Recommended Standard Care for People with Suicide Risk: Emergency Departments

Emergency Departments have a unique opportunity to help prevent suicide. Frequently, when someone dies by suicide, we hear that he or she fell through the cracks in healthcare. By some estimates, over 40% of those who died by suicide had an emergency department visit in the year prior. Most did not have a mental health diagnosis.

Healthcare organizations have recommended standards to improve care to address other urgent medical conditions, such as heart attack, stroke, and serious injury. The same can be done for suicide prevention.

The American Foundation for Suicide Prevention, and the Action Alliance, have determined a research-tested, low-cost, high-value approach to preventing suicide within emergency department settings.

"Brief follow-up contacts are commonly used for other presentations, like after outpatient surgery, and should be standard for individuals who are at risk of suicide."

Using the framework of "Lean Production" which is widely applied in healthcare, these recommendations help ensure that fewer people fall through the cracks, by:

- Proactively identifying intense suicide risk in the same way we screen for risk related to other medical conditions
- Acting effectively for safety, through methods such as safety planning and lethal means counseling
- Providing supportive contacts, in the same way brief follow-up is arranged after outpatient surgery

Each recommendation has been used successfully in healthcare settings. Suicide is a public health crisis, and currently the tenth leading cause of death in the United States. Action is overdue and urgently needed. It's time we address suicide prevention in health care systems in the same way we address many other leading causes of health-related mortality.

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Recommended Standard Care Elements for Emergency Departments

Identification and Assessment

Identify and assess patients for suicide risk who have mental illness or substance use disorder or treatment (e.g., psychiatric medications) using a standardized instrument. If risk is identified, proceed with an active referral for appropriate hospital or outpatient care.

For high risk patients, if immediate transfer is notpossible, provide a space for the patient that is "safe, monitored, and clear of items that the patient could use to harm himself or herself or others" (The Joint Commission, 2016).

Safety Planning

Complete the brief Safety Planning Intervention during the visit when risk is identified. With consent, discuss the safety plan with the family to gain support for the customized components of the patient's safety plan.

Lethal Means Counseling

As part of the safety plan, discuss any lethal means considered by and available to patient. Advise removal (even temporarily) of lethal means as feasible.

Caring Contacts

Make an appointment with a mental health professional. Complete several follow-up communications (phone call or, if preferred by patient, text or email) – one within 48 hours or the next business day following the patient's visit. Make the second caring contact within seven days of the visit.

AFSP has teamed up with the American College of Emergency Physicians (ACEP) to create the ICAR2E tool, which enables rapid identification of suicide risk in the Emergency Department. This point-of-care tool offers an easy-to-follow procedure, reminders of best practices and links to helpful resources, making it easy to provide immediate care and save lives. The ICAR2E Tool can be accessed directly on your smartphone or tablet by downloading the *ACEP emPOC* app from the App Store or Google Play. To learn more about this free online tool, visit **afsp.org/icar2e**.

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

To find out more, read the full report *Recommended Standard Care for People with Suicide Risk* at **ActionAllianceForSuicidePrevention.org**.