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A few simple questions could help doctors stem the suicide epidemic

But ERs say they lack the resources to screen patients for suicidal thoughts.

Edwin Boudreaux has tested suicide screening in emergency rooms in seven states. (Adam Glanzman/For The Washington Post)

By **William Wan**

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Edwin Boudreaux remembers the first time he was left in charge of a patient as a graduate student training to be a psychologist. The patient had come in for routine diabetes treatment but it quickly became apparent she was suicidal.

“She was so suicidal, I had to walk her from our clinic to the emergency department just to make sure nothing would happen in between,” Boudreaux said.

Almost three decades later, Boudreaux has produced compelling research showing an alarming number of emergency room patients coming in for unrelated problems have nascent, undetected suicidal thoughts — a large population who might be saved if doctors and nurses would simply ask if they’re having suicidal thoughts.

“It should be a no-brainer,” said Boudreaux, professor of emergency medicine and psychiatry at the University of Massachusetts Medical School, who has been one of many suicide prevention researchers pushing to make such screening mandatory in ERs nationwide. “You can save hundreds of lives doing this. But the amount of pushback has been frustrating.”

America’s suicide problem has now reached crisis levels. Every year since 1999, the country’s suicide rate has increased, climbing 33 percent in the past two decades. More

than 47,000 people now kill themselves every year, and more than a million attempt to do so. Alarmingly, new analyses show the increase has been sharper in teenagers and adolescents than any other age group. Gun violence is intertwined with the overall rise — nearly half of all fatal suicides involve firearms. Suicides now account for 60 percent of America's gun deaths.

Leading medical authorities argue the United States could reduce those skyrocketing rates with a relatively simple solution by screening for suicide in health clinics and ERs.

Universal screening entails asking everyone visiting a primary care clinic or ER whether they are having suicidal thoughts, and if so, following up with brief interventions such as telephone counseling and referrals for additional treatment.

The idea is endorsed by the National Institute of Mental Health, which has poured millions of dollars into researching the proposal and has tried to persuade physician groups, health-care companies and regulators to support it. Suicide prevention groups also have pushed for widespread screening.

Resistance has mainly come from the hospital industry and ER doctors and nurses, who say they don't have sufficient resources to deal with suicidal and mentally ill patients they're already aware of in their facilities — much less additional ones who would be identified by screenings. The American College of Emergency Physicians has come out against the idea, for those same reasons. The Joint Commission — which is in charge of accrediting hospitals and carries enormous influence on their policies — has said that screenings could be helpful but has not made them mandatory.

In an email, the commission's Executive Vice President for Health Care Quality Evaluation David Baker explained that after extensive consideration, his organization decided not to require universal screening because research showed screening alone wasn't effective when it isn't combined with counseling and follow up.

"At this time, most [emergency departments] are not able to provide this level of care," Baker said. "We would be willing to consider an expansion of the screening requirement in the future, and we continue to follow this issue closely."

Doctors and health experts say that mental health treatment is severely underfunded and understaffed in hospitals across the country. Patients coming into ERs with mental health problems often sit for 24 hours or more waiting to see a doctor. Some wait for days and even weeks for a bed in the psychiatric ward.

"If I have a patient with appendicitis or a heart attack, I can get a surgeon on the phone and get the patient taken care of instantly," said Sandra Schneider, an emergency physician and former president of the ACEP. "But if someone came in trying [to] kill themselves, in many hospitals in the country, the only person available is a psychiatric nurse or social worker or behavioral specialist on call that day. It's not even a doctor."

Mental health treatment in ERs is often harder to get reimbursed for than physical ailments, emergency doctors say. And in some cases, hospitals end up swallowing the cost.

Emergency physicians also point to the litany of screenings they do for other problems, such as tobacco, alcohol use and domestic violence. They say they would need more time, money and training to add suicide screening.

“I happen to be a fan of screening, but the question is how do you treat folks once you find out they want to hurt themselves?” said Michael Wilson, an emergency department physician and mental health researcher at the University of Arkansas. “You can’t just screen and send them out the door.”

As it is, he said, ER staff often have to decide among bad options: Hospitalizing patients, which can strain resources, or discharging them with a sheet of mental health clinics to call — which might not be able to see new patients for a month or even longer.

“Focusing on screening is a little like worrying about the lawn catching on fire when the house is burning down,” Wilson said.

Boudreaux acknowledged such concerns.

“There are real barriers to implementation,” he said. “No one denies that. But what’s the alternative? Would we rather not know that people want to kill themselves? Is it better to just not ask and not know?”

After spending the past decade testing suicide screening in ERs in seven states, Boudreaux said he is convinced the approach is saving lives.

As part of a $17 million federally funded study, Boudreaux and other researchers at eight hospitals found that adding screening in ERs almost doubled the number of patients identified as having suicidal thoughts or who had attempted suicide in the past — from 2.9 percent of adult patients to 5.7 percent.

Researchers also found that combining screening with brief telephone counseling after the visit led to 30 percent fewer total suicide attempts over the 52 weeks of follow-up, compared with standard emergency department care.

A different study last year — based on treatment of 1,200 patients at five Veteran Affairs hospitals — showed even a simple intervention by ER staff can reduce the chances of future attempts. By making a safety plan with suicidal patients before discharging them, ER staff reduced their risk of suicidal behavior by half.

The safety plans involved making a list of people to call when suicidal urges arise, including mental health providers and crisis lines, as well as coming up with coping strategies and limiting access to lethal means such as guns or poisonous materials.

“A lot of times, patients don’t seek further care other than what they get in the emergency department,” said Barbara Stanley, a Columbia University psychologist who wrote the study. “This may be the only time we have with them. So the idea was let’s give them something they can walk away with, even it’s small.”

Suicide prevention groups and emergency departments have started to find common ground. Over the past year, for example, emergency physicians have worked with the American Foundation for Suicide Prevention to develop a rapid suicide screening and intervention tool called ICAR2E, which they encourage ERs to adopt voluntarily, to help assess and manage suicidal patients.

“We took 31 studies on suicide prevention in emergency departments and boiled it down to best practices and steps,” Wilson said. “Every emergency physician I know got into this business to save lives. The question is what are the best ways to do that?”

Universal screenings are unlikely to become widespread unless an accreditation authority such as the Joint Commission makes them mandatory, or if funding for them were made available, ER doctors and mental health advocates said.

New funding, however, appears unlikely unless federal officials overseeing Medicare and Medicaid were to introduce reimbursements, financial incentives for safety planning or screening in hospitals, or change the way mental health treatment is funded in emergency departments, ER officials and suicide prevention advocates said.

Officials at Centers for Medicare and Medicaid Services did not respond to questions on whether they are considering any such change.

“The question is whether we as a society are willing to pay what it takes to address the problems of mental health,” Boudreaux said.

If you or someone you know needs help, call the National Suicide Prevention Lifeline at 800-273-TALK (8255). You can also text a crisis counselor by messaging the Crisis Text Line at 741741.