Review of current use and perceived barriers of suicide screening in the Emergency Room

Katie Koerner and Niki Eisenmann

Cheyenne Regional Medical Center
We Inspire Great Health!

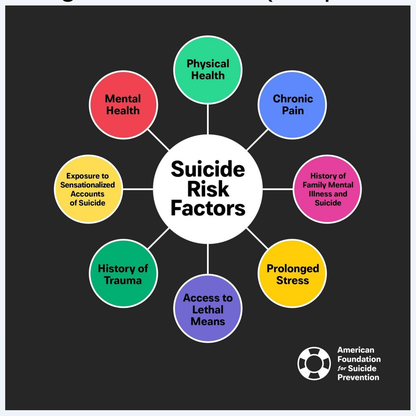
MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Introduction

Suicide is a leading cause of death worldwide claiming more than 800,000 lives every year. Wyoming has the highest suicide rate per capita in the United States. The emergency department (ED) can play a crucial role in identifying risk early and preventing future attempts. Currently the ED at CRMC uses the Columbia-suicide severity rating scale on all patients to screen for suicidal ideation. Screening is a crucial preventative measure in the ED.

Background

- **Suicide is a growing health concern**
  - Rates have increased by 35% from 1999 to 2018 (Simpson et al., 2021)
  - 10th overall cause of death and 2nd cause of death for those age 10-24 in 2018 (Horowitz, 2020)
- **Suicide screening in the medical setting is becoming crucial to suicide prevention**
  - Medical illness is one of the top risk factors for suicide (Horowitz, 2020)
  - Within 3 months of committing suicide 72% of adults saw a healthcare provider (Horowitz, 2020)
  - 38% of youth suicide victims saw a provider within 4 weeks of completing suicide (Horowitz, 2020)
  - 50% of youth were seen in the ED in the year prior (Horowitz, 2020)
  - Those treated in the ED are twice as likely than the general population to die by suicide in the year following their ED visit (Simpson et al., 2021)



Current Problem

- **Current self-perceived barriers witnessed in the ED**
  - Minimal differences between the care of high-risk patients and low-risk patients
  - Nurse perception that certain questions are unnecessary
  - Patients not answering honestly to avoid certain treatment outcomes

- **2022-2023 screening statistics from CRMC**
  - 11% of all patients seen were not screened at all
  - 86% were screened as no risk
  - Between July 2022 and June 2023 on average less than 1% of those who screened positive were considered low risk

How accurate are these statistics related to the current screening?

The C-SSRS has a low sensitivity and is unable to differentiate risk in general ED/ medical patients (Simpson et al., 2021). Therefore, the percentages of patients at high vs low vs no risk may be skewed.

Question

Will the use of the ASQ vs the use of the C-SSRS lower the current treatment barriers that influence the emergency room nurses' and patients' perceptions regarding suicide screenings?

Literature Review

- **Biggest problem with Screenings:**

  No scale has been found to accurately differentiate level of risk potentially leading to (Zortea et al., 2020)**:**
  - Missing a high percent of those at risk for future suicidal behaviors and missing the opportunity for preventative treatment (Zortea et al., 2020)
  - Excessive false positives leading to unnecessary treatments that yield no benefit (Zortea et al., 2020)

- **Columbia-Suicide Severity Rating Scale (C-SSRS)**
  - Not validated for the medical patient (Thom et al., 2020)
  - In-depth and long questions that are hard to administer quickly (Thom et al., 2020)
  - Potential for missing multiple combinations of SI and behaviors (Thom et al., 2020)
  - Contains ambiguous wording (Thom et al., 2020)

- **Ask Suicide-Screening Questions (ASQ)**
  - Only screen designed for medical patients with chief nonbehavioral health complaints (Thom et al., 2020)
  - 97% sensitivity (Aguinaldo et al., 2021)
  - 87% specificity (Aguinaldo et al., 2021)
  - Found to improve ability to predict future behaviors in both medical and psychiatric emergency patients (Aguinaldo et al., 2021)
  - Screens for acute suicidal vs non acute suicidal not high vs low vs moderate risk (Aguinaldo et al., 2021)
  - For all non-acute a brief safety assessment by the provider is conducted to determine if a more in-depth evaluation is needed (Aguinaldo et al., 2021)

Future Work

- **30 day trial period of ASQ in the ED**
- **Nurse feedback to address barriers with ASQ vs C-SSRS**
- **Evaluate nurse satisfaction and patient outcomes before and after trial**

References

Aguinaldo, L. D., Sullivant, S., Lanzillo, E. C., Ross, A., He, J.-P., Bradley-Ewing, A., Bridge, J. A., Horowitz, L. M., & Wharff, E. A. (2021). Validation of the ask suicide-screening questions (ASQ) with youth in outpatient specialty and primary care clinics. *General Hospital Psychiatry*, *68*, 52–58. https://doi.org/10.1016/j.genhosppsych.2020.11.006

Horowitz, L. M. (2020). Screening and managing suicide risk in medical settings: turning research into practice. *National Institute of Mental Health*.

Simpson, S. A., Goans, C., Loh, R., Ryall, K., Middleton, M. C., & Dalton, A. (2021). Suicidal ideation is insensitive to suicide risk after emergency department discharge: Performance characteristics of the columbia-suicide severity rating scale screener. *Academic Emergency Medicine*, *28*(6), 621–629. https://doi.org/10.1111/acem.14198

Thom, R., Hogan, C., & Hazen, E. (2020). Suicide risk screening in the hospital setting: A review of brief validated tools. *Psychosomatics*, *61*(1), 1–7. https://doi.org/10.1016/j.psym.2019.08.009

Zortea, T. C., Cleare, S., Melson, A. J., Wetherall, K., & O'Connor, R. C. (2020). Understanding and managing suicide risk. *British Medical Bulletin*, *134*(1), 73–84. https://doi.org/10.1093/bmb/ldaa013