Suicide Risk Assessment & Management in the Emergency Room

Adapted from: Thienhaus, O.J. & Piasecki, M.. Assessment of risk. *Psychiatric Services*, Vol. 48, No. 3, March, 1997.

If Pt presents to ER with suicidal ideation:

1. Establish Pt's situation. What's their perception of their current stressors/circumstances?
2. Where is Pt on the continuum of suicidality? (Nature of ideation, intent, plans, & access to means)?
3. Psychopathology:
   Affective disorder (& hopelessness)?
   Thought disorder?
   Panic/anxiety?
   Substance dependence/abuse?
4. Ask self: How realistic is Pt's plan?
5. Reasons for Living?
6. Avoid labeling suicidal behavior as "manipulative" or as a "suicidal gesture."
   Tells more about the assessor than it does abou the pt's risk of self-harm.
7. Imagine place & situation awaiting Pt if sent home (from Pt's perspective).
   Don't overestimate capacity of family to prevent suicidal beh,
   especially if they did not accompany pt to ER.
8. Effect of your interview: Able to establish working alliance?
   Pt capable of insightful exploration of causes of distress?
   Pt seeking/accepting help (vs. help-negation)?
9. Use "No suicide contract" only to assess Pt's ambivalence.
10. Get second opinion if you have any doubts about level of suicide risk or treatment decision.
11. Do NOT discharge an intoxicated patient to a less restrictive setting until he/she has attained clinical sobriety (not just a specific blood concentration of the intoxicant).
    Such Pts may harm self or others, either accidently or impulsively.
12. DOCUMENT thoroughly your dispositional decision and its rationale.
    If decision was to D/C from Emergency Room, describe the instructions given to Pt regarding what to do if suicidal thoughts return.