EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

# CLINICAL PRACTICE GUIDELINE:
## Suicide Risk Assessment

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## Clinical Question

What risk assessment tools and predictors are effective in screening for self-harm or suicidal ideation during initial assessment of patients across the life span in the emergency department?

## Background and Significance

According to the Centers for Disease Control and Prevention (CDC), suicide is currently the 10th leading cause of death in the United States (CDC, 2016). There were 44,193 deaths due to intentional self-harm (suicide) in 2015, and suicide deaths continue to rise. For 2015, the CDC reported suicides based on age as follows (CDC, 2015a; see Table 1):

**Table 1. CDC Reported suicides by Age for 2015**

| Age Group (in years) | Number of Suicides |
|---|---|
| 5-14 | 413 |
| 15-24 | 5,491 |
| 25-34 | 6,947 |
| 35-44 | 6,936 |
| 45-54 | 8,751 |
| 55-64 | 7,739 |
| 65 and older | 7,916 |

The Joint Commission (2016) discussed the rise in suicide rates, lack of screening for suicidal ideation by providers, and the fact that those who committed suicide received health care treatment — often for non-mental-health reasons — in the year before death. As a result, new requirements for screening were established. Emergency departments, primary care physicians, and behavioral health clinicians are now required to:

1.) Review each patient's personal and family medical history for suicide risks factors.
2.) Screen all patients for suicide ideation using a brief, standardized, evidenced-based screening tool.
3.) Review screening questionnaires before the patient leaves the appointment or is discharged.
4.) Take action based on the assessment results to inform the level of interventions needed.

(The Joint Commission, 2016, p. 3)

Individuals who attempt suicide or have suicidal ideations may present multiple challenges for emergency care providers. Patients often do not volunteer that their injuries are due to self-harm. In 2013, for example, 494,169 people were treated in emergency departments for non-fatal self-inflicted injuries at a cost of over 10 billion dollars in work loss and medical expenses (CDC, 2015b). Care providers need to maintain an elevated level of vigilance and attempt to identify the potential risk factors and personal characteristics associated with suicidal behaviors.

Research supports universal screening for suicide risk by emergency departments (Ballard, Horowitz, et al., 2013; Boudreaux, Jaques, Brady, Matson, & Allen, 2015; Caterino et al., 2013). When screening for the risk of suicide is limited to patients reporting a mental health chief complaint, a significant number of positive screenings are missed (Boudreaux et al., 2015). According to Boudreaux et al. (2015), suicidal ideation is estimated to be present in as many as 11% of all ED patients, while only 3% are identified by screening. In a multicenter study intended to evaluate compliance with suicide screening, Caterino