Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance

Ann M. Mitchell, PhD, RN [Assistant Professor of Nursing], University of Pittsburgh School of Nursing, Pittsburgh PA
Linda Garand, PhD, APRN, BC [Assistant Professor of Nursing], University of Pittsburgh School of Nursing, Pittsburgh PA
Diane Dean, RN, MA, LPC [Instructor of Nursing], University of Pittsburgh School of Nursing, Pittsburgh PA
George Panzak, MS, RN [Instructor of Nursing], and University of Pittsburgh School of Nursing, Pittsburgh PA
Melissa Taylor, PhD, RN [Assistant Professor of Nursing], University of Pittsburgh School of Nursing, Pittsburgh PA

Abstract

Suicide is a complex, multidimensional event with a host of contributing factors. Suicidal emergencies are among other behavioral and psychiatric emergencies that provide the basis for emergency department visits. Therefore, emergency departments are ideal clinical environments for the assessment of suicidal patients. A case example from an emergency department visit is provided as a basis of discussion as we describe subpopulations at high risk for suicide and review critical assessment parameters for the recognition and treatment of suicidal patients. Lastly, factors associated with patient satisfaction and treatment compliance are addressed to promote positive health outcomes among suicidal patients.

Keywords

Suicide assessment; Emergency department; Patient satisfaction; Patient compliance

Case Study

The police brought a 45 year-old man to the emergency department. The patient stated that his wife had left him and he felt suicidal with a plan for carrying it out. The patient was diagnosed with Major Depressive Disorder without psychotic features and his Global Assessment of Function (GAF) score was 25. The patient acknowledged two previous suicide attempts in the past few months. He received no treatment for these attempts. He reports that his first attempt involved taking a “bunch of pills and drinking alcohol.” His second attempt involved trying to shoot himself with a loaded gun. However, the gun failed to fire. He reports that he no longer has access to the weapon, as he threw the gun into the river.

The patient reports that his depression began approximately two years ago, after being separated from his wife of 23 years. He states that his symptoms worsened in recent months.
after finding out that his wife has a boyfriend. His current symptoms include hopelessness, helplessness, low motivation, anxiety, lack of energy, fatigue, guilt, and anorexia. He has become increasingly withdrawn and isolative over the past year and has lost over 20 pounds in the past two months. The patient also reports high levels of guilt related to regrets that he was not a good husband to his wife. He drank alcohol excessively and “cheated on her” during their marriage. The patient reports that he has been a heavy smoker and drinker for the past 15 years. He denies any history of psychiatric inpatient or outpatient treatment. He acknowledged a history of suicidal ideation (SI) but denied a history of homicidal ideation (HI). He acknowledged a family history of depression in his sister and reports that his father was a “heavy drinker.” His wife has “alcohol problems” as well.

The patient lacks a support system, stating that he has no close family members and that most of his friends have “given up” on him. He worked full-time on a maintenance team in manufacturing for the last ten years, but recently lost his job due to company layoffs. His children (18 year-old son and 16 year-old daughter) live with their mother and do not visit him. Along with suicidal thoughts, he endorses current homicidal thoughts. Patient states that he has intent to kill his wife but he does not have a concrete plan.

Introduction

Every 16.6 minutes, one American dies by suicide, totaling over 30,000 suicides per year.\(^1\) Suicide is a complex, multidimensional event with a host of contributing factors. Because suicide in America involves people of all ages, economic, social, and ethnic backgrounds, health care professionals must be skilled in the assessment of suicidal risk. Such assessment skills are essential for the detection, diagnosis, and treatment of mental illnesses and for the prevention of the occurrence of future harmful events. Because the hospital emergency department is often associated with traumatic events, it is the ideal environment to perform suicide risk assessments. Further, acutely suicidal individuals may report to the emergency department for crisis intervention and the staff must know how to properly assess the patient’s level of lethality and manage their care.

Sub-Populations at High Risk of Suicide

Suicide in Adolescents

Young adults aged 15 to 24 years old, account for a large number of America’s suicides each year, occurring about every two hours. Data on attempted suicide in general, are far fewer and less reliable than completed suicide because there is no systematic surveillance mechanism in the U.S. to track its incidence. Yet, the ratio of attempted to completed suicides in adolescents has been estimated to be 200:1,\(^2\) while the estimated risk for the general population ranges from 8:1 to 33:1.\(^3\) At these ages, suicide is the third leading cause of death, following accidents and homicides. In adolescents, the risk factors indicative of suicidal ideation are often subtle. However, they can include the presence of an already diagnosed psychiatric disorder, expression of suicidal thoughts, thoughts about death or afterlife, impulsive behavior, frequent bouts of rage or aggression, an increase in consumption of alcohol or the use of drugs, and a recent severe stressor, family instability, conflict, or loss. Early detection through comprehensive assessments is vital to ensure proper treatment, and in turn, to decrease the overall suicide rate in America.\(^4\)

Suicide in Older Adults

Older adults are another segment of the American population struggling with very high suicide rates. The suicide rate for people over 65 years of age is 50% higher than for the rest of the nation as a whole. While estimates of the prevalence of suicidal ideation in older adults vary
widely, studies suggest they are less likely to endorse suicidal ideation than are younger adults. To illustrate, epidemiologic studies suggest that approximately one out every 6 young adults (16%) describes having suicidal ideation, yet, in a community survey conducted in Florida, less than 6% of persons age 60 years or older endorsed ever having had suicidal thoughts. While suicidal ideation is less common in older adults, completed suicides are much more prevalent in late life. For example, there are approximately four suicide attempts for each completed suicide (4:1) in later life, whereas the ratio of attempted to completed suicides in adolescents has been estimated to be 200:1. Risk factors for suicide in older adults are different from those for younger adults and include the recent death of a loved one, physical illness, perceived poor health, uncontrollable pain or fear of prolonged illness, social isolation and loneliness, a major change in their social roles, and depression (often undiagnosed depression).

Psychiatric Co-morbidity

Suicide and Depression

Psychiatric co-morbidity (e.g., depression) plays a major role in the prevalence of suicidal ideation, as is evident in the case study. Studies show that the frequency of suicidal ideation is significantly higher in those with mental disorders and those taking anxiolytic and/or anti-psychotic medications. Two-thirds of the people that complete suicide are depressed at the time of death and the risk of suicide in persons with a diagnosis of depression is 20 times higher than it is in the general population. Therefore, a history of depression is a trigger to assess the patient for suicide risk. Risk assessment of depressed individuals is crucial for the detection of suicidal ideation and the prevention of attempts or completion of suicide. The warning signs of depression are difficult to detect and often go undiagnosed. For example, depressed patients (especially depressed older adults) often present to the emergency department with physical symptoms such as chest or non-specific pain, diffuse malaise, headaches, and/or other stress-related symptoms. Additional symptoms include extreme hopelessness, lack of interest in activities that were previously pleasurable, heightened anxiety or panic attacks, insomnia, irritability and agitation. At times, depressed patients will describe a history of suicidal thoughts or attempts. These symptoms were evident in the case study patient as he described two past suicide attempts, increasing withdrawal and isolative behavior, and a heightened feeling of anxiety.

Suicide and Substance Abuse

There are few specific recommendations for the assessment of suicidal in a patient with a history of alcohol dependence. Yet, alcohol dependence is strongly associated with an increased risk of suicide with an estimated 19% to 27% of all suicides being related to the use of alcohol. As illustrated in the case study, several major risk factors have been identified for the suicidal patient with a history of alcohol abuse. These risk factors include an episode of depression, recent interpersonal loss, poor social support, unemployment, living alone, serious medical illness, continued drinking, and communication of suicidal ideation. It is imperative that an assessment of alcohol use is performed in emergency departments to help determine if the patient has suicidal ideation, as well as alcohol dependence. This is best accomplished by asking specific, non-judgmental, objective questions, and avoiding vague questions and subjective terms such as “Do you have a problem with alcohol?” or “Do you drink a lot or a little?” or “Are you an alcoholic?” (See Figure 1 for sample questions to elicit a history of alcohol use and/or abuse).

In addition to the questions, the clinician should determine if alcohol use changes the person’s feelings in any way. A mental status assessment should be conducted which includes the assessment of mood and affect, along with other signs and symptoms of depression. Feelings of hopelessness should also be determined. It is important to obtain a history of suicidal
behavior, including ideation and threats, previous attempts and lethality of those events, and
family history of suicide and suicide attempts. The person may be experiencing symptoms of
impulsivity such as acting and reacting to situations without thinking about the consequences.
If the person is very impulsive, the use of alcohol can further impair their judgment. Impaired
judgment can further lead to suicidal ideation and attempts. Consideration of these risk factors
can aid clinicians in accurately determining if patients with a substance abuse history are at
risk for suicide.\textsuperscript{11}

**Assessment of Lethality**

Suicide has been characterized as “the final common pathway of diverse circumstances, or as
an interdependent network rather than an isolated cause.”\textsuperscript{12} Just as there is no single cause for
suicide, no two suicides can be understood to result from exactly the same constellation of
factors.\textsuperscript{13} Therefore, the effectiveness of any measures designed to screen for suicide will
depend upon the degree to which causal factors have been identified, the strengths of the causal
relationships and suicide, and their prevalence in the specific population.\textsuperscript{14}

In general, three domains related to the lethality of suicidal ideation should be made in patients
presenting to an emergency department. The three domains include predisposing factors, risk
factors, and protective factors. Predisposing factors are long-term factors that are invariable,
while risk factors are the more acute symptoms, stressors, or conditions. Protective factors can
increase or decrease a person’s risk level. For example, if the person does not have strong social
support network (such as the patient in the case study), then their risk may be higher for suicide.
\textsuperscript{15}

In an emergency department setting, suicidal patients must be assessed quickly and accurately.
The immediate focus of the assessment should be on the safety of the patient and the level of
observation necessary to maintain their safety. Their general medical condition should also be
assessed to determine if they need medical attention in addition to psychiatric assessment and
treatment. Some risk factors that may lead the practitioner to believe it is unsafe for a patient
to be alone include feelings of hopelessness, a definite suicide plan, a recent suicide attempt,
severe depression, psychotic symptoms, a recent discharge from a psychiatric unit, the use of
alcohol and/or street drugs, homelessness, or medical illness.\textsuperscript{16} If the patient is experiencing,
or has a history of, one or more of these risk factors, the health care provider needs to recognize
that the patient’s safety is in danger. Accordingly, for the man in the case study, the emergency
department personnel should request a sitter or hospital guard to observe him constantly in an
effort to maintain his safety.\textsuperscript{16}

In addition to recognizing warning signs and initiating close observation of the patient,
removing the weapon or other means of suicide can help save the patient’s life. The use of
firearms accounts for 54\% of all suicides in America.\textsuperscript{1} The other 46\% of suicides are due in
part to suffocation, hanging, falls, drowning, poisoning, cutting, and burning. Removing guns
or other means of suicide from the environment may help to prevent suicide completion. While
not always easy to accomplish, friends and family members of the patient may be called upon
and can often assist with the removal of such weapons from the patient’s home.\textsuperscript{1,16}

**Global Assessment of Suicide Risk**

A suicide risk assessment requires nonjudgmental, open-ended questions aimed at gaining
knowledge and insight into the person’s thoughts and feelings.\textsuperscript{17} There are many elements to
consider such as current suicidal thoughts, intent, plans, history of attempts, family history of
suicide, history of violence, intensity of depressive systems, previous or current treatment
regimens and response, recent or concurrent life stressors, alcohol and drug abuse patterns,
psychotic symptoms, and the person’s current living situation and social supports.\textsuperscript{17} Obtaining
a history of past suicide attempts is crucial to determining the risk of future attempts and inquiring about the patient’s current intent and plan are important to assess the degree of seriousness of their current suicidal ideation. The clinician will also need a clear understanding of the patient’s current life circumstances because changes in primary relationships or other life circumstances may trigger suicidal ideation. An understanding of the patient’s attitude and response to past psychiatric treatments is necessary to evaluate which treatment options are best for the patient at that particular time. As previously noted, there is a strong link between alcohol and drug abuse and suicide, so obtaining a drug and alcohol history can help determine the acuity of suicidal thoughts. It is also important to note whether the suicidal thoughts are occurring during intoxication or sobriety, or both.

Psychosis is also strongly linked to suicidal ideation. Three types of psychotic symptoms can be extremely dangerous and require immediate intervention: auditory hallucinations commenting on suicidal acts, thoughts of external control, and religious preoccupation. In addition to occurring with illnesses like schizophrenia or during alcohol withdrawal, psychotic symptoms can be associated with mood disorders, such as depression or bipolar disorders. Suicidal patients that have a history of depression can be categorized into three groups to help better determine lethality and treatment options: patients with suicidal ideation, a plan, and intent to harm themselves; patients with suicidal ideation and a plan, but without intent; and thirdly, patients with suicidal ideation but no plan or intent to harm themselves.

It is important for emergency department personnel to recognize that risk factors can guide the evaluation of suicide but that good communication among all personnel involved in the care of a suicidal patient is crucial. When patients report sad mood, or loss of interest in pleasurable activities, or when they appear to be depressed, clinicians should elicit responses to certain questions. (See Figure 2 for sample questions regarding suicide assessment for patients with a depressed mood).

The questions in Figure 2 should then be followed by more direct questions about suicide intent. If the answer is affirmative, patients should be asked whether they have thought about a specific method and whether they have access to lethal means.

When patients deny suicidal ideation, or endorse suicidal ideation but state that they would not act on it, they should also be asked about deterrents against suicide (e.g., religious beliefs, fear of disapproval, concerns about their legacy if death is by suicide). Further, family members or friends should be asked whether the patient is giving warnings or clues such as giving property away. If a patient reports suicidal ideation with a plan and lethal means are available, hospitalization is required. However, the clinician should not say that hospitalization is necessary to prevent suicide; rather, the patient should be assured that hospitalization is necessary for treatment by trained professionals and that it is hoped the hospitalization will make the patient feel better while providing for their safety.

If the patient endorses suicidal ideation, but does not have a plan, is not psychotic, has good judgment, has few risk factors (in particular, absence of depression or a history of suicide attempts) and lethal means are not available, the patient’s social support network needs to be activated. Permission to discuss their condition with a family member or significant other should be obtained immediately. Then the support person can be informed of the patient’s suicidal thoughts and plans. Once availability of the support person(s) is determined, the clinician can then determine the appropriateness of in-patient versus outpatient treatment options.
Formal Assessment of Suicide Risk

While acknowledging that administering a tool to determine suicide risk is only one aspect of the broader aspect of risk assessment, the Scale for Suicide Ideation (SSI)\textsuperscript{19} and the Nurses’ Global Assessment of Suicide Risk (NGASR)\textsuperscript{20} are two useful tools for the formal assessment of suicidal ideation and suicidal behavior. It is important to note that currently, no wide-scale validation studies have been conducted on the NGASR; yet, it may provide valuable support for nurses who are novice at such assessments.\textsuperscript{20} Such assessment tools can assist with the accurate overall assessment of a suicidal patient, but positive responses should be followed up with more specific questions to validate the patient’s degree of lethality and treatment options.

The NGASR involves determining risk factors because risk factors have been statistically shown to have a positive correlation with the risk of suicide. The NGASR was developed in a mental health facility in the United Kingdom that wanted to employ evidence-based practice in their suicide assessment protocols. Prior to using the NGASR, it was the responsibility of the admitting nurse to determine suicide risk in patients based on his or her understanding of the risk factors. This was problematic because confidence levels of some nurses were low and misdiagnosis of the problem was occurring at high rates. The NGASR was developed to aid the staff nurse staff in analyzing the risk of suicide in their patients. It is emphasized that clinical presentation of suicidal patients can be very unique, so the NGASR is to be used only as a guide in the assessment of suicide risk.\textsuperscript{20}

The NGASR is composed of several sections. The first section helps determine the patient’s level of hopelessness. Feelings of hopelessness are highly correlated with suicide risk.\textsuperscript{20} Feelings of hopelessness are determined by self-report and careful attention to verbalizations and behaviors suggesting hopelessness. In the case study, the patient’s perception that his “family has given up on him” is one such example. If it is determined that the patient is in a state of hopelessness, further in-depth hopelessness indexes can be used to assess its level. The NGASR also helps to establish if there has been a recent life-stressor that may be depleting the person’s resources and/or support. Because depression and suicide are closely related,\textsuperscript{20} one section of the NGASR evaluates the patient’s level of depression. Because unhealthy interpersonal and social interactions can be associated with an increased risk for suicide, the NGASR also evaluates the patient’s interpersonal and social interactions. The clinician should focus on any change in the patient’s social situation and evaluate how and why the change occurred. Next, the NGASR evaluates recent bereavement or relationship breakdowns, such as divorce, separation, or break-ups. The patient’s overall status in society should also be evaluated because socioeconomic factors also appear to be associated with an increased risk of suicide. And lastly, the NGASR guides the assessment of the patient’s physical health. A new diagnosis of a terminal illness (e.g., cancer) may contribute to a patient’s suicidal ideation. The person may think suicide is a means of taking control of an uncontrollable situation in their life.\textsuperscript{20}

Although the NGASR has not yet undergone any wide scale quantitative validation, health professionals that use it report consistent satisfaction.\textsuperscript{20} The tool has undergone face and context validity testing. Face validity is the extent to which the tool measures what it is intended to measure. An expert panel comprised of senior clinical nurses and senior psychiatrists were convened to determine the face validity of the NGASR. The panel concluded that the tool had high face validity, because it was comprised of factors that were already well established to lead to high risk of suicide.\textsuperscript{20} Context validity is the extent to which the items in the tool adequately cover suicide risk. The same expert panel evaluated this and determined that that the tool had high contextual validity, because there were not any clear omissions in it.
The NGASR provides clinicians with an important tool for interviewing a patient and evaluating suicide risk. Once the interview is complete, the clinician will determine the patient’s total score on the tool and then assign the patient to one of the four categories. The patient can be at very little risk, an intermediate degree of risk, a high degree of risk, or at an extremely high risk of suicide. The patient’s level of suicide risk, as identified by his or her score on the NGASR, will help the emergency department personnel decide if further psychiatric consultation and/or treatment is necessary for the safety of the patient. Re-assessing the patient multiple times may also be necessary to ensure their safety.  

Proper assessment and diagnosis of suicide risk and potential can help save the lives of many individuals that are involved in crisis situations. Because patients in crisis often present to the emergency department for treatment, it is an ideal place to perform the initial suicide risk assessment of all crisis patients seeking assistance. The methods of assessing suicide in emergency departments may vary from facility to facility, but the main topics discussed previously should always be included in a suicide risk assessment. 

Treatment of Suicidal Patients

As no single factor is universally causal, no single intervention will prevent all suicides. The multi-dimensionality of suicide presents great challenges, but also presents important implications for prevention and treatment. In assessing a patient with a risk for suicide, the clinician must first manage the patient’s current level of distress. Developing a working alliance with the patient is very important for gaining pertinent information. Therefore, the clinician must be empathetic toward the patient in order to gain their trust during the assessment interview. The patient’s comfort level will increase if the practitioner is calm and understanding of the patient’s wants and needs. 

The “no-suicide” or “no-harm” verbal or written contract, in which a patient agrees to inform a relative, friend, or healthcare provider of their suicidal ideation and/or intent and to not act on their thoughts, is widely used in clinical practice. However, research suggests that the no-suicide contract is not an effective deterrent to self-harm. Furthermore, there may also be ethical issues related to consenting to the no-suicide contract because such patient’s are in the midst of a psychiatric crisis. Such a contract may alleviate the mental health professionals’ anxiety related to caring for a suicidal patient, but studies show it does little to prevent people from attempting suicide. If a no-suicide contract is used as part of a patient’s treatment regimen, it should never be used with a new patient since the contract against self-harm is only as good as the underlying soundness of the therapeutic alliance. 

Patient Satisfaction

Suicidal emergencies are among other behavioral and psychiatric emergencies that provide the basis for frequent emergency department visits. These traumatic clinical events in turn, pose serious concerns and unique problems not only for patients but also for their families, their communities, and all health professionals involved with their care. A study by Allen, et al. suggests that patient satisfaction is a critical clinical component for evaluating the therapeutic alliance and the effectiveness of treatments the suicidal patient receives.

Emerging from these clinical challenges are growing concerns regarding the management of behavioral and psychiatric emergencies. Specifically, there is concern over the misapplication and overuse of physical and/or chemical restraints and seclusion. These problems have captured the attention of various mental health advocacy groups and policy makers in addition to the general public. As a result, the Health Care Financing Administration (HCFA) now known as the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are attempting to address these problems.
problems by recognizing the need for psychiatric emergency care regulations.23 This group surveyed emergency psychiatry and psychopharmacology experts, which resulted in publication of an important document entitled, “Expert Consensus Guidelines on the Treatment of Behavioral Emergencies.” A key finding from the survey was the importance of including the consumer in treatment decisions. The expert panel recommends that there be collaboration between clinicians and patients whenever possible in order to achieve the best short- and long-term treatment outcomes. To determine the best approaches for collaboration during behavioral emergencies, the expert panel recommended a survey of “expert consumers” who were identified as having personal experiences with emergency medications, restraints, or seclusions in order to ascertain their input. Patients were included in the survey if they had at least one emergency department visit that included the use of medication, restraint, or seclusion. The investigators held four emergency department forums that included a consumer survey and a workshop to ascertain and prioritize consumer recommendations for improving psychiatric emergency care. These forums were conducted in New York, Iowa, and California. A total of 57 participants completed the survey and of those participants, fourteen experienced depression, suicidal ideation, or made a suicide attempt. The most common diagnoses among the participants included major depression (70%), bipolar disorder (51%), posttraumatic stress disorder (46%), schizophrenia (40%), substance use disorders (30%), and personality disorders (30%). The most common problems that precipitating the emergency department visit were feeling out of control (68%), relationship problems with families, friends, or spouse (58%), and being afraid (54%).23

The majority of participants reported that staff did not treat them with respect (63%), visited with them in a timely manner (65%), listened to them or their concerns, or spent enough time with them (77%), or adequately spoke to their problem (80%). Furthermore, staff did not explain the proposed treatment plan, including the risk/benefit ratio before having them consent to treatment (82%) or relate to their specific ethnic, racial, cultural, or religious background needs (53%).23

With respect to medication issues, 50% of these participants reported they had not been asked about past medication use (44% were asked). A number of consumers (35%) felt that medications were forced on them (58% did not) and 37% responded that they did not want any medication and had not taken it willingly (46% expressed that they did take medication willingly). A majority (61%) of the participants reported that the medication they were administered during the behavioral emergency caused troublesome side effects.23

Among the 57 consumers surveyed, 36 (63%) reported experiences with restraint and seclusion usage. Of those 36 consumers, 24 (67%) indicated that the staff had not attempted any other measures before placing them in the restraint, 69% felt that the staff did not make a responsible decision to use restraints, 68% expressed that the time placed in restraints was over extended, and 77% reported that no one paid attention to their appeals for help. Over half of the consumers (54%) responded that being placed in restraints made them reluctant to seek out psychiatric care in the future. Furthermore, of the 36 (68%) consumers experiencing seclusion, 69% reported that the staff did not use good clinical judgment for implementing seclusion, 69% felt that seclusion was lengthy, 55% indicated that staff did not make frequent checks on them while in seclusion, and 60% responded that their experience with seclusion made them reluctant to seek out psychiatric care in the future. The findings for these expert consumers placed in seclusion are consistent with those placed in restraints.23

These results established various levels of agreement between the recommendations of the expert consumer panel and expert psychiatry panel. The first of these agreements stresses the importance of establishing collaboration between the nurse and patient, especially during a crisis event. This agreement is consistent with the findings of Szanto, et al.18 whereby the
The efficacy of interventions is dependent on the development of a therapeutic alliance. Thus, whenever possible and appropriate, listening to the concerns and honoring the request of patients is imperative for facilitating healthy outcomes. Additional agreements between the two panels were found in the use and acceptance of oral medications. With respect to restraints and seclusion for episodes of impeding violence, the expert panel would advocate the use of verbal interventions, voluntary medications, show of force, emergency medications, and offering food and drink and other assistance as a first line of intervention, with the implementation of restraints or seclusion as a second line consideration. The expert panel also recommended continuous monitoring of a patient placed in restraints or seclusion, at no longer than 15-minute intervals.

Additionally, in contrast, only 38% of the expert panel felt that the use of restraints or seclusion would likely have a negative impact on adherence to future psychiatric treatment compared to the expert consumer panel that were reluctant to seek future psychiatric care due to experiences with restraints (54%) or seclusion (60%) in the emergency department. These recommendations are presently the focus of the development of new regulations. Adverse experiences reported within general hospital emergency departments by the majority of the expert consumer panel warrants the development of specialized psychiatric emergency services similar to those recommended by the Expert Consensus Guidelines. Other important recommendations for improving psychiatric emergency care include the development of alternatives to traditional emergency department services, providing a more comfortable physical environment for waiting and treatment, increasing the use of peer support services, providing improved training of emergency room staff to promote a more humanistic and person-focused approach, and improved discharge planning and post-discharge follow-up care.

### Compliance with the Treatment Regimen

Although there have been few studies examining a patient’s status several weeks following an emergency department visit, clinicians consider the post-emergency risk highest during this time period, with an increased risk for suicide following discharge from emergency psychiatric care. Two studies that evaluated patient status shortly after an acute suicidal episode suggest that emergency department nurses are critical to the identification of signs and symptoms that may predict patient deterioration following emergency department visits.

A study by Cremniter and associates sought to determine factors that predict short-term (within three weeks of initial treatment) deterioration, factors that predict compliance with recommendations for outpatient care of non-hospitalized patients, and the relationship between short-term outcome and treatment compliance. This study included male and female patients age 15 or older that had been referred to a psychiatric emergency department. A total of 457 patients were given a comprehensive evaluation, including the Brief Psychiatric Rating Scale (BPRS) while in the emergency department.

To evaluate treatment compliance and short-term outcomes during the three weeks following the psychiatric emergency department visit, the investigators developed a four-level rating scale to establish “significant improvement,” “incomplete improvement,” “unchanged condition,” or “deterioration” in the patient’s status. The patient’s clinical status at the emergency department visit was compared with their status three weeks post-visit. Other factors evaluated included: compliance with the prescribed treatment regimen, response to environmental stressors, suicide attempts, and the quality of the patient’s social network.

A stepwise logistic regression analysis was utilized to predict the strongest predictors of patient treatment compliance and positive mental health outcomes. The strongest predictors of positive compliance were a previous psychiatric history (p < .008), marital status (p < .03), a low BPRS hostility sub-scale score (p < .04), and older age (p < .004). The strongest predictors of
deterioration three-weeks following the emergency department visit were non-compliance with the treatment regimen (p < .0005), a previous psychiatric history (p < .005), and low BPRS hebephrenic (disinhibited, unorganized) sub-scale score (p < .01). Because the main predictor of deterioration post-visit was non-compliance with the treatment regimen initially proposed by the emergency department psychiatrist, it is imperative that nurses increase efforts to improve patient satisfaction with emergency care in an attempt to enhance compliance with the prescribed treatment regimen. This is true of all patients, but especially so in patients who display ongoing hostility, agitation, or disinhibited and organized behaviors. Interventions that can assist nurses towards improving compliance may include such activities as developing a trusting nurse-patient relationship, scheduling immediate follow-up appointments, working with the patient’s family, and making home visits. The nurse’s ability to assess the patient’s history, identify signs and symptoms swiftly and accurately, and evaluate current risk factors is vital to providing appropriate interventions and improving patient outcomes throughout the psychiatric emergency department experience.

References


1. How many drinks containing alcohol do you drink in a typical week?
2. Do you end up drinking more than you intended?
3. Has drinking alcohol ever contributed to problems in terms of attendance or performance at work, school, or with parenting?
4. When was your last drink, what did you drink, and how much did you drink?

Figure 1.
Questions to Elicit a History of Alcohol Use and/or Abuse
1. Have you been feeling so sad lately that you were thinking about death or dying?
2. Have you had thoughts that life is not worth living?
3. Have you been thinking about harming yourself?

**Figure 2.**
Suicide Assessment Questions for Patients with Depressed Mood