**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 care setting?

**Problem:** Suicide is the leading cause of injury mortality in the United States (Rockett, et al. 2012). The Joint Commission’s National Suicide Patient Safety Goal (NPSG) requires facilities to “conduct a risk assessment that identifies specific patient characteristics and environmental factors that may increase or decrease the risk for suicide” (The Joint Commission, 2012, p.10). Patients often do not volunteer that their injuries are due to self-harm. Care providers need to have a high level of suspicion and attempt to identify potential risk factors and personal characteristics that are 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 setting of initial assessment in an emergency department (ED).

### Description of Decision Options / Interventions and the Level of Recommendation:

#### INITIAL SUICIDE ASSESSMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Level</th>
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</thead>
<tbody>
<tr>
<td>Suicide screening tools should be used as a part of the assessment process for appropriate ED patients (based upon presentation)</td>
<td>A</td>
</tr>
<tr>
<td>Screening for risk of suicide in pediatric patients over age 10 based upon presentation, is appropriate, feasible, and practical in the ED</td>
<td>B</td>
</tr>
<tr>
<td>Training ED personnel improves confidence in screening for suicide risk</td>
<td>B</td>
</tr>
<tr>
<td>The use of computer based tools for suicide risk assessment in the ED is feasible and acceptable to staff and for patients ages 11 and older</td>
<td>C</td>
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</tbody>
</table>

#### SUICIDE RISK INSTRUMENTS

The following suicide risk instruments are not recommended for assessment of risk in the ED setting:

- Beck Hopelessness Scale (BHS)
- Beck Scale for Suicide Ideation (BSS)
- Behavioral Activity Rating Scale (BARS)
- Centers for Epidemiologic Studies Depression Scale (CES-D)
- Centers for Epidemiologic Studies Depression Scale for Children (CES-DC)
- Columbia Suicidal Screen (CSS)
- Risk of Suicide Questionnaire (RSQ)
- Suicidal Ideation Questionnaire (SIQ)
- Suicide Ideation Questionnaire-Junior (SIQ-Jr)
- Violence and Suicide Assessment Form (VASA)

#### SUICIDE RISK PREDICTORS

Previous episodes of deliberate self-harm are a strong predictor of future suicide attempts.

- History of Major Depressive Disorder (MDD)
- Post Traumatic Stress Disorder (PTSD)

#### SUICIDE RISK PREDICTORS

Screening for suicide risk should be part of the assessment process based upon patient presentation, is appropriate, feasible, and practical in the ED. Patients with the following presentations should be considered for screening:

- Chronic illness in adults
- Substance abuse
- Recent negative life events
- Young female
- Males over 55 years of age
- Lethal methods of self-harm with self-cutting being significantly associated with repeat episode
- Binge or high episodic drinking for adolescents and young adults
- Living alone
- Lower socioeconomic status

**Overview and Purpose of CPGs:**

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 Guidelines for the Development of Clinical Practice Guidelines.

For more information on this topic, please go to [http://www.ena.org/practice-research/research/CPG/Documents/SuicideRiskAssessmentCPG.pdf](http://www.ena.org/practice-research/research/CPG/Documents/SuicideRiskAssessmentCPG.pdf)

The purpose of CPG’s is to positively impact patient care in emergency nursing by bridging the gap between practice and currently available evidence.

**Key:**

- **Level A (High) Recommendation:** Based on consistent and good quality of evidence; has relevance and applicability to emergency nursing practice.
- **Level B (Moderate) Recommendation:** There are some minor inconsistencies in quality evidence; has relevance and applicability to emergency nursing practice.
- **Level C (Weak) Recommendation:** There is limited or low-quality patient-oriented evidence; has relevance and applicability to emergency nursing practice.
- **Not Recommended:** Based upon current evidence.

**I/E:** Insufficient evidence upon which to make a recommendation.

**N/E:** No evidence upon which to make a recommendation.