Time To Talk A Little Nerdy: Assessing Suicide Risk in the Emergency Department

It is Time to Talk a Little Nerdy and I am your host Ken Milne.

This month I am going to talk about assessing suicide risk in the emergency department. As always, the basis for all these episodes come from the lecture series created for the Emergency Medicine and Acute Care course. Thank you to Dr. Ashley Shreves for writing the original lecture.

These episodes are broken down into digestible chunks but only represent a starting point and you should be skeptical of anything you hear. I encourage you to always go and read the primary literature. How you apply the literature to your patients in your practice environment will depend on many factors.

Emergency providers regularly see patients with mental health complaints, including suicidal thoughts. A critical task in evaluating such patients includes estimating the subsequent risk of serious self-harm and/or suicide.

Determining who can safely be sent home, who needs professional mental health involvement and who needs to be admitted can be a daunting process. This is often made more challenging in settings with limited access to trained mental health professionals. The responsibility of assessing and making high-risk decisions can often fall solely on the shoulders of the emergency provider. To make matters even worse, timely access to appropriate mental health care (outpatient or inpatient) seems to be a universal problem.

For emergency providers working in settings without abundant psychiatric resources, understanding the epidemiology of suicide and the best evidence on risk stratification of suicidal patients is critical to the safety of patients with mental health issues.

So, let's start talking a little nerdy about assessing suicide risk in the emergency department with asking five questions. We will draw upon the extensive EMA database to try and address each of these questions.

Five Questions:
1. What is the emergency provider’s role in evaluating patients with suicidal thoughts or behaviors?
2. Is universal suicide screening routinely done in emergency departments?
3. In patients presenting to the emergency department with suicidal thoughts or attempts, are there high risk clinical features that predict subsequent suicide?
4. What is the rate of subsequent self-harm and suicide in emergency department patients seen after suicidal behavior?
5. What are current practice patterns in the emergency department for patients seen for deliberate self-harm?
**FIVE Nerdy Questions:**

**Question #1: What Is The Emergency Provider’s Role In Evaluating Patients With Suicidal Thoughts Or Behaviors?**

The first paper this month is an editorial from 2016 highlighting the important conceptual issues regarding suicide. The World Health Organization considers reducing suicide risk a global health imperative. There is an initiative called the Mental Health Action Plan. The four major objectives of the action plan are to:

1. Strengthen effective leadership and governance for mental health.
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
3. Implement strategies for promotion and prevention in mental health.
4. Strengthen information systems, evidence and research for mental health.

There are one or two specific targets that accompany each of the four objectives. Under the third objective a target for member states is to reduce the suicide rate 10% by 2020.

The risk of suicide in the general population is <1%, while in patients with schizophrenia, bipolar disorder and major depression it is 7% in men and 5% in women.

There are risk factors for suicide that have been identified at the population level such as increasing age and male sex but these individual variables have poor predictive value when applied at the bedside in the patient with acute suicidal thoughts. We generally do not treat populations in the emergency department we treat patients one at a time.

Providers who are tasked with assessing suicidality in the acute care setting should be focused on performing this job with high sensitivity (true positives) and be willing to sacrifice specificity (true negatives) towards the goal of NOT missing patients at risk for serious self-harm.

The role of the emergency physician can be seen as identifying the lowest risk group of patients who can go home and then grouping all others together to be further risk stratified by a trained mental health professional.

- **Listen To The Patient: Challenges In The Evaluation Of The Risk Of Suicidal Behaviour**
  

  The World Health Organization considers suicide prevention a global health imperative. Countries committed to the Mental Health Action Plan aim to reduce suicide rate 10% by 2020. The Danish author of this editorial highlights factors associated with increased suicide risk and the importance of identifying them in clinical practice. In high-income countries, mental disorders represent a large suicide risk group, the risk being 7% for men and 5% for women with schizophrenia, bipolar disorder or major depression compared with less than 1% in the general population. For national health planners, risk factors to consider include (but are not limited to) increasing age, male sex, mental disorders, substance abuse, self-harm, family history, severe illness, divorce, loss of a spouse, child, or job, and homelessness. For clinical practice, such factors have low predictive power to detect those at immediate risk. One study of patients with depression, published in the same issue, reported worthlessness and a previous suicide attempt as significant factors. Another study from this issue showed that among euthymic bipolar disorder patients with suicidal ideation, those with motor impulsivity, increased admissions, and poor control over suicidal thoughts had increased risk. This author notes that because suicide is a rare event, prediction based on risk factors cannot have high sensitivity, specificity, and positive predictive ability simultaneously, and emphasizes that since the priority is to avoid missing potential risk, the major criterion should be high
sensitivity. Worthlessness, for example, had low predictive value but high sensitivity. The author suggests that in clinical practice the focus should be to identify individual patients at immediate risk by looking for risk factors such as sense of desperation, worthlessness, hopelessness, guilt, unspoken signals, and suicidal thoughts, plans, and attempts.

8 references

**Question #2: Is Universal Suicide Screening Routinely Done In Emergency Departments?**

Does your hospital do universal suicide screening? Some emergency departments do and some do not. Prior evidence suggests that the risk of suicidal ideations in emergency department patients is 8%, compared to 3% in the general population, so from a public health perspective, this is considered a vulnerable, high risk cohort.

A study by Caterino et al published in AEM in 2013 describes the current patterns of assessment for self-harm in the emergency department. It is a prospective chart review or an observational study meaning they can really only determine associations.

The study took place in eight urban level one trauma centers so it may not apply to your environment. Self-harm was identified in 3% of patients. However, only 11% of patients presenting to these emergency department were screened and the variability was as low as 4% and as high as 31% of patients.

- **Evaluating Current Patterns Of Assessment For Self-Harm In Emergency Departments: A Multicenter Study**

**BACKGROUND:** Evidence suggests that assessment for self-harm (including suicide attempts, suicidal ideation and non-suicidal self-injury) is suboptimal in patients presenting to the ED with psychiatric conditions.

**METHODS:** The authors, coordinated at Ohio State University, conducted a prospective observational cohort study of self-harm assessments in eight urban Level 1 trauma centers and 94,354 triaged adults.

**RESULTS:** Self-harm was identified in 2.7% of charts. Excluding one institution, 11% of ED patients were assessed for self-harm, with a range of 3.5-31%. There was one outlier, an institution in which 95% of patients were assessed. Rates of assessment were highest for institutions with specific self-harm policies. With the exception of the outlier ED, triage nurses assessed the risk of self-harm based on the patient’s complaint, behavior or history. Being male was a predictor for being assessed, with or without inclusion of the outlier ED (adjusted risk ratio (aRR) 1.17, 95% CI 1.10-1.26). Among all EDs, patients aged 65 or older were less likely to be assessed (aRR 0.56, 95% CI 0.35-0.92), and assessments were more likely on weekends (aRR 1.3, 95% CI 1.04-1.62) and after 3 PM (aRR 1.36, 95% CI 1.01-1.85). Although likely due to the outlier ED’s population, assessment rates were higher for American Indians or Alaskan natives (aRR 2.3, 95% CI 1.53-3.47) and Hispanics (aRR 2.41, 95% CI 1.67-3.48) among all EDs.

**CONCLUSIONS:** This study demonstrated substantial variability in assessment of patients for self-harm in the ED, and the importance of development of standardized self-harm assessment policies.

The previous study showed lots of variability and raised the issue of standardizing self-harm assessment policies. But is universal screening for suicide risk feasible?

A paper by Bourdeaux et al in American Journal of Preventive Medicine 2016 looked at the feasibility of universal screening for suicide risk. It was a multi-centered study involving 3 phases. Those phases included treatment as usual, universal
screening and universal screening plus intervention. The screening was done at triage or during the primary nursing assessment. It was considered a positive screen if the patient reported active suicidal ideation in the previous two weeks or a suicide attempt in last six months.

Screening increased significantly from approximately 25% to over 80% by phase three. Positive screens also doubled from 3% to almost 6%. This study demonstrated that you could screen and identify more patients at risk of suicide. However, it did not look into the patient oriented outcome of whether or not screening and identifying patients actually decreased self-harm and/or suicide. This would have been a very important patient oriented outcome.

• Improving Suicide Risk Screening And Detection In The Emergency Department

  BACKGROUND: Over the last two decades, the suicide rate in the United States has increased almost 30%. The prevalence of active ideation among emergency department (ED) patients has been reported to be 8%. It is important to identify suicide risk in patients during ED visits.

  METHODS: These researchers, coordinated at the University of Massachusetts, conducted a multicenter three-phase interrupted time series study termed the “ED Safety Assessment and Follow-up Evaluation” (ED-SAFE). The phases were treatment as usual, universal suicide risk screening, and universal screening plus intervention. Active suicidal ideation in the previous two weeks or a suicide attempt within the last six months constituted a positive screen. The first primary outcome was documentation of any screening in the medical records. The second was a positive screen. The screening outcome was evaluated across the three study phases. Patients with a positive screen were interviewed.

  RESULTS: Overall 236,791 ED visit records were reviewed, 10,625 patients identified who had a positive screen, and 3,101 interviews completed. Any documentation of screening increased from 26% in Phase 1 to 73% and 84% in Phases 2 and 3, respectively. Positive screen detection improved from 2.9% in Phase 1 to 5.2% and 5.7% in Phases 2 and 3, respectively. Interview data showed that 74% of patients screening positive reported suicidal ideation or attempt within the previous week.

  CONCLUSIONS: The authors consider this to be a landmark study as it shows that not only can universal suicide risk screening be successfully implemented in the ED, but also that it leads to a substantial improvement in suicide risk detection, which in turn facilitates intervention.
  26 references (edwin.boudreaux@umassmed.edu – no reprints)

When it comes to universal suicide screening, it’s complicated. In the resource-limited setting of the emergency department; however, the benefits of universal screening for any condition should probably be weighed against the potential costs in terms of diversion of resources away from other important health issues. Another problem is that the resources are not available currently for those identified at risk. How is the system going to possibly accommodate potentially double the number of patients requiring acute mental health care?
Question #3: In Patients Presenting To The Emergency Department With Suicidal Thoughts Or Attempts, Are There High Risk Clinical Features That Predict Subsequent Suicide?

A literature review by Ronquillo et al in the Journal of Emergency Medicine did identify several high risk features for suicide.

The highest risk features for suicide include:

- History of suicide attempt
- Current lethal plan
- Recent psychosocial stressor
- Older age
- Caucasian race
- Previous psychiatric illness

The presence of any of these factors, especially a history of a prior suicide attempt and current lethal plan, should prompt consultation with psychiatry in patients with suicidal thoughts.

Although various scoring systems/clinical decisions tools have been investigated, there is no validated, widely accepted scoring system for assessing subsequent suicide risk. In addition, contracts to safety do not protect physicians from negligence claims and do not substitute for medical record documentation of suicide risk.

- Literature-based Recommendations For Suicide Assessment In The Emergency Department: A Review
  

BACKGROUND: It is estimated by the CDC-P that every completed suicide is preceded by 100 to 200 attempts. Patterns of the ED management of suicidal ideation are highly variable.

METHODS: The authors, from the California School of Professional Psychology in San Diego and UC San Diego, reviewed 51 published articles of suicide assessment in adult ED patients.

RESULTS: The ED approach to potential suicide often includes psychiatric holds and/or safety contracts in which the patient agrees not to harm him or herself during a specified timeframe. Criteria and methods for psychiatric holds vary by state, whereas contracts do not protect physicians from negligence claims and do not substitute for medical record documentation of suicide risk. Identification of acute and historical or chronic risk factors for suicide is also important for assessing patients. Strong predictors of suicide include previous history, current lethal plans, older age, psychiatric diagnoses, a recent psychosocial stressor, and being Caucasian, with the first two being most important. Chronic alcohol/drug use can increase suicide risk when acute risk factors are present and the patient’s thought processes are impaired. There are currently no validated methods available to predict patients at risk of suicide, requiring use of clinical judgment.

CONCLUSIONS: Suicide assessment scales are not completely reliable for identifying high-risk patients. Low risk characteristics include absence of past suicidal ideation and hopeless or depression, with no loss of rational thinking or plan for completion of suicide, absence of excessive use of drugs or alcohol, and adequate social support. Psychiatric holds and psychiatry consults while the patient is in the ED might not be necessary for low-risk patients.

60 references
There is no widely accepted clinical decision tool but researchers continue to try. An example is the "Manchester Self-Harm Rule" that Cooper et al published in Annals of Emergency Medicine in 2006. They derived and internally validated a simple decision tool with the goal of predicting those at risk of subsequent self-harm and/or suicide.

These British authors identified four variables as most useful in this dataset of over 9,000 patients after presentation to the emergency department with an episode of self-harm.

- Prior history of self-harm
- Previous psychiatric treatment
- Use of benzodiazepines in the current episode
- Current psychiatric treatment.

There is some overlap between the variables identified in this study and those identified in the previous literature review. This tool demonstrated good sensitivity (true positives) with low specificity (true negatives). When the outcome in question is death you want high sensitivity, and will sacrifice specificity.

In the validation set the sensitivity was 97% and the specificity 26%. The tool identified all the suicides (22) but missed 3% of self-harms. Would a self-harm miss rate of 3% be acceptable in your practice environment?

- A Clinical Tool For Assessing Risk After Self-Harm

**BACKGROUND:** About one-fourth of patients who commit suicide had presented to a hospital following an episode of self-harm in the previous year; most repeat episodes occur during the six months after the index episode.

**METHODS:** These British authors developed and validated a simple decision tool for the identification of patients at high risk for repeated self-harm or suicide during the six months after presentation following an episode of self-harm. The instrument was derived based on findings in 6,933 patients presenting to three EDs over a three-year period and validated in 2,153 patients presenting to two other EDs.

**RESULTS:** Within the six months after ED presentation, 17% of the patients had a recurrent episode of self-harm and 0.2% died by suicide. In the derivation cohort, four characteristics were predictive of increased risk: any prior history of self-harm, previous psychiatric treatment, use of benzodiazepines in the current episode, and current psychiatric treatment. The presence of any of these four variables was considered consistent with moderate to high risk, and in both the derivation and validation cohorts, 78% of the patients were so classified. The sensitivity and specificity of the instrument for identification of repeated self-harm in the subsequent six months were 94% and 25%, respectively, in the derivation set, and 97% and 26%, respectively, in the validation set. This decision rule identified all 22 patients who completed suicide within six months after presentation.

**CONCLUSIONS:** The authors suggest that their “Manchester Self-Harm Rule” is a useful tool for identifying patients presenting after self-harm who are at increased risk for a repeat episode in the subsequent six months. 31 references

As with many clinical decision tools, when attempts are made to externally validate them in other practice environments they do not perform as well. The Manchester Self-Harm Rule was investigated in Scandinavia. The tool had a much lower sensitivity (89%) and similar specificity (21%).
Deliberate Self-Harm Patients In The Emergency Department: Who Will Repeat And Who Will Not? Validation And Development Of Clinical Decision Rules

OBJECTIVES: (1) Validate an existing clinical tool for assessing risk after deliberate self-harm (DSH), Manchester Self-Harm Rule, in a new setting and new population, (2) develop a clinical decision rule based on factors associated with repeated self-harm in a Swedish population and (3) compare these rules.

DESIGN: A consecutive series of 1524 patients attending one of Scandinavia’s largest emergency departments (ED) due to DSH during a 3-year period were included. Explanatory factors were collected from hospital charts and national databases. A nationwide register-based follow-up of new DSH episode or death by suicide within 6 months was used. We used logistic regression, area under the curve and classification trees to identify factors associated with repetition. To evaluate the ability of different decision rules to identify patients who will repeat DSH, we calculated the sensitivity and specificity.

MAIN OUTCOME MEASURE: Repeated DSH or suicide within 6 months.

RESULTS: The cumulative incidence for patients repeating within 6 months was 20.3% (95% CI 18.0% to 22.0%). Application of Manchester Self-Harm Rule to our material yielded a sensitivity of 89% and a specificity of 21%. The clinical decision rule based on four factors associated with repetition in the Swedish population yielded a sensitivity of 90% and a specificity of 18%.

CONCLUSIONS: Application of either rules, with high sensitivity, may facilitate assessment in the ED and help focus right resources on patients at a higher risk. Irrespective of the choice of decision rule, it is difficult to separate those who will repeat from those who will not due to low specificity.

Ronenson et al published a large cohort study in the British Medical Journal. It consisted of almost 50,000 patients from a Swedish registry of patients who had an episode of self-harm. They followed these patients for risk of subsequent suicide.

The results showed the method of suicide was a strong predictor of completed suicide risk. Specifically, hanging, strangulation, or suffocation in the index attempt had a six fold risk of compared to self-poisoning. More than half who initiated an attempt with these methods completed suicide, 88% within one year of the index attempt.

Method Of Attempted Suicide As Predictor Of Subsequent Successful Suicide: National Long Term Cohort Study

BACKGROUND: Although not well-studied, it has been theorized that particularly well-planned, violent or drastic attempts at suicide are more likely to be followed by a later, successful attempt.

METHODS: This study from the Karolinska Institute linked several Swedish national registries to follow a cohort of 48,649 patients who had been hospitalized in 1973-1982 after attempting suicide. The authors evaluated how the attempt method predicted subsequent successful suicide during a follow-up period of 21-31 years. They adjusted their findings for sociodemographic factors and concurrent psychiatric illness.

RESULTS: The main outcome, completed suicide, 1973-2003, occurred in 5740 patients (12%). Self-poisoning was the most common method of attempters (84%), and was linked to 4270 subsequent suicides. With poisoning as the reference category, those using hanging, strangulation, or suffocation in the index attempt had six times the risk of completed suicide; more than half of men and women who initiated an attempt with these methods completed suicide, 88% within one year.
of the index attempt. The relative risks associated with gassing, firearms or explosives, jumping from a height, and drowning as initial attempts (adjusted hazard ratios 1.8, 3.2, 3.2, and 4.0, respectively) were also elevated; within one year of the index attempt 55-78% had committed suicide with these methods.

**CONCLUSIONS:** Those who initially attempted suicide by hanging, drowning, firearm, jumping from a height, or gassing were at a much higher risk of completed suicide. Intensified aftercare is recommended for such patients.

12 references

**Question #4: What Is The Rate Of Subsequent Self-Harm And Suicide In Emergency Department Patients Seen After Suicidal Behavior?**

It should not come as a surprise to those providing emergency department care that patients who present with self-harm often return to the for the same thing. However, the risk of subsequent completed suicide is relatively low.

This was quantified in a paper from New Zealand by Howson et al and published in Emergency Medicine Australasia ten years ago. They found in just over 750 patients who presented with deliberate self-harm that 18% re-presented to the emergency department within the next year. The average number of repeat episodes observed in this study was about four. These patients often bounced-back to the emergency department fairly quickly with a median time of one month. It was observed more often in woman and the most common type of self-harm in this population was self-poisoning. Eight patients (1.1%) completed suicide in the subsequent year.

- **Re-presentation And Suicide Rates In Emergency Department Patients Who Self-Harm**

**BACKGROUND:** People who present following deliberate self-harm are at increased risk for subsequent suicide when compared with the general population, and also have higher morbidity and mortality rates unrelated to suicide.

**METHODS:** This study from New Zealand evaluated rates of re-presentation for self-harm and subsequent suicide in 754 patients aged 15 or older who presented to an emergency care center following an episode of self-harm.

**RESULTS:** Re-presentation within one year was documented for 136 patients (18%), and the average number of repeat presentations in this group of patients was about four. Repeat presentations for self-harm were more common in women than in men. The median interval to re-presentation was 32 days (mean, 85 days); nearly half of this group (45%) re-presented within one month of the index presentation. Self-poisoning was the most common reason for a single presentation (81%) as well as for multiple re-presentations (76%). Suicide within one year of initial presentation was documented for eight patients (1.1% of the total cohort), four of whom were female and four male. Four of the eight completed suicide within one month of initial presentation, and the initial presentation for deliberate self-harm involved a drug overdose in six of the eight cases.

**CONCLUSIONS:** In this study, nearly one in five patients presenting after deliberate self-harm re-presented within one year. Completed suicide within one year was documented in about 1% of all presentations for deliberate self-harm.

9 references
A larger, American cohort (n > 200,000) study of patients seen in the emergency department for suicidal behavior or thoughts was published by Crandall et al in Academic Emergency Medicine in 2006. It examined the risk of completed suicide in patients aged ten years or older presenting for suicidal ideation, overdose and/or self- harm. The observed rate of subsequent completed suicide was 0.2% during the study period, which spanned 10 years.

This is a much lower number than the 1% over one year observed in the New Zealand study. However, this relatively low incidence is 5-7 times higher than the incidence observed in patients seen in the emergency department for non-mental health related complaints.

This is an important point about looking at small numbers. You want to know absolute numbers not relative numbers. Saying someone is at five to seven-times higher risk of committing suicide sounds very frightening. This serious outcome must be put into perspective. The actual risk is a fairly small number (0.2%).

- **Subsequent Suicide Mortality Among Emergency Department Patients Seen For Suicidal Behavior**
  

  **METHODS:** This study, from the University of New Mexico, examined the risk of completed suicide in patients aged ten years or older presenting to the ED for suicidal ideation, overdose and/or self- harm. The authors reviewed datasets from the electronic ED patient tracking system, university physician billing data and the state medical examiner’s office for the period February 1994 to November 2004.

  **RESULTS:** The study included follow-up of 218,304 patients for an average of six years. The 6,470 deaths occurring during the study period represented an overall patient mortality rate of 2.96%. Suicide was the cause of death in 449 of these 6,470 fatalities (6.9% of deaths, 0.2% of all patients, incidence rate [IR] 31.2 per 100,000 person-years). The IR for completed suicide was nearly four times higher for males than for females (48.3 vs. 13.5 per 100,000 person-years, relative risk [RR] 3.6). When compared with ED patients not having one of the three diagnoses of interest, the RR for suicide was 5.7 in patients having an ED visit for overdose, 5.8 for those presenting for self-harm, and 6.7 for those presenting to the ED for suicidal ideation.

  **CONCLUSIONS:** The immediate risk of completed suicide in patients presenting to the ED for suicidal ideation, overdose or self-harm appears to be low, but the overall risk is substantially higher than that observed in patients presenting for other complaints. The authors feel that their findings justify a policy of mandatory psychiatric evaluation for patients presenting with one of the three diagnoses of interest.

39 references
Question #5: What Are Current Practice Patterns In The Emergency Department For Patients Seen For Deliberate Self-Harm?

The final paper in the March 2018 episode of Time to Talk a Little Nerdy looked at current emergency department practice patterns across the country for Medicaid patients seen for suicide attempt.

They observed that most (62%) of these patients were discharged to the community. Only about half of discharged patients had a documented mental health assessment and only half had a 30-day follow-up with outpatient mental health services.

Surprisingly, lethality of suicide method DID NOT predict involvement of mental health services. Not surprisingly, patients in states with mental health coverage by Medicaid were more likely to receive outpatient mental health services.

Like all studies, you must remember to consider the type of patients included. These were Medicaid patients and it is unclear if these results can be extrapolated to the care of privately insured and Medicare patients.

- Emergency Treatment Of Deliberate Self-Harm
  Ofson, M., et al, Arch Gen Psych 69(1):80, January 2012

**BACKGROUND:** An ED visit for deliberate self-harm is associated with a nearly six-fold increase in the risk of subsequent suicide. Because it has been reported that more than 90% of persons who deliberately harm themselves have at least one mental disorder, mental health assessment in the ED has been recommended but studies have reported under-identification of mental health problems and under-referral for outpatient mental health care in this situation.

**METHODS:** The authors, coordinated at Columbia University, examined national Medicaid data for 2006 to evaluate the rate of mental health assessment in the ED and referral to outpatient mental health care among 4,440 adults aged 21-64 discharged from the ED after treatment for 4,595 episodes of deliberate self-harm (representing 62.5% of 7,355 episodes of deliberate self-harm treated in the ED among Medicaid patients in 2006).

**RESULTS:** A mental health assessment in the ED was documented for only 47.5% of the episodes, and provision of outpatient mental health care within 30 days after the ED visit was documented for 52.4%. A mental health assessment in the ED was less likely for Hispanics than for Caucasians and more likely for persons with a history of receipt of mental health care within the previous 60 days. Provision of outpatient mental health care was more frequent for females than for males, for Caucasians, and for persons eligible for Medicaid on the basis of disability rather than poverty. Lethality of the method of self-harm did not influence the likelihood of having a mental health evaluation in the ED or provision of outpatient mental health care during the subsequent 30 days.

**CONCLUSIONS:** Most patients treated in the ED for deliberate self-harm in this series were discharged from the ED but about half of these discharged patients received no mental health assessment in the ED or outpatient mental health care during the subsequent 30 days.

60 references
Take To Work Points:

1. Emergency providers should aim for high sensitivity (true positives) when assessing patients with mental health complaints for risk of subsequent suicide.

2. Universal emergency department screening for suicidal thoughts may be an emerging public health tool to counter the growing epidemic of suicide.

3. When risk-stratifying emergency department patients with suicidal thoughts, the highest risk clinical features include a history of suicide attempt and a current lethal plan. Other important variables are recent psychosocial stressors, older age, Caucasian race, and previous psychiatric illness.

4. Patients who present after deliberate self-harm using a method with high lethality are at an exceptionally high risk of having a subsequent completed suicide.

5. In patients seen in the emergency department for a self-harm episode, subsequent rates of completed suicide remain low (less than 1%), though rates of repeated self-harm are high.

That’s it for Time to Talk a Little Nerdy about assessing suicide risk in the emergency department. It does only represent a starting point and I would encourage you to be skeptical of what you have just heard and read the primary literature yourself.

And remember, you’ve got a get a little nerdy to provide patients with the best care.

I will be back to talk a little nerdy in April!

Wm. Kenneth Milne MD
Adjunct Professor Emergency Medicine, Western University, London, Ontario
Chief of Staff South Huron Hospital, Exeter, Ontario
Creator of The Skeptics Guide to Emergency Medicine www.TheSGEM.com