Critical decisions in emergency medicine

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Exit Plans

While emergency physicians are adept at evaluating a wide range of high-risk medical conditions, providing ideal care to suicidal patients represents a significant challenge. The inherent complexity in estimating an individual's suicide risk can be compounded by the waxing and waning nature of suicidal thoughts, changes in a patient's psychiatric condition, acute social stressors, and alcohol or substance abuse. As such, clinicians must be prepared to approach these cases systematically and with utmost care.

Protecting Your Nest

Although the topic of personal finance is seldom broached during clinical training, it remains as essential to a physician's livelihood as the medical skills learned during residency. Throughout their careers, emergency clinicians must make wise, calculated decisions about wealth. To create and sustain financial stability, it is paramount to understand basic budgeting principles, know how and when to start investing, and stay abreast of the latest tax laws.

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Exit Plans

Suicidal Patients

LESSON 3


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OBJECTIVES

On completion of this lesson, you should be able to:

1. Identify patients at high risk of suicide.
2. Discuss the critical interventions that must be performed when managing suicidal patients.
3. Understand the indications for diagnostic testing in the evaluation of suicidal patients.
4. Recognize important elements in a patient's history that can guide a suicide risk assessment.
5. Discuss which patients are safe to discharge and which require inpatient psychiatric care.

FROM THE EM MODEL

14.0 Psychobehavioral Disorders
- 14.2 Mood Disorders and Thought Disorders
  - 14.2.3.1 Suicidal Risk

CRITICAL DECISIONS

- What should the initial assessment of a suicidal patient entail?
- What diagnostic tests are indicated for the evaluation of suicidal patients?
- Which factors should be considered when performing a suicide risk assessment?
- Which clinical decision tools can aid in the disposition of suicidal patients?
- Which suicidal patients are safe for discharge and which require inpatient psychiatric hospitalization?
- What interventions should be performed prior to discharging a suicidal patient?

According to the CDC, suicide ranks among the top 10 leading causes of death in all age groups and is the third most common killer of Americans younger than 35 years.[1] Sadly, the prevalence of suicide has increased steadily over the past two decades.[2] While emergency physicians are adept at evaluating a wide range of high-risk medical conditions, providing ideal care to these vulnerable patients represents a unique and daunting challenge.

CASE PRESENTATIONS

CASE ONE

An 18-year-old woman presents after a drug overdose. She admits to swallowing a "handful" of acetaminophen tablets following a fight with her boyfriend. She has never had suicidal thoughts before and has never attempted to harm herself. She has no history of mental illness and does not take any medications. Her vital signs are blood pressure 128/80, heart rate 85, respiratory rate 17, and temperature 37.0°C (98.6°F). A physical examination reveals no signs of trauma.

CASE TWO

A 40-year-old man presents with ankle pain after missing a step on a staircase. He has a history of alcohol abuse and depression and was recently evicted from his apartment. He has been living on the street and has no close family or friends. Upon further discussion, the patient reports recent suicidal ideation and scores at moderate risk on the universal screening tool, but he denies any current suicidal thoughts.

His vital signs are blood pressure 140/85, heart rate 75, respiratory rate 15, and temperature 37.5°C (99.5°F). His physical examination is remarkable for right ankle swelling and tenderness to palpation over the lateral malleolus; his neurovascular examination is normal, and x-rays reveal no acute fracture or dislocation.

CASE THREE

A 75-year-old Caucasian man is brought in by a family member who is concerned that the patient may be suicidal. The patient explains that he has felt lonely since his wife passed away, and he is not sure life is worth living. His family is particularly concerned because he lives alone and has a gun at home. His vital signs are blood pressure 156/75, heart rate 70, respiratory rate 14, and temperature 37.0°C (98.6°F).

The patient's history reveals that he was diagnosed with Parkinson disease 2 years ago, and his neurologic status has progressively worsened since that time. He appears to be well kept and is in no acute distress. His physical examination is remarkable for a resting tremor, rigidity, and bradykinesia, and he is noted to have a flat affect.

The inherent complexity in estimating an individual's suicide risk can be compounded by the waxing and waning nature of suicidal thoughts, changes in a patient's psychiatric condition, acute social stressors, and alcohol or substance abuse.[3,4] Moreover, the US is faced with a steady decline in mental health resources, a dearth that is magnified by the conspicuous lack of education related to mental health in current clinical training models.[3,5] In light of these obstacles, emergency clinicians must be more prepared than ever to approach these cases systematically and with utmost care.[4]

CRITICAL DECISION

What should the initial assessment of a suicidal patient entail?

Risk Screening

While many suicidal patients are easily identifiable, not all exhibit traditional warning signs (*Figure 1*). Approximately 6% to 10% of emergency department patients, regardless of chief complaint, admit to recent suicidal ideation or behavior.[6] Moreover, approximately 40% of those who successfully commit suicide visited the emergency department for nonpsychiatric complaints in the year prior to death.[5,7]

The Joint Commission's *National Patient Safety Goals* require emergency physicians to screen for suicidality in patients who present for primary emotional or behavioral disorders.[8] However, in the absence of validated tools and practice guidelines specific to suicide risk screening, clinicians face significant challenges when integrating this aspect of care into clinical practice.[9]

Of note, universal screening has been shown to identify nearly twice as many patients who are at risk of suicide than targeted screening algorithms.[5,10] Regardless of the screening process employed, it is imperative for physicians to maintain a high index of clinical suspicion for occult suicide risk.

General Approach

Emergency physicians should strive to establish rapport with any suicidal patient using a sympathetic but direct approach. This enhances communication and improves the quality of the acute assessment.[4] Talking to the patient alone in a quiet and secure area, maintaining eye contact throughout the interview, and speaking in a nonjudgmental tone can help to promote patient engagement. Clinicians should use open-ended questions aimed at gaining insight into the patient's thoughts and feelings. Attempts should be made to verbally calm agitated patients by engaging in collaborative and respectful conversation.[4]

Although this can often be uncomfortable, emergency physicians are urged to explicitly inquire about suicidal ideation, as this is an essential component of any at-risk patient's initial assessment. It is important to understand that merely asking about suicidal thoughts or plans does not incite or encourage self-harm.[11] In fact, most patients report a sense of relief and support when a clinician attempts to explore and understand their current psychological distress.[4,12]

Unfortunately, approximately 25% of suicidal patients initially deny suicidal ideation when asked. Many fear the clinician's judgment, the stigma associated with mental disorders, and

FIGURE 1. Suicide Warning Signs

the loss of autonomy and control over the situation. An initial denial of suicidal thoughts should not represent the end of the risk assessment; it should merely serve as the beginning of a systematic inquiry. The recognition of certain observable behavioral cues, including profound social withdrawal, irrational thinking, paranoia, a depressed affect, and anxiety and irritability, can also be clues to the possible presence of suicidal ideation.

A variety of structured tools can help guide the initial interview, including the Columbia Suicide Severity Rating Scale (*Table 1*), which provides a flexible interview format to help facilitate the disclosure of sensitive patient information.[13]

Collateral Information

After taking a thorough history, it is important to obtain collateral information from appropriate resources when possible, including police, family members, friends, and outpatient health care providers.[11] This corroboration is particularly crucial for patients who screen positive for suicidal ideation but decline treatment. In addition, collateral information is invaluable when managing patients with an altered level of consciousness and those who appear to be unreliable narrators.[14]

Asking the patient's permission before contacting collateral sources may enhance rapport.[15] However, the Health Insurance Portability and Accountability Act of 1996 allows health care providers to establish contact without permission when managing patients who appear to pose a risk to themselves or others.[2]

Safety Precautions

Patients who are actively suicidal should be kept under one-to-one observation. Physicians should confirm that the patient does not have access to potentially dangerous objects (eg, belts, shoelaces, sharp medical instruments) that could be used for self-harm.[4] In addition, the patient's belongings should be well secured; purses and backpacks may contain weapons, lighters, medications, and other potentially harmful items.[12]

Suicidal patients should not be allowed to leave the emergency department until their evaluation is complete.[16] Because the criteria and methods for placing patients under an involuntary hold vary from state to state, clinicians should know and follow all local and state regulations regarding this practice.[17]

CRITICAL DECISION

What diagnostic tests are indicated for the evaluation of suicidal patients?

A focused medical assessment is required for any patient who presents with acute psychiatric symptoms.[4] The goal of this evaluation, which relies primarily on a thorough history and physical examination, is to identify any medical issues that require emergent or urgent treatment.[4] The examination should include details about previous drug ingestions, trauma, and other medical conditions that may affect the patient's mental state.

Although the differential diagnosis for behavioral symptoms is broad and beyond the scope of this article, physicians should consider infections, metabolic derangements, endocrine abnormalities, medications, substance abuse and withdrawal, and CNS disorders as potential etiologies.[11] The failure to recognize an organic cause of the patient's psychiatric symptoms

TABLE 1. Columbia-Suicide Severity Rating Scale[13]

1. Wish to die	
	Have you wished you were dead or wished you could go to sleep and not wake up?
2. Active thoughts of suicide	
	Have you actually had any thoughts of killing yourself?
3. Plan	
	Have you been thinking about how you might do this?
4. Intent	
	Do you have some intention of acting on these thoughts?
5. Plan PLUS Intent	
	Have you done anything, started to do anything, or prepared to do anything to end your life?

can lead to delays in treatment and increased morbidity and mortality.[11]

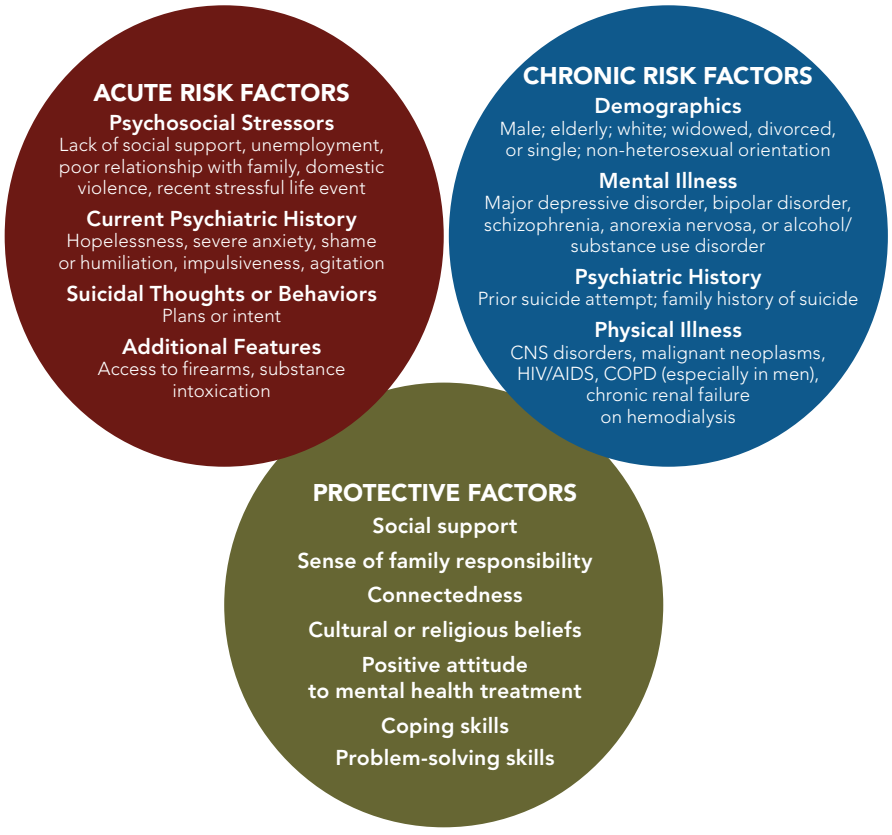
In general, there are no data to support the use of routine laboratory tests for psychiatric patients whose history and physical examination exclude significant medical illness.[4,18,19] In an awake, alert patient with no acute medical complaints, a normal physical examination, and a clear psychiatric cause for presentation, routine laboratory studies are unlikely to yield clinically significant findings.[11] In order to expedite the care of psychiatric patients, a mutual agreement between emergency physicians and mental health consultants regarding minimal diagnostic testing for psychiatric clearance is of paramount importance.[3]

While routine diagnostic testing has not demonstrated any clinical advantage, there is a subset of high-risk patients who may benefit from further testing, including those who are elderly, immunosuppressed, have a history of substance abuse, lack a prior psychiatric history, have new-onset psychosis, and suffer from preexisting medical disorders.[3,11]

Those who are under the influence of alcohol or substances must be observed and reassessed when clinically sober, as the patient's ability to participate in the clinical examination is critical.[4] There is no particular blood alcohol level that must be reached before a psychiatric evaluation is required.[3,4] A clinical assessment based on the patient's cognitive abilities is preferred over blood alcohol testing for assessing intoxication.[2]

American College of Emergency Physicians (ACEP) guidelines cite normal coordination, cognition, and a lack of emotional lability as signs of sobriety that indicate when the patient is ready for a psychiatric assessment.[2,3,20] For patients who receive medications in the emergency department or who present with alcohol or substance use, the serial monitoring of vital signs is important to detect adverse events or signs of withdrawal.[12]

FIGURE 2. Risk and Protective Factors for Suicide[2,12]



As the suicide assessment proceeds, the physician should be alert for previously unrecognized symptoms of trauma or toxicity resulting from ingestion, as suicidal patients may withhold this information during the initial assessment. Any change in the patient's physical condition or level of consciousness should prompt further evaluation.[12]

CRITICAL DECISION

Which factors should be considered when performing a suicide risk assessment?

Risk assessment is a critical element in the management of any suicidal patient.[17] Ultimately, the goal is to determine an appropriate intervention for each individual, with options ranging from discharge to involuntary psychiatric hospitalization.[4] The breadth and depth of any assessment varies depending on the practice setting, the patient's mental state and ability or willingness to provide information, and the availability of collateral information.[12]

Despite the lack of guidelines and the fact that there is no validated method for risk stratification, it is imperative for emergency physicians to take an organized, systematic approach in their assessment of suicidal patients.[4] This is especially true for clinicians who practice in settings without easy access to mental health consultants.[5]

Comprehensive Risk Assessment

The vast majority of suicidal patients who present to the emergency department require a comprehensive risk assessment to inform decisions regarding their treatment and disposition.[4] This assessment must be based on the clinician's ability to obtain a good qualitative history when the patient is alert, sober, and cooperative.[2] Comprehensive assessments are typically conducted by mental health consultants (eg, psychiatrists, psychologists, social workers), but may vary based on the clinical environment and available resources.[4]

Although not specifically designed for the acute setting, the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) tool provides a risk-

assessment framework that can be used with or without the aid of a mental health specialist.[5,21] The SAFE-T steps are:[21]

- Identify risk factors.
- Identify protective factors.
- Conduct a suicide inquiry.
- Determine the patient's risk level and need for intervention.
- Document findings.

Risk Factors

A number of critical factors are associated with increased suicide risk (*Figure 2*).[2,12] Acute risk factors generally fluctuate over time, whereas chronic threats are considered fixed or nonmodifiable.[2,17] Although no pathognomonic elements are predictive of imminent suicide, several are strong predictors of *eventual* suicide. These factors include a previous suicide attempt, a current lethal plan, recent psychosocial stressors, older age, Caucasian race, and a previous psychiatric diagnosis.[17] A prior suicide attempt is the best known predictor of future suicidal behaviors.[22] Physicians should be aware that even one or two very serious risk factors (eg, a near-lethal suicide attempt with strong intent to die) can significantly elevate the threat of self-harm.[12]

While a minority of individuals are chronically suicidal, most become suicidal in response to negative life events or psychosocial stressors that overwhelm their capacity to cope, especially in the presence of a psychiatric disorder. A critical element of the risk assessment should be focused on *why now*? In other words, clinicians should aim to understand what it is about the patient's current circumstances that has led them to consider or act on their suicidal thoughts and impulses.[9] Acute stressors that can serve as "tipping points" include relationship problems, financial hardships, legal difficulties, public humiliation or shame, and worsening prognosis of a medical condition.

Alcohol or Substance Use

Intoxication can be a particularly onerous clinical element, as some patients may report suicidal ideation while intoxicated but deny these thoughts when clinically sober.[23] Alcohol and drug addiction should be considered a vital component of any emergency department evaluation, as those with substance use disorders are more likely to have serious suicidal thoughts, plans, and attempts.[4] Chronic alcohol and drug use increase the long-term risk of suicide, but these factors can also pose an acute danger by impairing patients' thought processes or increasing their impulsivity.[24]

Studies have shown that individuals with alcohol dependence have a 9-fold increased risk of suicide, and acute alcohol use in the final hours of life confers an even greater threat than the dangers attributed to chronic alcohol use alone.[9,25] More than one-third of patients who have attempted suicide report consuming alcohol before their attempt.[23] Additionally, alcohol and drug intoxication can mask important medical symptoms that could suggest an organic reason for the patient's suicidal ideation.

Protective Factors

Physicians should also aim to identify protective factors, or characteristics that reduce the likelihood of suicide. A patient's social support system and the strength of their bond with others, including family members and friends, is a critical defense against suicide.[12] The ability to identify reasons for living is an equally important reflection of the patient's degree of optimism about life. A sense of responsibility to family, particularly children, commonly makes suicide a less viable option.[12]

While risk factors and protective elements can help clinicians weigh the relative probability of a patient engaging in suicidal behaviors, no evidence-based system exists to inform how much weight should be assigned to any given factor. Because the way in which these factors interact is sometimes unclear, clinicians cannot simply "balance" one set of elements against another. As discussed previously, no single risk factor necessarily conveys increased suicidal risk. Similarly, the interaction and strength of protective factors varies among individuals and fluctuates over time.

TABLE 2. Estimation of Suicide Risk and Intervention[4,21]

Risk Level	Risk/Protective Factor	Suicidality	Intervention
Low	• Modifiable/limited risk factors • Strong protective factors	• Recent suicidal ideation • No intention to act or plan • No previous attempt or plan	• Consider consultation with mental health to arrange outpatient referral/treatment • Develop safety plan
Moderate	• Multiple risk factors • Limited protective factors	• Current suicidal ideation with plan • No intention to act • No recent attempt or preparatory behavior	• Admission may be necessary depending on risk factors • Consult mental health for a more thorough assessment
High	• Acute state of mental disorder or acute psychiatric symptoms • Acute precipitating event • Inadequate protective factors	• Recent suicide attempt or preparatory behavior • Persistent suicidal ideation • Strong intent to act or plan	• Admission generally indicated • Suicide precautions

Modified from Betz ME, Boudreaux ED. Managing suicidal patients in the emergency department. *Ann Emerg Med.* 2016;67(2):276-282.

Suicide Inquiry

It is vital to conduct a thorough inquiry regarding the patient's suicidal thoughts, plans, behaviors, and intent. If suicidal ideation is present, the physician should ask about specific plans for suicide and whether any steps have been taken to enact those plans (ie, rehearsing suicide, hoarding medications, writing a suicide note).[12] Although some suicidal acts occur impulsively with little or no planning, a detailed strategy generally heralds a greater risk.[12] A conversation about the timing, location, and lethality of the patient's plan, as well as the availability of means (particularly firearms), can also elicit critical information.

Regardless of whether a specific plan has been developed, the patient's level of intent should be explored. Suicidal intent, which reflects the intensity of a patient's wish to die, can be assessed by determining the motivation for suicide.[12] In general, the greater and clearer the intent, the higher the risk. If a suicide plan has been developed, the physician should assess the extent to which the patient expects to carry it out and whether they believe the plan to be lethal as opposed to self-injurious.[12]

The strength of a patient's intent to die and their subjective belief about the lethality of the method are more relevant than the *actual* lethality of the method itself. For instance, even a patient with a low-lethality plan or attempt may be at high risk in the future if their intentions are strong and they believe that the chosen method will be fatal.[12]

Evaluating Risk

Ultimately, physicians must use their clinical judgement to categorize patients as low, moderate, or high risk of suicide (*Table 2*).[4,21] This assessment should be based on a thorough review of risks and protective factors in the context of a complete clinical evaluation.

In general, high-risk patients will have one or more of the following characteristics: prior suicide attempt, psychiatric disorder, an acute precipitating event, substance abuse, active plan or strong intent, and poor social support. In contrast, low-risk patients lack these characteristics and often have mostly modifiable risks with strong protective factors.[12]

TABLE 3. MSPS Scale[26]

Risk Factors		Points
S	Sex: male	1
A	Age: <19 or >45 years	1
D	Depression or hopelessness	2
P	Previous attempt or psychiatric care	1
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated/divorced/ widowed	2
O	Organized or serious attempt	2
N	No social support	1
S	Stated future intent	2

CRITICAL DECISION

Which clinical decision tools can aid in the disposition of suicidal patients?

Although a number of suicide screening tools exist, the modified SAD PERSONS (MSPS) scale and the Manchester Self-Harm Rule have been proposed specifically for use in the emergency department. The MSPS incorporates 10 criteria for assessing potentially suicidal patients by differentially weighting each factor (*Table 3*).[26] Patients with a score of 5 or less may be discharged home with a referral for an outpatient psychiatric evaluation. Those with a score of 6 or higher require an emergent psychiatric consultation and possible hospital admission. The MSPS has been demonstrated to correctly identify patients with a sensitivity of 94% and a specificity of 71%.[26] One major limitation of this rule, however, is that it was developed at a single institution and consequently may not be externally generalizable.[17]

The Manchester Self-Harm Rule, which is comprised of 4 questions, was designed to determine the short-term risk of suicide in patients presenting after self-harm (*Table 4*). If any of the criteria are true, the patient is deemed at high risk of repeated self-harm (sensitivity 94%, specificity 25%).[27] However, as with the MSPS, the rule may have limited generalizability. In addition, the tool excludes other important risk factors.[17]

Unfortunately, there is a limited amount of prospective research on the effectiveness of both the MSPS and Manchester Self-Harm Rule. In accordance with ACEP's clinical policy, screening tools should not be used in isolation to guide decisions regarding the disposition of suicidal patients.[3]

CRITICAL DECISION

Which suicidal patients are safe for discharge and which require inpatient psychiatric hospitalization?

The physician's estimation of a patient's suicide risk is a key component in determining any safe disposition. Other factors that should be considered include the patient's ability to provide adequate self-care, understand the risks and benefits of various treatments, know what to do in a crisis, and cooperate with treatment planning and implementation.[12]

Psychiatric inpatient admission remains the most common disposition for those at moderate-to-high risk

TABLE 4. The Manchester Self-Harm Rule[27]

- Any history of self-harm
- Previous psychiatric treatment
- Any current psychiatric treatment
- Benzodiazepine use in attempt

TABLE 5. Criteria for Inpatient Psychiatric Hospitalization[12]

Admission is generally indicated if:
• Attempt was violent, near-lethal, or premeditated
• Persistent plan or intent is present
• Limited family/social support or unstable living situation
• Impulsive behavior, severe agitation, psychosis, poor judgement, or refusal of help is evident
• Altered mental status with a metabolic, toxic, infectious (or other) etiology requiring further workup

Modified from Jacobs et al. Practice guidelines for the assessment and treatment of patients with suicidal behaviors. *Am J Psychiatry.* 2003;160(11):53.

of suicide.[4] Inpatient care is usually indicated for those who pose a serious threat to themselves or others.[12] Although voluntary admission is preferable for building patient rapport, physicians should be knowledgeable regarding the criteria for involuntary hospitalization based on the laws of the state in which they practice, the length of commitment, and other requirements (*Table 5*).[28]

Low-risk patients who do not require inpatient treatment may be appropriate for discharge from the emergency department.[12] In general, this includes those with no suicide plan or intent, no prior suicide attempt, no history of mental illness or substance abuse, and no agitation or irritability.[4] The stability of a patient's support system and ability to cooperate with follow-up recommendations should also be considered carefully prior to discharge.[12]

Despite an emergency physician's best efforts at measuring risk, a substantial number of patients fall within the "gray zone." In such cases, the involvement of mental health consultants is particularly useful, as they may be able to provide alternative types of support, including brief interventions, crisis housing, acute diversion efforts, and expedited mental health appointments.[29]

CRITICAL DECISION

What interventions should be performed prior to discharging a suicidal patient?

While the vast majority of disposition decisions should be made in consultation with a psychiatrist, emergency physicians retain the final authority over and responsibility for discharge decisions.[4] A thorough discharge plan is required for those who are deemed appropriate for outpatient management. First, the physician should help the patient formulate a written safety plan that can be followed during times of crisis.[2,4] The basic components of the plan include recognizing the warning signs of suicidality, identifying coping strategies, and contacting family members or mental health professionals in the event of a crisis.[2,30] A printable safety plan template is available online at suicidesafetyplan.com.[4]

It is important to note that a safety plan is distinctly different than a "no-suicide contract." A written or verbal agreement between the clinician and patient requesting that the patient refrain from self-harm, commonly referred to as "contracting for safety," has not been shown to prevent suicide and is no longer recommended.[30] Furthermore, a safety contract is not legally binding and does not protect physicians against negligence claims.[2]

Second, the clinician should make every effort to limit the patient's access to potentially lethal means. Because suicidal acts are often impulsive, survival can depend on the lethality of the method chosen.[31,32] Suicide attempts involving firearms are associated with the highest fatality rate (>90%).[33] As such, all suicidal patients should be routinely questioned regarding their access to guns. Patients and their families should be counseled to store firearms outside the home; any guns should be locked, unloaded, and separated from ammunition.[4]

Finally, all patients who are discharged require a rapid referral for outpatient psychiatric care.[4] A patient's risk of suicide is significantly heightened following discharge from the emergency department, so the efficient transition to the outpatient setting is critical.[4] A specific appointment should be made prior to discharge, and enlisting the assistance of family or friends may help to ensure follow-up.[4] In addition, patients and family members should be given the number to the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and other information regarding peer support and local crisis contacts.[2] The appropriate coordination of care improves treatment adherence and reduces hospitalization and emergency department recidivism rates.

Summary

As the incidence of suicide rises and the access to mental health resources declines, emergency physicians will be called upon with increasing frequency to provide care for suicidal patients. Because access to mental health specialists is not always possible, clinicians must be comfortable with managing these high-stakes cases and systematic in their approach. Moreover, it is vital for clinicians to familiarize themselves with the statutes that govern involuntary psychiatric hospitalization protocols in their practice region.

Once a suicidal patient has been identified, it is critical to institute appropriate safety precautions while conducting a thorough history and physical examination. Physicians must be knowledgeable regarding the indications for admission as well as the steps that should be taken to ensure the safe discharge of low-risk patients from the emergency department.

Pearls

- Patients should be asked directly about their suicidal thoughts; such questioning does not incite or encourage suicidal behavior.
- A thorough history and physical examination should guide the medical workup of suicidal patients; routine diagnostic testing has not been shown to be beneficial in this population.
- Inpatient psychiatric hospitalization is usually indicated for those who pose a serious threat of harm to themselves or others.
- Physicians should understand the criteria for involuntary hospitalization based on the laws of the state in which they practice.

CASE RESOLUTIONS

CASE ONE

The young woman who impulsively ingested acetaminophen was remorseful and adamant that she had no intention of harming herself. A full medical workup determined that no further treatment for drug toxicity was required. Give the patient's acute intoxication, however, a longer period of observation and a more thorough risk assessment were warranted. The patient was agreeable to having the physician contact her boyfriend and parents to obtain additional collateral information.

CASE TWO

Although the middle-aged man initially presented with ankle pain, he also admitted to having recent suicidal thoughts upon further questioning. His history of chronic alcohol use and depression were especially worrisome. In addition, the patient appeared to lack social support and was dealing with a recent psychosocial stressor. Although he denied any current thoughts of harming himself and had no prior suicide attempts, he was determined to be at moderate risk, and psychiatry was consulted regarding a more comprehensive risk assessment.

CASE THREE

The elderly man with depressive symptoms had a significant number of factors that placed him at high risk of suicide. First, there is evidence that elderly Caucasian men are among the highest-risk group for suicide. Second, the patient had a chronic, disabling condition that caused him pain, which undoubtedly contributed to his worsening depression. Third, the recent death of his wife was determined to be a significant acute stressor that affected his ability to cope.

Finally, and most importantly, he reported feeling hopeless and said he was unsure that life was worth living. The clinician determined that the patient would benefit from a psychiatric evaluation. Due to his high risk of self-harm and his access to a firearm, he was admitted for inpatient psychiatric care.

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Pitfalls

- Relying solely on a clinical decision tool to guide the disposition of a suicidal patient.
- Dismissing an intoxicated patient's claims of suicidal ideation.
- Being unfamiliar with the basic components of a suicide risk assessment.
- Failing to inquire about a patient's access to lethal means, specifically firearms, prior to discharge.