Reducing Suicide Risk: Challenges and Opportunities in the Emergency Department

Marian E. Betz, MD, MPH; Matthew Wintersteen, PhD; Edwin D. Boudreaux, PhD; Gregory Brown, PhD; Lisa Capoccia, MPH; Glenn Currier, MD, MPH; Julie Goldstein, PhD; Cheryl King, PhD; Anne Manton, PhD, APRN; Barbara Stanley, PhD; Christine Moutier, MD; Jill Harkavy-Friedman, PhD*

*Corresponding Author. E-mail: JHarkavyFriedman@afsp.org, Twitter: @JillHF_AFSP.

Emergency departments (ED) are prime locations for identifying individuals at high risk of suicide and for making life-saving interventions. In an ideal scenario, all ED patients at risk of suicide could be identified and connected with effective, feasible interventions, and this would occur in a supportive system not overburdened by screening or assessment requirements. In this review, we focus on challenges to achieving this ideal—along with potential solutions—at the level of patients, providers, the ED environment, and the larger health care system. [Ann Emerg Med. 2016;–:1-8.]

INTRODUCTION

Suicidal ideation and behavior represent compromised mental health and can be fatal. When suicide occurs, multiple biological, psychological, social, and environmental contributors have converged in the context of access to lethal means, and often in response to 1 or more acute stressors. Risk fluctuates with time and circumstance, which means that a patient deemed nonsuicidal yesterday may require a fresh evaluation today. Unfortunately, many emergency department (ED) providers may not know or believe suicide can be prevented.1,2

EDs are prime locations for identifying individuals at high risk of suicide and for making lifesaving interventions. In 2014, 42,773 persons died by suicide in the United States3, and nearly 650,000 ED visits annually relate directly to suicidal behavior.4,5 Because access for screening and detection in the general population is difficult, EDs are an important and feasible setting for identifying and intervening with individuals at increased risk for suicide.6 A recent review summarized current evidence and best practices to assist ED providers in both recognizing patients at increased risk for suicide and implementing strategies to reduce risk.7 In an ideal scenario, all ED patients at risk of suicide could be identified and connected with effective, feasible interventions, and this would occur in a supportive system not overburdened by screening or assessment requirements. Here, we will focus on challenges to achieving this ideal—along with potential solutions—at the level of patients, providers, the ED environment, and the larger health care system (Table).

ED PATIENTS

Challenge: Identification of At-risk Patients

Individuals who die by suicide usually have a mental health or substance use disorder,8 often accompanied by behavioral and social problems that exacerbate suicide risk. However, not every person with a mental disorder has suicidal thoughts or behaviors,10 and approximately 40% of suicide decedents had previously visited an ED for nonpsychiatric chief complaints.11,12 Unfortunately, when individuals visit the ED for reasons other than mental illness or suicidal ideation or behavior, their suicide risk often remains undetected. For example, only 50% of suicide decedents who visited an ED within a year of their death had been recognized as having a mental health problem at their visit.13 Overall, approximately 6% to 10% of all adult ED patients, including those with a medical (nonpsychiatric) reason for their visit, are experiencing suicidal ideation.14-16 Prevalent suicide risk factors among general ED patients include depression (35%) and previous suicide attempts (13%).17 Persons with suicide risk may not speak about their mental health or suicidal ideation and behavior unless asked.

Identification of individuals at short-term risk of suicide is also difficult because suicide morbidity and mortality cut across all ages, income levels, educational attainment, geographic regions, and state of health. Suicide risk factors are present at both population and individual levels18,19 and can be static or dynamic over time. At the population level, particular groups with higher suicide risk include men (78% of all deaths), especially those who are white and aged 44 years and older3, adolescents3,20; veterans21; American...
Indian or Alaska Native male teenagers; persons with particular occupations (eg, agricultural workers, physicians, veterinarians, and attorneys); persons living in western regions of the country; youths and adults who identify as gay, lesbian, or bisexual; and persons with mental illness, disabilities, or chronic pain.

Both risk factors and warning signs—signals that a patient’s suicide risk is more immediate, such as having a suicide plan or making preparations for suicide—can help ED providers identify patients with higher acute risk. Nonetheless, given the myriad presentations and interactions among risk and protective factors, identifying risk without any type of screening among all ED patients is overly challenging. ED clinicians may also have a somewhat skewed picture of the face of suicide; when asked about their ED’s population of patients with suicide risk, some ED clinicians may think of patients who communicate their suicide risk as conditional, aimed at addressing unmet needs, secondary gain, or dependency needs. But malingering does not invalidate the existence of genuine medical and psychiatric conditions it feigns for secondary gain. Although challenging, this profile of patients also does not actually represent the dominant population of patients with suicide risk.

**Challenge: Assessing Level of Suicide Risk**

Once identified, patients with at least some level of suicide risk need a more comprehensive suicide risk assessment to more fully estimate their level of risk. Assessment of risk is based on the patient’s personal risk and protective factors and will assist with the determination of the most appropriate level of future care (such as inpatient or outpatient treatment). A comprehensive risk assessment is most often completed by mental health consultants (at the request of an ED provider) because they typically have more training and time to spend with patients. Unfortunately, mental health consultants may not be immediately available within the ED, requiring either transfer of patients or time spent waiting for a consultant to arrive. There are also brief interventions that can be conducted in the ED by staff.

The quality of the risk assessment depends on factors such as the clinician’s level of skill, the patient’s ability and motivation to disclose accurate and complete information, the degree to which there is access to other sources of “collateral” information (eg, medical record, family members), and the length of time available to conduct the assessment. In general, it is recommended that a risk assessment be conducted with all sources of information that are currently available. Documentation of medical decisionmaking, including the elements of a risk assessment, is important for communication and protection from liability.

**Potential Solution: Expanded Screening**

Expanded screening—an approach not without criticism—could help detect ED patients who present with nonspecialist complaints or concerns and yet may be at elevated risk. Such patients are a diverse group; they may present as an otherwise physically healthy older adult with a gardening injury, a Latina adolescent with strong family ties, or a middle-aged man with chronic pain, to list only a few examples. The goal of screening is to identify persons who may need further assessment of their mental health and current suicide risk, as well as short- or long-term intervention. Asking about suicide will not make someone suicidal. Rather, screening for suicide appears to be acceptable to ED patients with and without suicidal ideation, including pediatric patients and their parents, and gives an individual freedom and comfort to discuss personal struggles.

Some EDs have chosen to institute universal screening to comply with The Joint Commission’s (TJC’s) National Patient Safety Goal 15. The goal requires identification of “patients at risk for suicide” in psychiatric hospitals and for “patients being treated for emotional and behavioral disorders in general hospitals.” This mandate could likely be met by either universal or targeted screening (see below), given the potential complexity of defining “emotional and

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**Table.** Sample challenges and solutions to ideal care of suicidal patients in EDs, by level.

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<th>Level</th>
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<td>Limited outpatient mental health resources</td>
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behavioral disorders.” TJC previously suggested, but did not require, suicide screening in EDs. For identified patients, additional TJC performance elements include conducting a risk assessment, addressing the immediate safety needs and appropriate treatment setting, and providing suicide prevention information. The most recent TJC suggestion includes the assessment of risk for suicide, assessment of suicidal ideation and behavior, and integration of behavioral health care in clinical settings.

There are 2 primary approaches to detecting hidden suicide risk in the ED: universal and targeted screening. Universal screening, which seeks to screen all individuals who present for care regardless of the reason for presentation, is recommended by the Suicide Attempt Survivors Task Force of the Surgeon General’s National Action Alliance for Suicide Prevention and TJC. Recently, the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE), a multicenter pragmatic clinical trial of universal screening conducted within 8 EDs across the United States, demonstrated the feasibility of incorporating universal screening for suicide risk into clinical care. After training ED staff to conduct suicide risk screening, documented screening rates increased from 26% at baseline to 84% after the intervention. Across the sites, universal screening led to a nearly 2-fold improvement in suicide risk detection, with the proportion of patients identified with suicide risk improving from 2.9% to 5.7% among whole ED populations. Despite this nearly 2-fold increase in detection, the screening protocols did not appear to overwhelm the ED systems. All sites improved, although the ability of sites to implement universal screening varied, with implementation rates of 75% to 90%. In sum, universal screening can be implemented—although the best method of implementation needs to be determined—and leads to improved detection of suicide risk.

The effect of universal screening on suicide outcomes is not yet known, but analyses of ED-SAFE data are ongoing and should yield at least some answers. The goal is to reduce the rate of completed suicide after ED visits. The hope is that ED efforts, accompanied by efforts outside the ED, may lead to an overall reduction in suicide rates across the country.

The second approach, targeted screening, has not yet been formally tested. However, there are known risk factors that could be used to identify subgroups of patients for screening. These subgroups include, but are not limited to, patients with acute psychiatric symptoms; intoxication; past psychiatric ED visits or hospitalizations; evidence of nonsuicidal self-injury; aggressive, hostile, or violent behavior; highly stressful social conditions, such as homelessness; or chronic pain.

A number of suicide risk screening tools have been developed for use with adolescents and adults. Many are brief (eg, a few questions for administration by the primary nurse), but all current screening tools have limitations. Tools designed to identify individuals at risk with high sensitivity (missing as few at-risk individuals as possible) generally have low specificity (too many false-positive results). This can create work-flow challenges in the ED because of problems in regard to triage decisions and the potential number of referrals for mental health evaluations. One strategy for dealing with this technical difficulty is to choose a validated screening tool (or screening tool threshold) that will identify as many at-risk patients as possible yet have sufficient feasibility in the ED. We anticipate continual improvement in screening strategies for use in EDs because the National Institute of Mental Health has funded large studies in this area. These include the ED-SAFE and Emergency Screening for Teens at Risk for Suicide studies. Evolving approaches may include both verbal and computerized screeners that help to efficiently flag persons who need further clinician evaluation. Additional unanswered questions about screening include how to optimize fidelity (including the actual wording providers use when screening) and understanding the variable risk profiles among patients with suicide risk who self-identify versus who are revealed through screening.

**ED PROVIDERS**

**Challenge: Limited Training**

Traditionally, many ED providers have received minimal education in mental health conditions and have learned to view suicidal ideation and behavior as conditions at high risk for adverse outcomes and liability. Because of these factors, combined with limited training or guidelines for risk assessment and brief intervention, ED providers may tend to rely extensively on the recommendations of mental health consultants in making decisions about patient disposition for their suicidal patients. This is unlike other high-risk emergency conditions (eg, acute myocardial infarction, stroke, sepsis), in which emergency physicians are trained to determine, according to their initial evaluation, the need for involvement of a consultant. As an example, not every patient with chest pain will receive an extended evaluation in the ED or a cardiology consultation or admission to the hospital. ED providers take pride in their ability to perform an initial risk stratification of patients with chest pain (including interpreting vital signs, ECGs, and other data) and to work closely with consultants but determine treatment and disposition. Yet they often do not have the
same level of comfort with initial evaluation or risk stratification of suicidal patients and may feel the need to involve a consultant in every case. ED providers already conduct an initial assessment of patients’ mental states because agitation, anxiety, and other alterations in mental state can be both the cause and the result of emergency conditions. Providers should take pride in their ability to take the “emotional pulse” but should not stop there; rather ED providers should be supported in conducting the next steps of initial risk assessment of a suicidal patient to determine when further testing or consultation is indicated. Whether or not a consultant is involved, in cases of patients with suicide risk—as in other conditions—the emergency physician holds final responsibility for any medical decisions, including disposition. Therefore, ED providers need guidelines and resources to support them in risk assessment and brief ED interventions for suicidal patients. This is especially true because many emergency physicians practice in settings without easy access to mental health consultants.41

**Challenge: Provider Attitudes**

Previous work suggests ED providers may be unaware or skeptical about the preventability of suicide.2,42 Many may not know that only a small percentage of patients who are at elevated risk for suicide actually die by suicide43 or that most persons who attempt suicide are typically highly ambivalent until the attempt. In addition, although a suicide attempt elevates the risk for future suicide death, overall only a fraction (<10%) of attempt survivors later die by suicide.14-46

Although ED providers may embrace preventing death from physical illness or injury as a core challenge of emergency medicine, talking to a patient about suicide risk may be uncomfortable. It can raise anxiety and even frustration on the part of providers, given challenges related to patients who are intoxicated, frequent ED visitors, or possibly malingering. Discomfort with the topic of suicide may also stem from inadequate resources for care and follow-up, personal experience, and concern over saying the wrong thing. In addition, some ED providers may also hold conscious or unconscious biases against patients with suicidal ideation or behavior, sometimes based on previous experience or on unawareness of the preventability of suicide.2,47-49 Another deterrent for some ED providers for assessing, treating, and especially discharging patients at risk for suicide may be concerns over liability. Understandably, factors that may increase these concerns include barriers to patients following up with outpatient care and a lack of capacity in the mental health service system.

**Solution: Improved Provider Training**

One of the goals of the National Action Alliance for Suicide Prevention is to change attitudes toward suicide with messaging that emphasizes “hope, resiliency, recovery and prevention.”50 Such messaging is important for ED providers; indeed, preventing suicide is another way to save a life and part of the model of clinical practice of emergency medicine.51 In fact, interventions in EDs might prevent up to 20% of annual suicide deaths in the United States.52 Training, if combined with a systematic approach to screening and risk assessment (including easy access to available guidelines2,47), may help providers to manage the various anxieties and biases mentioned above. It is unrealistic to expect ED staff to engage in lifesaving behavior without any training in assessment and intervention. But there are ED-based short- and long-term treatments currently available for the suicidal individual (below).45 It is hoped—in light of the recent national attention to mental health care and with continued research—that the availability of ED-based and outpatient treatment options will increase.

**Solution: Available Guidelines**

Various guidelines exist to help providers in suicide screening and ED care of suicidal patients.7 One of the most up-to-date and accessible is the new ED guide by the Suicide Prevention Resource Center (http://www.sprc.org/ed-guide).27 This guide, developed through a robust expert consensus process, summarizes evidence-based practices in decision support, initial interventions, and discharge planning for adults who have been identified as having some risk of suicide. It is an excellent source of information when an ED approach to suicide prevention is being planned. Another resource is “Continuity of Care for Suicide Prevention: The Role of Emergency Departments.”53 This guide addresses screening options, how to discuss a suicide risk concern with patients, and the steps involved in discharge planning and referral for follow-up services. In addition, although not specifically designed for the ED setting, the Suicide Assessment Five-step Evaluation and Triage tool can guide ED providers in conducting a risk assessment when a mental health consultant is not available.54 ED systems that focus on following national guidelines, providing patient-centered care, and fully documenting each visit and decisionmaking process can reduce litigation in the event of an adverse event.27

**Solution: ED-based Interventions for Suicidal Patients**

Effective resources are available to manage acute suicide risk, including crisis hotlines, educational resources for
family members, and safety plans. In a “safety planning intervention,” the provider works with the patient to develop a list of coping strategies and resources that he or she can use before or during suicidal crises. The plan is brief, in the patient’s own words, and easy to read. Safety planning is not the same as “contracting for safety,” which has no evidence of effectiveness and is no longer recommended. As part of a patient’s safety plan, access to lethal means should be assessed, with counseling provided to the patient and family or friends about how to temporarily reduce access. It is important this include specific discussion of access to firearms, given their high lethality and the fact they are the method used in almost half of suicide deaths. Additional suggested ED interventions include partnerships with crisis lines, “caring contacts” after discharge, efforts to bridge the gap between ED visit and outpatient care, and the use of telepsychiatry in areas with limited local resources. All of these facilitate continuity of care for suicidal patients and might decrease risk of death.

ED AND HEALTHCARE SYSTEM

Challenge: ED Environment

The clinical practice of emergency medicine emphasizes the identification and prevention of short-term morbidity and mortality. Typically working with large numbers of patients during each shift, ED providers focus on the “life threat”—the emergency—and emphasize triage, stabilization, and disposition. Because of ED crowding, the efficient throughput of patients is of substantial and increasing importance. Even providers most interested and invested in caring for suicidal patients must struggle with system issues. Heavy ED volumes, shortage of appropriate services (eg, mental health consultants, inpatient psychiatric beds), and lack of appropriate referral options at discharge are examples of the myriad challenges ED providers face. For most hospitals, there is an absence of overarching policies and guidelines in regard to systematic approaches and steps for working with patients at risk for suicide, as well as a lack of patient education resources.

Solution: Efficient ED Pathways for Care

Providers and administrators may worry that screening, by identifying more patients at risk for suicide, will cause additional drains on already limited resources for mental health consultations and boarding of psychiatric patients. However, evidence from the ED-SAFE trial suggests that universal screening may be feasible in appropriately resourced settings, even if it does result in additional mental health consultations.

Yet it is also important to remember that a subset of patients at low risk of suicide can be discharged home without a consultation, after appropriate ED care and discharge planning. Secondary screening or risk-stratification tools can help providers identify which suicidal patients require a full mental health evaluation and which can be discharged home with appropriate ED counseling and outpatient referral. For providers lacking access to mental health consultants, the Suicide Assessment Five-step Evaluation and Triage provides a stepwise framework for risk assessment. Additional ED-based interventions, as discussed below, are also available and summarized in new guidelines for ED care of suicidal patients.

Challenge: Outpatient Mental Healthcare Deficits

The entire community mental health system is in flux in the United States, and resources are inconsistent or even nonexistent to provide adequate continuity of care. In the month after a psychiatric hospitalization, the risk of a suicide attempt or death remains high. Even when resources do exist, patients may not use them; for many reasons, up to 70% of patients with a suicide attempt do not attend their first outpatient appointment.

Solution: ED and System Policies

A clear and accessible ED plan for identification and care of suicidal patients can decrease anxiety and frustration in providers, perhaps leading to less reliance on hospitalization and a reduction of negative attitudes toward patients. System interventions to redirect patients to mental health services might reduce ED visits in high ED users, many of whom have underlying mental health needs that also increase their risk for suicide. With minimal additional specialty education, ED providers could offer brief interventions in the ED and make appropriate discharge dispositions for these patients, meeting the triple aim of reducing cost (eg, shortening overall lengths of stay, reducing ED visits), enhancing the experiences and outcomes of the patient, and improving health for those at risk for suicide.

Given current challenges in outpatient mental health treatment, care provided within the ED is critically important to continued patient engagement. Within the hospital, there can sometimes be limited communication and collegiality between emergency and psychiatry departments. However, many examples exist of systems that work together well both within the hospital and at discharge. Crisis respite, 23-hour beds, ambulatory crisis care, or specialized psychiatric EDs may be alternatives to...
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inpatient hospitalization. Crisis centers or hotlines can also partner with EDs in caring for patients with suicide risk; these services are staffed with counselors who provide continuous confidential services, including assessment and referrals, at no cost to the individual. Hospitals may also consider making formal agreements with crisis centers to provide follow-up telephone calls or interventions for at-risk patients while they wait for outpatient care. Family and support networks are also valuable resources.

At the level of health care systems, the Zero Suicide framework of the National Action Alliance for Suicide Prevention provides a 7-step structure for prevention of suicide by individuals cared for within a health or behavioral health system. The campaign includes an implementation tool kit and other resources for interested organizations.

CONCLUSION

Numerous challenges to ideal ED care of suicidal individuals exist from the level of individual patients and providers up to health care system organization and availability of mental health resources. Although there is no single solution, many smaller opportunities to enhance ED-based identification and care of suicidal patients exist. These include options for universal or targeted screening for suicide risk, a new guide developed specifically for ED settings with risk-assessment tools and brief interventions, and novel partnerships with crisis hotlines and the larger mental health treatment community. Enhanced training for ED providers could also be useful to improve knowledge about the preventability of suicide and the options for effective treatment. Responsibility for improving care of suicidal individuals—and for preventing deaths—does not fall on EDs alone. Indeed, the best results will likely come from collaboration with medical and public health organizations and large-scale interventions to increase awareness and treatment options for mental health problems. ED providers can take pride in the leadership role they can play in these efforts and remember that, as in the case of each suicidal individual, there is hope and the promise of better treatment options to come. ED care focuses on saving lives through identification and treatment of life threats, so identification and treatment of patients at risk of suicide (by definition a life threat) falls naturally within the domain of emergency care.

Supervising editor: Megan L. Ranney, MD, MPH

Author affiliations: From the Department of Emergency Medicine, University of Colorado School of Medicine, Denver, CO (Betz); the Department of Psychiatry and Human Behavior, Sidney Kimmel Medical College at Thomas Jefferson University, Philadelphia, PA (Wintersteen); the Departments of Emergency Medicine, Psychiatry, and Quantitative Health Sciences, University of Massachusetts Medical School, Worcester, MA (Boudreaux); the Department of Psychiatry, Perelman School of Medicine of the University of Pennsylvania, Philadelphia, PA (Brown); the Center for the Study of the Prevention of Injury, Violence, and Suicide, Waltham, MA (Capoccia); the Department of Psychiatry and Behavioral Neurosciences, Morsani College of Medicine, University of South Florida, Tampa, FL (Currier); the Suicide Prevention Resource Center, Education Development Center, Inc., Waltham, MA (Capoccia, Goldstein); the Department of Psychiatry, University of Michigan Medical School, Ann Arbor, MI (King); the Center for Behavioral Health, Cape Cod Hospital, Hyannis, MA (Manton); the Department of Psychiatry, Columbia University Medical Center, and New York State Psychiatric Institute, New York, NY (Stanley); the American Foundation for Suicide Prevention, New York, NY (Moutier); and the American Foundation for Suicide Prevention, New York, NY (Harkavy-Friedman).

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