

# Suicide Risk: A Guide for ED Evaluation and Triage

Companion resource to the *Is Your Patient Suicidal?* poster.

**1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.**

## Signs of acute suicide risk

- ❖ **Talking about suicide** or thoughts of suicide
- ❖ **Seeking lethal means** to kill oneself
- ❖ **Purposeless**—no reason for living
- ❖ **Anxiety or agitation**
- ❖ **Insomnia**
- ❖ **Substance abuse**—excessive or increased
- ❖ **Hopelessness**
- ❖ **Social withdrawal**—from friends/family/society
- ❖ **Anger**—uncontrolled rage/seeking revenge/partner violence
- ❖ **Recklessness**—risky acts/unthinking
- ❖ **Mood changes**—often dramatic

## Other factors:

- ❖ **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- ❖ **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- ❖ **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

**Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.**

## Ask if you see signs or suspect acute risk—regardless of chief complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

*How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.*

These questions ease the patient into talking about a very difficult subject.

- Patients who respond “no” to the first question may be “faking good” to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
  - frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

**10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.**

## Evaluation and rapid triage

**High risk patients** include those who have:

- Made a serious or nearly lethal suicide attempt
- Persistent suicide ideation or intermittent ideation with intent and/or planning
- Psychosis, including command hallucinations
- Other signs of acute risk
- Recent onset of major psychiatric syndromes, especially depression
- Been recently discharged from a psychiatric inpatient unit
- History of acts/threats of aggression or impulsivity

**Recommended interventions:**

- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete (*see below*)

**Moderate risk patients** include those who have:

- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current and active therapeutic alliance with a mental health professional

**Interventions to consider:**

- Guard against elopement until evaluation is complete (*see below*)
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend to monitor in ED if a locked door prevents elopement

**Low risk patients** include those who have:

- Some mild or passive suicide ideation, with no intent or plan
- No history of suicide attempt
- Available social support

**Interventions to consider:**

- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation

## Before discharging

**Check that:**

- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED

**Document:**

- Observations
- Mental status
- Level of risk
- Rationale for all judgments and decisions to hospitalize or discharge
- Interventions based on level of risk
- Informed consent and patient's compliance with recommended interventions
- Attempts to contact significant others and current and past caregivers

## When patients elope

- Follow policies and procedures specific to retrieving all suicidal patients who have eloped
- Document the timeliness and reasonableness of actions taken
- The following actions may need to be modified to match each situation:
  1. For Involuntary Patients or Patients with High Suicidal Intent:
    - Follow your state's mental health statute dealing with involuntary returns
    - Immediately ask security and law enforcement personnel to return patient
    - Have a policy for authorizing physical restraint matching the risks posed
    - In addition, take steps outlined below (for voluntary patients)
  2. For Most Voluntary Patients with Low Suicidal Intent:
    - Attempt to contact the patient or significant others and request return
    - If an emergency exists, it may be necessary to breach patient confidentiality

**For additional resources and materials, visit:**

Suicide Prevention Resource Center at  
[www.sprc.org](http://www.sprc.org)



Emergency Nurses Association



American Association of Suicidology



American Association for Emergency Psychiatry



American Foundation for Suicide Prevention



Suicide Prevention Resource Center

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57392). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.



**National Suicide Prevention Lifeline: 1-800-273-TALK (8255)**

This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.