Suicide Risk Assessment

About the Guideline

- This Clinical Practice Guideline (CPG) from the Emergency Nurses Association (ENA) provides an evidence-based, validated resource for emergency room departments to comply with the Joint Commission suicide screening requirements.
- The goal of the guideline is to improve screening of all patients who enter the healthcare system for suicide ideation using a brief, standardized, evidence-based tool that is easy to administer and validated to identify those at risk for suicide.
- The guideline was developed based on review of scientific literature on screening tools and scales that can effectively screen patients for suicide ideation regardless of their chief complaint. A focus was placed on tools with five or less questions, taking into consideration typical time restraints of those providing care in the ED.

Key Clinical Considerations

Background and Significance

- Suicide is the tenth leading cause of death in the US (CDC, 2016).
- The development of the guideline was driven by a trending rise in suicide rates and a lack of suicide ideation screening as noted by The Joint Commission (2016).
- Healthcare professionals should be vigilant and recognize potential risk factors and personal characteristics associated with suicidal behaviors and have the resources to take action to intervene in those individuals with these high-risk features.
- For both children and adults, emergency departments, behavioral health clinicians, and primary care physicians are required by The Joint Commission to:
  1. Review each patient’s personal and family medical history for suicide risk factors.
  2. Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool.
  3. Review screening questionnaires before the patient is discharged or leaves the appointment.
  4. Take action based upon the assessment results to inform the level of interventions needed.
- Suicide screening will not identify all patients at risk for self-harm; depends on the accuracy and completeness of the responses.
- The goal of screening is to identify those at risk that currently go undetected, to allow providers to complete more in-depth screening to assist with placement and discharge.

Terminology (Crosby, Ortega & Melanson, 2011)

- Suicidal
  - Self-directed behavior that deliberately results in injury or the potential for injury to oneself
Evidence of suicidal intent

- Non-suicidal
  - Self-directed behavior that deliberately results in injury or the potential for injury to oneself
  - No evidence of suicidal intent

- Undetermined self-directed violence
  - Self-directed behavior that deliberately results in injury or the potential for injury to oneself
  - Evidence of suicidal intent is unclear

- Suicide attempt
  - A non-fatal self-directed potentially injurious behavior with any intent to die as a result
  - Injury may or may not result

- Interrupted self-directed violence
  - A person takes steps to self-injure but is stopped by self or by other.

- Other suicidal behavior including preparatory acts
  - Preparations for a suicide attempt, but before potential for harm has begun

- Suicide
  - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior

Potential Predictors for Suicide

These are not all inclusive, nor should they be used in isolation.

Demographics

- Lower socioeconomic status
- Female gender
- In older adults, whites greater than non-white populations

Prior Medical and Psychiatric History (ENA, 2017)

- Previous suicide attempts and methods (i.e. deliberate self-harm, self-cutting, or self-poisoning by medications)
- Previous mental health diagnosis (i.e. Major Depressive Disorder [MDD], mood disorder or hopelessness)
- Military history (i.e. post-traumatic stress disorder [PTSD])
- Substance abuse (i.e. alcohol or drugs)
- Binge drinking or episodes of excessive drinking in adolescents and young adults
- Chronic physical illness

Significant Life Events

- Living alone or not having a significant other
• Significant negative life events (i.e. loss of family member, job, or relationship)
• History of being bullied

**Recommendations (ENA, 2017)**
The following are recommendations that can improve the screening process for patients at risk for suicide:

• Offer suicide risk training to emergency department staff to improve their ease of screening.
• Psychiatric nurses, nurses with crisis intervention training, or psychiatrists can be beneficial to emergency departments where access to psychiatric services may be limited.
• Emergency department personnel should be provided time to properly implement screenings for patients and to also stay up-to-date on current screening recommendations.

The ENA (2017) literature review recommends the following five instruments that are useful in identifying patients at risk for suicide:

• *Ask Suicide Screening Questions (ASQ)* (Horowitz et al., 2012)
  ▪ A four-question screening tool for pediatric and young adult patients in the emergency department with medical complaints.

• *Manchester Self-Harm Rule (MSHR)* (Cooper et al., 2006)
  ▪ Four questions to identify patients at suicide risk
    1. History of self-harm
    2. Previous psychiatric treatment
    3. Current psychiatric treatment
    4. Benzodiazepine taken as an overdose

• *Risk of Suicide Questionnaire (RSQ)* (Horowitz et al., 2001)
  ▪ A four-item suicide screening tool for adolescents and adults

• *The Patient Safety Screener (PSS)* (Boudreaux, et al., 2015)
  ▪ A two and three question version that can assist in identifying patient at suicide risk

• *Suicide Affect-Behavior-Cognitive Scale (SABCS)*
  ▪ A self-reporting survey in which patients rate their responses on a Likert scale to measure their risk of feeling suicidal

Tools that can be utilized to evaluate lethality for discharge from the ED:

1. Behavioral Health Screening-Emergency Department (BHS-ED) – focuses on depression, suicidal ideation, posttraumatic stress, risk behaviors, and stress
2. The Columbia-Suicide Severity Rating Scale (C-SSRS) – used to quantify the spectrum of suicidal thoughts and behaviors and track changes in each
3. Geriatric Depression Scale (GDS) – 15 question depression scale for the geriatric population (Cheng et al., 2010)
4. The ReACT Self-Harm Rule – uses four elements to identify patients at risk for suicide) (Steeg et al., 2012)
   a. Recent self-harm (past year)
   b. Living status (alone or homeless)
c. Cutting used as a method of harm  
d. Currently under treatment for a psychiatric disorder

References:


Link to Practice Guideline:
https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/cpgsuicide.pdf?sfvrsn=409a64fe_14