suicide Prevention Resource Center and SPAN USA. David Litts, editor. *Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead*. 2010. Newton, MA: Education Development Center, Inc. Accessed 03/27/14 at [http://www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture\\_Fullbook.pdf](http://www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Fullbook.pdf)

<sup>9</sup> Caterino, op. cit.

<sup>10</sup> Cochrane-Brink, KA et al. Clinical Rating Scales in Suicide Risk Assessment. *General Hospital Psychiatry*, 2000; 22, 445–451.

attempts or psychiatric illness<sup>11</sup> and may be erroneously considered low risk. Particularly challenging are objective assessments for suicidality of patients who have frequent ED visits related to substance abuse and behavioral health issues.

- Suicide is one of the top 5 leading causes of death between the ages of 15-54.<sup>12</sup>
- The highest risk for suicide is found in men 75 years of age and older.<sup>13</sup> Older adults give fewer warnings and apply the chosen method with greater planning and resolve.<sup>14</sup>
- Risk factors include: male gender, substance abuse, previous suicide attempt, psychiatric diagnosis including depression, social isolation, lack of support systems, chronic pain or medical illness, and access to agents to inflict harm.<sup>15,16</sup>
- Warning signs of increasing desperation and risk of self-harm include: blunted affect, increased irritability/anxiety/agitation, refusing visitors or medication, and requesting early discharge.<sup>17</sup>

**2. Staff Education, Communication and Environmental Safety:** The Joint Commission has reported that the three most common factors related to inpatient suicide were environmental safety failures, patient assessment missteps, and staff and training issues.<sup>18</sup> EDs were designed for acute care medical and surgical patients and often require changes in staffing and physical plant to safely accommodate patients at risk for suicide.

- **Staff Education:** Many ED staff members, both clinical and lay (e.g. security), do not have adequate training regarding suicidality and patient safety. Training in psychiatric patient care can improve general understanding and care as well as improve patient safety.<sup>19,20</sup> For non-mental health professionals, The Joint Commission suggests mental health training programs such as Mental Health First Aid ([www.MentalHealthFirstAid.org](http://www.MentalHealthFirstAid.org)).
- **Communication:** ED providers and staff and the BH teams need to communicate regularly and effectively. Self-harm incidents can occur with inadequate patient assessment or reassessment, failure to communicate risk to other staff,<sup>21</sup> lack of available patient information and inappropriate care planning. It is important to break down provider, staff and BH team silos of care to ensure collaborative and complementary efforts for patient safety, and prompt evaluation and treatment. ED staff should be empowered to act independently and quickly when the potential for self-harm is detected.
- **Environmental Safety:** Safe rooms require that the patient can be observed clearly by staff, and

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<sup>11</sup> The Joint Commission, 2010, op. cit.

<sup>12</sup> CDC Suicide: Facts at a Glance Datasheet, 2012. Accessed 03/27/14 at [http://www.cdc.gov/violenceprevention/pub/suicide\\_datasheet.html](http://www.cdc.gov/violenceprevention/pub/suicide_datasheet.html)

<sup>13</sup> Ibid.

<sup>14</sup> Folse, VN et al. Suicide Risk Screening in an Emergency Department: Engaging Staff Nurses in Continued Testing of a Brief Instrument. Clin Nurs Res, 2009; 18:253-271. (citation to reference to another article, p 254)

<sup>15</sup> Manton, A. Care of the Psychiatric Patient in the Emergency Department, White Paper. Emergency Nurses Association, 2013.

<sup>16</sup> The Joint Commission, 2010, op. cit

<sup>17</sup> Ibid.

<sup>18</sup> Tischler, CL. Inpatient Suicide: Preventing a Common Sentinel Event. General Hospital Psychiatry, 2009; 31:103-109.

<sup>19</sup> Slade, MS et al. Best Practices for the Treatment of Patients with Mental and Substance Use Illnesses in the Emergency Department. Illinois Hospital Association, 2007. Accessed 03/27/14 at <http://www.aha.org/content/00-10/2007oct-ihabehavreport.pdf>

<sup>20</sup> The Joint Commission, 2010, op. cit.

<sup>21</sup> Mills, PD et al. Suicide Attempts and Completions on Medical-Surgical and Intensive Care Units. J of Hosp Med, 2013. Accessed 03/27/14 at <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2141/abstract>

that all objects with potential use for self-harm (e.g. wall cords, sharp instruments) and anchor points for hanging be removed or secured. Security features such as alarms, locks and breakaway hardware should be tested regularly.

- **Behavioral Health Consultation:** Prompt referral to BH teams should be initiated when patients present with suicidality or other mental health issues. Open and frequent communication should occur both within the BH team, and between BH providers, clinical providers and ED staff. Clear documentation will allow for smoother and safer transitions between care teams and staff at shift changes.
- **Medical Clearance:** The purpose of medical clearance is to determine whether or not a medical condition may be contributing to or causing a patient's psychiatric presentation. Diagnostic testing should be done as indicated by the history and physical<sup>22,23</sup> and the medical clearance process should be expedited to avoid delays in BH referrals.
- **Patient-Centered Care:** The Joint Commission recommends that providers engage the person at risk and his/her family in the care plan and decision-making.<sup>24</sup> The plan should include BH care after discharge. Certified peer support specialists or volunteers with similar life experiences can be offered during the ED stay. Effective "contracting for safety" requires a long-term relationship between the patient and the provider, is difficult after unsuccessful attempts and in dual diagnoses patients, and is therefore generally not an appropriate tool for use in the emergency department.<sup>25,26</sup>

### 3. Mental Health Services: Availability of Staff and Beds

Patients with a variety of behavioral health problems, including suicide risk, may be boarded in the ED for hours, days and even weeks awaiting appropriate placement. Due to the extended length of stay and acute care needs of other patients, ED boarders may suffer from decreased provider attention, intermittent BH team visits, communication break down during shift change and boredom; all potentially increasing the risk for self harm. The Joint Commission standards call for boarding times of less than 4 hours,<sup>27</sup> but the ED and the hospital may not have control over patient discharge to an appropriate inpatient unit. Health care facilities are encouraged to develop multidisciplinary care plans for these patients, to mitigate the impact of an extended length of stay in the ED.

### Conclusion

Emergency department staff and providers manage high volumes of patients with a wide variety of overlapping conditions including medical, surgical, psychiatric and substance abuse. Maintaining a heightened awareness of occult suicidal ideation and risk for self-harm is challenging, particularly as a brief lapse can have disastrous consequences for the patient and staff. To maximize patient safety and well being, EDs should develop consistently applied dynamic screening protocols, provide adequate

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<sup>22</sup> Meyer, D et al. Medical Clearance Task Force Consensus Statement by the Massachusetts Psychiatric Society and the Massachusetts College of Emergency Physicians Task Force (developed 4/2/01). Accessed 03/13/14 at <http://www.macep.org/files/medical%20Clearance%20taskforce%20consensus%20statement.pdf>.

<sup>23</sup> Lukens, TW et al. Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department. *Annals of Emerg Med*, 2006; 47(1):79-87.

<sup>24</sup> The Joint Commission, 2010, op. cit.

<sup>25</sup> Hoffman, RM. Contracting for Safety: A Misused Tool. *Pennsylvania Patient Safety Advisory* 2013; 10(2):82-84. Accessed 03/27/14 at [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2013/Jun;10\(2\)/Pages/home.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2013/Jun;10(2)/Pages/home.aspx)

<sup>26</sup> Zun, LS. Pitfalls in the Care of the Psychiatric Patient in the Emergency Department. *J Emerg Med*, 2012; 43(5):829-835.

<sup>27</sup> The Joint Commission. Patient Flow through the Emergency Department. R<sup>3</sup> Report, 2012; 4. Accessed 03/27/14 at [http://www.jointcommission.org/assets/1/18/R3\\_Report\\_Issue\\_4.pdf](http://www.jointcommission.org/assets/1/18/R3_Report_Issue_4.pdf).

training to all ED staff, maintain safe rooms, and foster prompt and clear communication within and between BH teams and ED staff and providers.

### **Additional References and Resources**

Fujisaw, D et al. The Development of a Brief Screening Instrument for Depression and Suicidal Ideation for Elderly: the Depression and Suicide Screen. *Psych and Clinical Neurosciences* 2005. 59, 634–638.

Horowitz, LM. Ask Suicide-Screening Questions (ASQ): A brief instrument for the pediatric emergency department. *Arch Pediatr Adolesc Med*. 2012;166(12):1170-1176.

Columbia-Suicide Severity Rating Scale (CSSRS): [http://www.cssrs.columbia.edu/about\\_cssrs.html](http://www.cssrs.columbia.edu/about_cssrs.html)

SAMHA-HRSA Center for Integrated Health Services BH/SA screening tools include SAFE-T and Suicide Behaviors Questionnaire (SBQ-R) <http://www.integration.samhsa.gov/clinical-practice/screening-tools#suicide>.

Institute of Medicine. Hospital-Based Emergency Care at the Breaking Point. Washington, D.C.: National Academies Press, 2007: [http://www.nap.edu/catalog.php?record\\_id=11621](http://www.nap.edu/catalog.php?record_id=11621).

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.  
<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>.

ED-SAFE is an ongoing multicenter study (including two MA hospitals) led by the University of Massachusetts, Worcester, which is looking at treatment as usual, universal screening, and universal screening plus follow up interventions. <http://clinicaltrials.gov/show/NCT01150994>

Agency for Health Care Research and Quality. Screening for Suicide Risk: A Systematic Evidence Review for the US Preventive Services Task Force. May 2004.  
<http://www.ahrq.gov/downloads/pub/prevent/pdfser/suicidser.pdf>

US Preventive Services Task Force. Screening for Suicide Risk. (update in progress).  
<http://www.uspreventiveservicestaskforce.org/uspstf/uspssuic.htm>