# CLINICAL PRACTICE GUIDELINE:

## Synopsis Suicide Risk Assessment

### CLINICAL QUESTION:

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

### PROBLEM:

Suicide is the 10th leading cause of death in the United States (Centers for Disease Control and Prevention, 2015). Owing to the rise in suicide rates, lack of suicidal ideation screening by providers, and the fact that those who committed suicide often received health care treatment for non-mental health reasons in the year before death, the Joint Commission has established new requirements for screening. Emergency departments (EDs) are now "required to screen all patients for suicidal ideation using a brief, standardized, evidence-based screening tool. They must also review these screening questionnaires prior to the patient being discharged" (Joint Commission 2016, p. 3). Patients often do not volunteer that their injuries are due to self-harm. Care providers need to maintain a high level of vigilance and attempt to identify the potential risk factors and personal characteristics associated with suicidal behaviors. Although assessment tools are available to help with assessing potentially suicidal patients, the tools often have limitations for use in the initial assessment in an emergency department.

| Description of Decision Options / Interventions and the Level of Recommendation: | | |
|---|---|---|
| INITIAL SUICIDE ASSESSMENT | Suicide screening tools should be used as a part of the assessment process for all ED patients. | A |
| | Previous episodes of deliberate self-harm are a strong predictor of future suicide attempts. | A |
| | For initial suicide assessment, training ED personnel improves confidence in screening for suicide risk | B |
| SUICIDE RISK INSTRUMENTS | There is a moderate amount of evidence to support that the following instruments are valid, feasible, and reliable for initial assessment of suicide risk in the ED:<br>• The Ask Suicide-Screening Questions (ASQ)<br>• Manchester Self-Harm Rule (MSHR)<br>• Risk of Suicide Questionnaire (RSQ) | B |
| | There is a moderate amount of evidence to support that the following instruments may be used to evaluate lethality for discharge from the ED setting:<br>• Behavioral Health Screening Emergency Department (BHS-ED)<br>• Columbia Suicide Severity Rating Scale (C-SSRS)<br>• Geriatric Depression Scale (GDS)<br>• The ReACT Self-Harm Rule | B |
| | There is a weak amount of evidence to support that the following instruments are valid, feasible, and reliable for initial assessment of suicide risk in the ED:<br>• Suicide Affect-Behavior-Cognition Scale (SABC)<br>• Patient Safety Screener (PSS) | C |
| | There is insufficient evidence to make a recommendation for the following instruments to be used for further assessment in the ED setting:<br>• Beck Hopelessness Scale (BHS)<br>• Beck Scale for Suicide Ideation (BSS)<br>• Behavioral Activity Rating Scale (BARS)<br>• Centers for Epidemiologic Studies Depression Scale (CES-D)<br>• Centers for Epidemiologic Studies Depression Scale for Children (CES-DC)<br>• Death/Suicide Implicit Association Test (IAT)<br>• General Health Questionnaire (GHQ-12)<br>• Geriatric Suicide Ideation Scale (GSIS)<br>• Modified SAD Persons Scale (MSPS)<br>• Nurses Global Assessment of Suicide Risk (NGASR)<br>• Patient Health Questionnaire (PHQ-2 and PHQ-9)<br>• Patient Health Questionnaire for Adolescents (PHQ-A)<br>• SAD Persons Scale (SPS)<br>• Scale for Suicidal Ideation (SSI) | I/E |

# CLINICAL PRACTICE GUIDELINE:

## Synopsis Suicide Risk Assessment

| Description of Decision Options / Interventions and the Level of Recommendation: | | |
|---|---|---|
| SUICIDE RISK PREDICTORS | Previous episodes of deliberate self-harm are a strong predictor of future suicide attempts. | A |
| | Patients with a history of Major Depressive Disorder (MDD) or Post Traumatic Stress Disorder (PTSD) should be considered at higher risk for suicide. | B |
| | Patients with the following presentations should be considered at higher risk for suicide:<br>• Chronic illness in adults<br>• Binge or high episodic drinking in adolescents and young adults<br>• History of lethal methods of self-harm and self-cutting<br>• Living alone<br>• Lower socioeconomic status<br>• Males over 55 years of age<br>• Recent negative life events<br>• Substance abuse<br>• Young females | C |

| | | |
|---|---|---|
| A | Level A (High) | Based on consistent and good quality of evidence; has relevance and applicability to emergency nursing practice. |
| B | Level B (Moderate): | There are some minor inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice. |
| C | Level C (Weak) | There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice. |
| NR | Not Recommended | Not recommended based upon current evidence. |
| I/E | Insufficient Evidence | Insufficient evidence upon which to make a recommendation. |
| N/E | No Evidence | No evidence upon which to make a recommendation. |

*ENA Clinical Practice Guidelines (CPGs) are evidence-based documents that facilitate the application of current evidence into everyday emergency nursing practice. CPGs contain recommendations based on a systematic review and critical analysis of the literature about a clinical question. CPGs are created following the rigorous process described in ENA's Requirements for the Development of Clinical Practice Guidelines. The purpose of CPGs is to positively impact patient care in emergency nursing by bridging the gap between practice and currently available evidence.*

**ACCESS THE FULL CLINICAL GUIDELINE AT:**
https://bit.ly/2qnS3sx

915 Lee Street, Des Plaines, IL 60016-6569 ▪ 800.900.9659 ▪ www.ena.org ▪ Follow us