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Managing Suicidal Patients in the Emergency Department

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INTRODUCTION

Caring for emergency department (ED) patients with suicidal thoughts and behaviors is challenging, given time pressures, boarding of patients waiting for psychiatric beds, and the inherent difficulty in predicting imminent self-harm. However, providers—like patients—should not lose hope: most suicidal crises are short-lived and repeated attempts are not inevitable.¹ Not every ED patient with suicidal thoughts needs inpatient admission, or even a mental health consultation, and ED providers should take pride in their skills to care for this at-risk population.

IDENTIFICATION OF SUICIDAL PATIENTS

Approximately 10% of *all* adult ED patients, regardless of chief complaint, have recent suicidal ideation or behaviors,^{2, 3} but many will not disclose unless asked. The Joint Commission requires suicide screening and assessment for patients with primary emotional or behavioral disorders or presenting symptoms.⁴ This mandate could be fulfilled with targeted screening (e.g., all patients with mental health complaints) or universal screening (all ED patients). As in the case of screening for any condition, a program not designed to fit an ED's flow and culture may not perform, and there will be some patients who do not answer questions honestly. Early data suggest screening *does* identify people with otherwise hidden suicidal ideation⁵ without negatively impacting ED flow,⁶ and cost-effectiveness analyses are in progress. In this piece, we focus on management of suicidal ED patients, regardless of how they are identified.

Meetings: None

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GENERAL APPROACH

Suicidal patients are in acute emotional pain and, like patients in physical pain, deserve care that is empathetic and patient-centered. Small efforts, like explaining what to expect and providing basic comforts,^{7, 8} can improve the patient's experience. ED providers may be skeptical about the preventability of suicide prevention or may harbor biases against patients with mental illness,⁹ so providers should strive to overcome their own areas of discomfort. Establishing rapport through a sympathetic but direct approach can enhance communication with the patient and thereby also the quality of the assessment. Importantly, asking a patient about suicidal thoughts or plans does *not* incite or encourage suicidal behavior,¹⁰ and providers should ask specific questions about the nature and content of suicidal thoughts, as described below in greater detail.

Information from appropriate "collateral" sources is particularly important for suicidal patients; relevant sources include prehospital or police personnel, the patient's family or friends, or outpatient healthcare providers.^{10, 11} Asking the patient for permission enhances rapport, but an ED provider can make these contacts without consent when necessary to protect the individual or the public from an imminent and serious safety threat.¹²

SAFETY PRECAUTIONS

Patients being evaluated for suicidal thoughts or behaviors should not be allowed to leave the ED until the evaluation is complete¹³ and should be protected from self-harm while in the ED.^{14, 15} Typically, this includes placing the patient in a private room without access to potentially dangerous objects (e.g., belts, shoelaces, or sharp medical instruments).¹⁴ Mechanical or chemical restraints can be traumatic to the patient and impair rapport, so ED providers should first try to verbally de-escalate agitated patients (for example, by having extra personnel step out of sight and by engaging in collaborative, respectful conversation). Providers should advocate for a written ED policy concerning care of suicidal patients to clarify pathways and support provider actions, including use of constant observation, personal searches by security staff,¹³ or restraints.¹⁶

FOCUSED MEDICAL ASSESSMENT

A "focused medical assessment" – a term experts prefer over to "medical clearance,"¹⁷ which implies absence of medical issues– aims to identify medical issues requiring emergent or urgent treatment. A focused medical assessment relies primarily on the history and physical exam, including evaluation of the patient's cognitive and emotional status and identification of drug ingestion, trauma, or other medical conditions that may affect the patient's mental state. Routine diagnostic testing, including non-targeted laboratory or radiographic studies, has not demonstrated clinical benefit^{18–21} and is not recommended.¹⁷ However, mental health consultants often will request tests like toxicologic screens.

SUICIDE RISK ASSESSMENT

There are many risk factors for suicide; some are fixed and some fluctuate, and their strength and interaction varies among and within individuals. An ED suicide risk assessment

aims to determine appropriate treatment, including options across the spectrum from discharge with outpatient services to involuntary psychiatric hospitalization. Ultimately, risk assessment remains an inexact science, and the process should incorporate an individual's personal history, current mental state, home environment, and specific suicidal thoughts or behaviors.

A small subset of patients with suicidal thoughts or behaviors can be managed by the ED provider and discharged home without a mental health consultation.⁸ Analogous to the use of decision "rule out" algorithms for patients with chest pain, the emergency provider should ask initial questions to triage patients and then consult a specialist when indicated. Emergency physicians pride themselves in risk-stratifying patients for myriad physical conditions without consulting specialists for every patient potentially at risk. Similarly, we suggest emergency physicians take ownership (and pride) in identifying which suicidal patients do not require an emergent mental health consultation. These lowest risk patients are those with no suicide plan or intent, no prior suicide attempt, no history of significant mental illness or substance abuse, and no agitation or irritability (Figure 1). These patients are often already identifiable to experienced clinicians – as an example, a middle-aged woman with her first bout of depression and vague suicidal thoughts who says she has a strong support system and would not actually kill herself because of her religion. The new Suicide Prevention Resource Center ED Guide,⁸ developed with input from multi-disciplinary experts and the major emergency medicine organizations, supports providers' decision to forgo consultation in these low-risk cases. Specifically, the guide includes a six-question Decision Support Tool (Figure 1),⁸ which can be used to document medical decision-making justifying why a mental health consultation is or is not indicated. It may be especially useful in settings with universal screening, where there may be a larger volume of patients identified with low levels of suicidality.

The majority of suicidal ED patients, however, do need a comprehensive risk assessment to inform decision-making about treatment and disposition. For an adequate risk assessment, the patient should be cognitively able to participate; those intoxicated with alcohol or drugs should be observed and then have their cognitive capacity reassessed.^{8, 17} There are no data to support a particular blood alcohol level as the point at which a patient with normal vital signs and a noncontributory history and exam can undergo a psychiatric evaluation.¹⁷ However, as with urine testing, toxicologic screens may help mental health consultants in identifying concomitant substance abuse issues, so the issue merits discussion and collaboration. Patients who express suicidal thoughts when intoxicated and then deny them when more sober pose a particular and frustrating challenge, especially as patients with chronic alcohol or substance abuse may be frequent ED visitors. Both acute and chronic alcohol use raise the risk of suicide; over a third of suicide decedents use alcohol before their death,²² and adults with a substance use disorder are more likely to have serious suicidal thoughts, plans, and attempts.²³ While the most conservative approach is to observe intoxicated patients until cognitively able to participate in a comprehensive suicide risk assessment, more work in this area is clearly needed.

Comprehensive assessments are typically done by mental health consultants (e.g., psychiatrists, psychologists or social workers), who generally have both more training and

more time to spend with patients. ED physicians, however, retain final authority over and responsibility for discharge decisions. Consultations may be done either in person (by an on-site mental health specialist or one who comes to the ED on request) or remotely via electronic communication (“telepsychiatry”);⁸ decisions about consultations often depend on the ED environment and available resources. If a mental health consultant is not readily available, the ED provider can use the Suicide Assessment Five-step Evaluation and Triage (SAFE-T; Figure 2).²⁴ This tool, available as a pocket-card and smartphone application,²⁵ guides a provider through a step-wise evaluation of a patient’s risk and protective factors and the specifics of the suicidal thoughts or plans in order to estimate overall risk. Even when the ED provider is not completing the comprehensive assessment, the SAFE-T domains provide useful reminders about specific questions to ask patients.

ED-BASED INTERVENTIONS

Suicidal patients often have long ED lengths of stay while awaiting evaluation or psychiatric hospitalization. Brief ED interventions may be both therapeutic and helpful in preventing future self-harm, and they may be especially important for patients being discharged home. Recommended interventions focus on helping patients develop skills to recognize and cope with suicidal thoughts, including action plans for making their environment safer and for identifying sources of help. While interventions may be most effective when implemented as a bundle, local practices should be tailored to both need and feasibility.⁸ Templated materials and other resources exist for each of the example interventions discussed below (Table 1).⁸

Patient education and joint *safety planning* in the ED should include personalized plans with warning signs, follow-up, and emergency contacts.^{8, 26, 27} Safety planning is distinct from “contracting for safety”, which has not been shown to prevent suicide and is no longer recommended.²⁷ Safety planning uses a step-by-step approach to help patients identify mechanisms for coping and help-seeking during times of crisis. The plan can be completed on paper and then stored in a free smart phone app (e.g., MY3 or SuicideSafe). Discharged suicidal patients need *rapid referral* for outpatient follow-up care, as the days just after discharge from an ED are a high risk period. Making a specific appointment before the individual leaves the ED and enlisting help from family or friends may help ensure follow-up.²⁸

Counseling to reduce home access to lethal means (e.g., firearms and toxic medications) is an important aspect of ED care of suicidal patients. There is evidence that such counseling by providers can affect home storage behaviors²⁹ and is acceptable to patients.³⁰ The rationale behind means restriction is that suicidal acts are often impulsive³¹ and occur during short-lived crises,³² and that survival depends on the lethality of the chosen method.³³ Guns have the highest suicide case-fatality rate (over 90%),³⁴ and numerous studies have shown both an association between gun access and suicide risk,³⁵ and that safe gun storage (i.e., locked, unloaded, and separated from ammunition) can mitigate this risk.^{36, 37} State “gag laws” do not prohibit physicians from asking suicidal patients about gun access.^{38, 39} ED providers should counsel all suicidal patients and their families to store firearms off-site (e.g., at a gun shop, police department, or other legal option) during a crisis;

gun cabinets or locks at home may be a reasonable alternative as long as the patient does not have access.

DISPOSITION

For patients in acute crisis with moderate to high suicide risk, psychiatric hospitalization remains the typical disposition. In such cases, voluntary hospitalization is preferable when possible, in alignment with goals of collaborative, patient-centered care. When involuntary hospitalization (“emergency commitment”) is required, providers should adhere to their state laws, as these vary in definitions, length of commitment, and other requirements.⁴⁰

Patients whose risk for imminent suicide is deemed acceptably low can often be managed as outpatients, depending on ED and outpatient resources. Such patients should be discharged to supportive, stable environments without access to guns or lethal medications. *Caring contacts* (Table 1), brief telephone, email or mail contacts after discharge, appear to decrease suicide attempts and deaths.⁴¹ All patients should be given the number for the National Suicide Prevention Hotline (1-800-273-TALK [8255]), a national, free telephone and online chat resource with crisis guidance, connection to local resources, and special services for veterans.

CONCLUSION

Through an empathetic, evidence-based, and collaborative approach⁴⁹ to managing suicidal patients, ED providers can help prevent future injury and death. Focused medical assessment and suicide risk assessment can help providers determine if a mental health consultation is required and if the patient needs hospitalization. Brief ED interventions — including counseling about reducing access to firearms and toxic medications— may be both feasible and effective, depending on the ED environment and resources.. Suicide remains a leading cause of death in the United States, but ED providers have an opportunity to ease emotional pain and save lives.

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Figure 1. Framework for care and evaluation of suicidal patients in the ED

Intended for use with adult ED patients who do not require medical hospitalization for concomitant acute or chronic medical problems. Patients who are intoxicated or otherwise lacking in decision-making ability should be treated, observed, and reevaluated as clinically indicated. *See Figure 2. Adapted from Cappocia and Labre, 2015.⁸

Figure 2. Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

Risk assessment modified slightly^{42–44} from original SAFE-T.^{24, 25}

Table 1

ED-Based Brief Suicide Prevention Interventions

Intervention	Comments	Additional resources
Brief patient education	<ul style="list-style-type: none"> Goal: Instill hope of recovery, reduce shame and stigma Include: Diagnosis, home care, follow-up instructions, warning signs for return to ED or call to crisis line Use teach-back techniques and provide written version with community resources 	<ul style="list-style-type: none"> "After an Attempt," brochures for ED providers, patients, and family members (available from Substance Abuse and Mental Health Services Administration in English & Spanish: 45-47 http://store.samhsa.gov/home) "With Help comes Hope" support website: http://lifelineforattemptedsurvivors.org/
Safety planning	<ul style="list-style-type: none"> Structured plan to identify coping strategies and contacts 	<ul style="list-style-type: none"> One-page printable template: http://www.suicidesafetyplan.com Free mobile apps include <i>MY3</i> and <i>SuicideSafe</i>
Lethal means counseling	<ul style="list-style-type: none"> Goal: Reduce patient access to lethal methods (e.g., guns, toxic medications) Discuss options for safe storage with others or in home 	<ul style="list-style-type: none"> Detailed recommendations for clinicians: http://www.hsph.harvard.edu/means-matter/recommendations/clinicians/ Supported by American College of Emergency Physicians⁴⁸
Rapid referral	<ul style="list-style-type: none"> Follow-up appointment within 7 day, ideally 24 hours Troubleshoot barriers (e.g., transportation) to facilitate follow-up 	<ul style="list-style-type: none"> Template for developing community resource list available in Suicide Prevention Resource Center ED Guide⁸ Services locator (therapists and support groups): http://www.suicidepreventionlifeline.org/learn/therapy.aspx
Caring contacts (after discharge)	<ul style="list-style-type: none"> Brief communications (letter, telephone, text, email) to promote treatment adherence and feeling of connectedness May be automated or made by non-clinical staff 	<ul style="list-style-type: none"> Toolkit for phone call system: http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html Sample messages available in Suicide Prevention Resource Center ED Guide⁸

Note: Each of the above should also include crisis line information: 1-800-273-8255 and <http://www.suicidepreventionlifeline.org/> (online chat available)