Managing Suicidal Patients in the Emergency Department

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Editor's Note: *The Expert Clinical Management series consists of shorter, practical review articles focused on the optimal approach to a specific sign, symptom, disease, procedure, technology, or other emergency department (ED) challenge. These articles—typically solicited from recognized experts in the subject area—will summarize the best available evidence relating to the topic while including practical recommendations where the evidence is incomplete or conflicting.*

INTRODUCTION

Caring for ED patients with suicidal thoughts and behaviors is challenging, given time pressures, boarding of patients waiting for psychiatric beds, and the inherent difficulty in predicting imminent self-harm. However, providers—like patients—should not lose hope: most suicidal crises are short-lived and repeated attempts are not inevitable.[1] Not every ED patient with suicidal thoughts needs inpatient admission or even a mental health consultation, and ED providers should take pride in their skills in caring for this at-risk population.

IDENTIFICATION OF SUICIDAL PATIENTS

Approximately 8% of all adult ED patients, regardless of chief complaint, have had recent suicidal ideation or behaviors,[2,3] but many will not disclose unless asked. The Joint Commission requires suicide screening and assessment for patients with primary emotional or behavioral disorders or presenting symptoms.[4] This mandate could be fulfilled with targeted screening (eg, all patients with mental health complaints) or universal screening (all ED patients). As in the case of screening for any condition, a program not designed to fit an ED's flow and culture may not perform, and there will be some patients who do not answer questions honestly. Early data suggest screening does identify people with otherwise hidden suicidal ideation[5] without negatively affecting ED flow,[6] and cost-effectiveness analyses are in progress. In this article, we focus on management of suicidal ED patients, regardless of how they are identified.

GENERAL APPROACH

Suicidal patients are in acute emotional pain and, like patients in physical pain, deserve care that is empathetic and patient centered. Small efforts, such as explaining what to expect and providing basic comforts,[7,8] can improve the patient's experience. ED providers may be skeptical about the preventability of suicide or may harbor biases against patients with mental illness,[9] so providers should strive to overcome their own areas of discomfort. Establishing rapport through a sympathetic but direct approach can enhance communication with the patient and thereby the quality of the assessment. Asking a patient about suicidal thoughts or plans does not incite or encourage suicidal behavior,[10] and providers should ask specific questions about the nature and content of suicidal thoughts, as described below in greater detail.

Information from appropriate collateral sources is particularly important for suicidal patients; relevant sources include out-of-hospital or police personnel, the patient's family or friends, or outpatient health care providers.[10,11] Asking the patient for permission enhances rapport, but an ED provider can make these contacts without consent when necessary to protect the individual or the public from an imminent and serious safety threat.[12]

SAFETY PRECAUTIONS

Patients being evaluated for suicidal thoughts or behaviors should not be allowed to leave the ED until the evaluation is complete[13] and should be protected from self-harm while in the ED.[14,15] Typically, this includes placing the patient in a private room without access to potentially dangerous objects (eg, belts, shoelaces, sharp medical instruments).[14] Mechanical or chemical restraints can be traumatic to the patient and impair rapport, so

ED providers should first try to verbally calm agitated patients (for example, by having extra personnel step out of sight and by engaging in collaborative, respectful conversation). Providers should advocate for a written ED policy concerning care of suicidal patients to clarify pathways and support provider actions, including use of constant observation, personal searches by security staff,[13] or restraints.[16]

FOCUSED MEDICAL ASSESSMENT

A focused medical assessment—a term experts prefer over "medical clearance,"[17] which implies absence of medical issues—aims to identify medical issues requiring emergency or urgent treatment. A focused medical assessment relies primarily on the history and physical examination, including evaluation of the patient's cognitive and emotional status and identification of drug ingestion, trauma, or other medical conditions that may affect the patient's mental state. Routine diagnostic testing, including nontargeted laboratory or radiographic studies, has not demonstrated clinical benefit[18-21] and is not recommended.[17] However, mental health consultants often will request tests such as toxicologic screens.

SUICIDE RISK ASSESSMENT

There are many risk factors for suicide; some are fixed and some fluctuate, and their strength and interaction vary among and within individuals. An ED suicide risk assessment aims to determine appropriate treatment, including options across the spectrum from discharge with outpatient services to involuntary psychiatric hospitalization. Ultimately, risk assessment remains an inexact science, and the process should incorporate an individual's personal history, current mental state, home environment, and specific suicidal thoughts or behaviors.

A small subset of patients with suicidal thoughts or behaviors can be managed by the ED provider and discharged home without a mental health consultation.[8] Analogous to the use of decision rule-out algorithms for patients with chest pain, the emergency provider should ask initial questions to triage patients and then consult a specialist when indicated. Emergency physicians pride themselves in risk-stratifying patients for myriad physical conditions without consulting specialists for every patient potentially at risk. Similarly, we suggest emergency physicians take ownership (and pride) in identifying which suicidal patients do not require an emergency mental health consultation. These lowest-risk patients are those with no suicide plan or intent, no previous suicide attempt, no history of significant mental illness or substance abuse, and no agitation or irritability (Figure 1). These patients are often already identifiable to experienced clinicians; as an example, a middle-aged woman with her first bout of depression and vague suicidal thoughts who says she has a strong support system and would not actually kill herself because of her religion. The new Suicide Prevention Resource Center ED Guide,[8] developed with input from multidisciplinary experts and the major emergency medicine organizations, supports providers' decision to forgo consultation in these low-risk cases. Specifically, the guide includes a 6-question decision support tool (Figure 1),[8] which can be used to document medical decisionmaking justifying why a mental health consultation is or is not indicated. It may be especially useful in settings with universal screening, where there may be a larger volume of patients identified with low levels of suicidality.

The majority of suicidal ED patients, however, do need a comprehensive risk assessment to inform decisionmaking about treatment and disposition. For an adequate risk assessment, the patient should be cognitively able to participate; those intoxicated with alcohol or drugs should be observed and then have their cognitive capacity reassessed.[8,17] To our knowledge, there are no data to support a particular blood alcohol level as the point required for a patient with normal vital signs and a noncontributory history and examination result can undergo a psychiatric evaluation.[17] However, as with urine testing, toxicologic screens may help mental health consultants identify concomitant substance abuse problems, so the issue merits discussion and collaboration. Patients who express suicidal thoughts when intoxicated and then deny them when more sober pose a particular and frustrating challenge, especially because those with chronic alcohol or substance abuse may be frequent ED visitors. Both acute and chronic alcohol use raise the risk of suicide; more than a third of suicide decedents use alcohol before their death,[22] and adults with a substance use disorder are more likely to have serious suicidal thoughts, plans, and attempts.[23] Although the most conservative approach is to observe intoxicated patients until they are cognitively able to participate in a comprehensive suicide risk assessment, more work in this area is clearly needed.

Comprehensive assessments are typically conducted by mental health consultants (eg, psychiatrists, psychologists, social workers), who generally have both more training and more time to spend with patients. Emergency physicians, however, retain final authority over and responsibility for discharge decisions. Consultations may be conducted either in person (by an on-site mental health

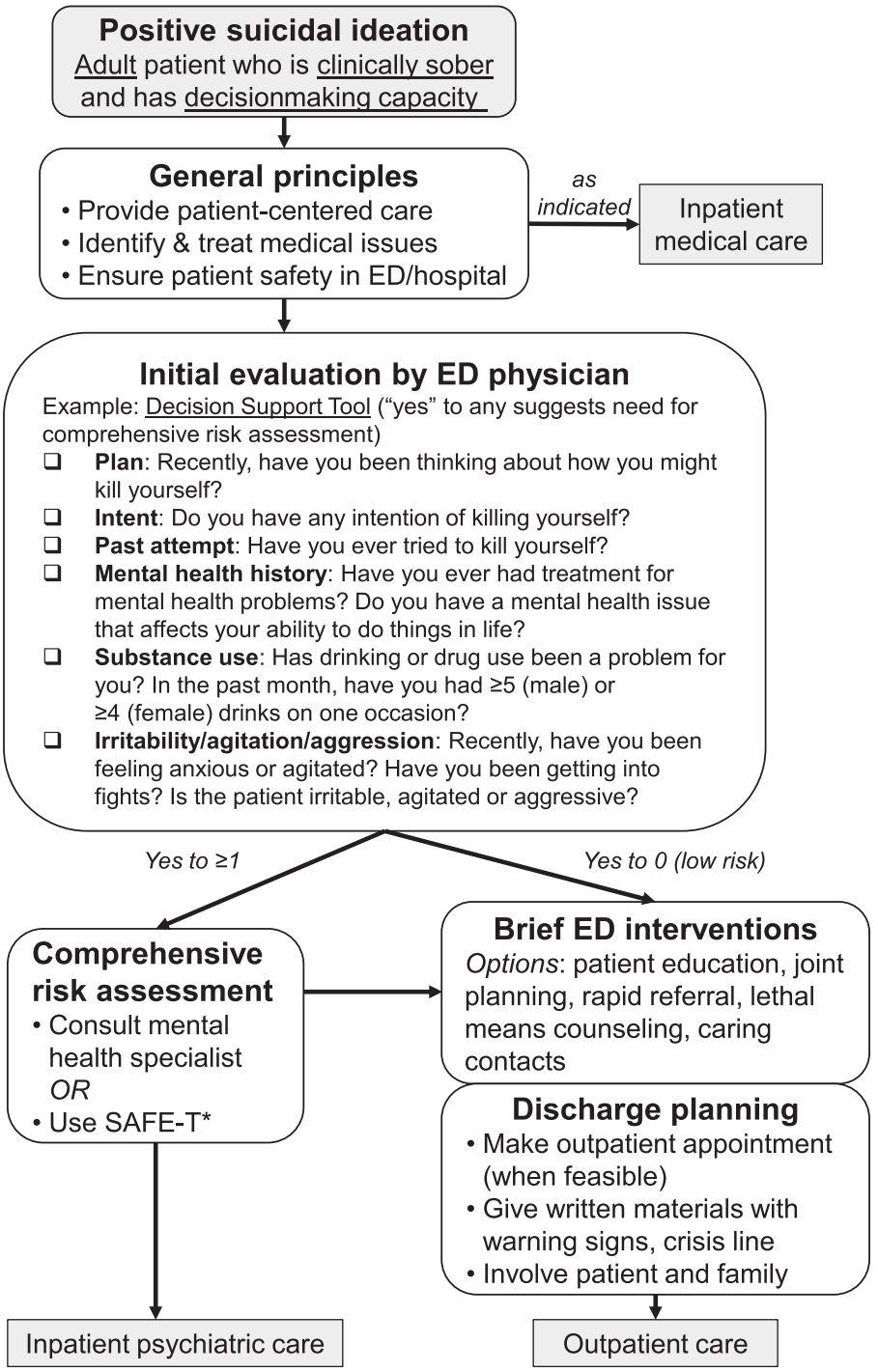

Figure 1. Framework for care and evaluation of suicidal patients in the ED, intended for use with adult ED patients who do not require medical hospitalization for concomitant acute or chronic medical problems. Patients who are intoxicated or otherwise lacking in decisionmaking ability should be treated, observed, and reevaluated as clinically indicated. *See Figure 2. Adapted from Capoccia and Labre, 2015.[8]

specialist or one who comes to the ED on request) or remotely by electronic communication ("telepsychiatry")[8]; decisions about consultations often depend on the ED environment and available resources. If a mental health consultant is not readily available, the ED provider can use the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (Figure 2).[24] This tool, available as a pocket-card and smartphone application,[25] guides a provider through a stepwise evaluation of a patient's risk and protective factors and the specifics of the suicidal thoughts or plans to

estimate overall risk. Even when the ED provider is not completing the comprehensive assessment, the SAFE-T domains provide useful reminders about specific questions to ask patients.

ED-BASED INTERVENTIONS

Suicidal patients often have long ED lengths of stay while awaiting evaluation or psychiatric hospitalization. Brief ED interventions may be both therapeutic and helpful in preventing future self-harm, and they may be especially important for patients being discharged home. Recommended interventions focus on helping patients develop skills to recognize and cope with suicidal thoughts, including action plans for making their environment safer and for identifying sources of help. Although interventions may be most effective when implemented as a bundle, local practices should be tailored to both need and feasibility.[8] Templated materials and other resources exist for each of the example interventions discussed below (Table).[8]

Patient education and joint safety planning in the ED should include personalized plans with warning signs, follow-up, and emergency contacts.[8,26,27] Safety planning is distinct from "contracting for safety," which has not been shown to prevent suicide and is no longer recommended.[27] Safety planning uses a step-by-step approach to help patients identify mechanisms for coping and help-seeking during crises. The plan can be completed on paper and then stored in a free smartphone application (eg, MY3, Suicide Safe). Discharged suicidal patients need rapid referral for outpatient follow-up care because the days just after discharge from an ED are a high-risk period. Making a specific appointment before the individual leaves the ED and enlisting help from family or friends may help ensure follow-up.[28]

1. Identify risk factors

- **Suicidal behavior**: prior suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders**: especially mood disorders, psychotic disorders, alcohol/substance abuse, attention deficit hyperactivity disorder, traumatic brain injury, posttraumatic stress disorder, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
- **Key symptoms**: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history**: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal**: triggering events leading to humiliation, shame or despair (eg, loss of relationship, financial or health status—real or anticipated); ongoing medical illness (especially CNS disorders, pain); intoxication; family turmoil/chaos; history of physical or sexual abuse; social isolation
- **Change in treatment**: discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. Identify protective factors

- **Internal**: ability to cope with stress, religious beliefs, frustration tolerance
- **External**: responsibility to children/pets, positive therapeutic relationships, social supports

3. Conduct suicide inquiry

- **Ideation**: frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan**: timing, location, lethality, availability, preparatory acts
- **Behaviors**: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent**: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious
- **Explore** ambivalence: reasons to die vs. reasons to live

4. Determine risk level & intervention

- **Assessment** of risk level based on clinical judgment, after completing steps 1-3. (Chart intended to represent a sample range of risk levels/interventions)

Risk level	Risk or protective factor	Suicidality	Possible interventions
High	Psychiatric disorders with severe symptoms, or acute precipitating event	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral

5. Document

- Risk level and rationale; treatment plan to address/reduce current risk (eg, setting, medication, psychotherapy, ECT, contact with significant others, consultation); firearm instructions, if relevant; follow-up plan
- For youths, treatment plan should include roles for parent/guardian

Figure 2. SAFE-T. Risk assessment modified slightly[47-49] from original SAFE-T.[24,25] *CNS*, Central nervous system; *ECT*, electroconvulsive therapy.

Counseling to reduce home access to lethal means (eg, firearms, toxic medications) is an important aspect of ED care of suicidal patients. There is evidence that such counseling by providers can affect home storage behaviors[29] and is acceptable to patients.[30] The rationale behind means restriction is that suicidal acts are often impulsive[31] and occur during short-lived crises,[32] and that survival depends on the lethality of the chosen method.[33] Guns have the highest suicide case-fatality rate (>90%),[34] and numerous studies have shown both an association between gun access and suicide risk[35] and that safe gun storage (ie, locked, unloaded, and separated from ammunition) can mitigate this risk.[36,37] State "gag laws" do not prohibit physicians from asking suicidal patients about gun access.[38,39] ED providers should counsel all suicidal patients and their families to store firearms off site (eg, at a gun shop, police department, other legal option) during a crisis; gun cabinets or locks at home may be a reasonable alternative as long as the patient does not have access.

DISPOSITION

For patients in acute crisis with moderate to high suicide risk, psychiatric hospitalization remains the typical disposition. In such cases, voluntary hospitalization is preferable when possible, in alignment with goals of collaborative, patient-centered care. When involuntary hospitalization ("emergency commitment") is required, providers should adhere to their state laws because these vary in definitions, length of commitment, and other requirements.[40]

Patients whose risk for imminent suicide is deemed acceptably low can often be managed as outpatients, depending on ED and outpatient resources. Such patients should be discharged to supportive, stable environments without access to guns or lethal medications. Caring contacts (Table), which are brief telephone, e-mail, or mail contacts after discharge, appear to decrease suicide attempts and deaths.[41] All patients should be given the number for the National Suicide Prevention Hotline (1-800-273-TALK [8255]), a national, free telephone and online chat resource with crisis guidance, connection to local resources, and special services for veterans.

CONCLUSION

Through an empathetic, evidence-based, and collaborative approach[46] to managing suicidal patients, ED providers can help prevent future injury and death. Focused medical assessment and suicide risk assessment can help providers

Table. ED-based brief suicide prevention interventions.*

Intervention	Comments	Additional Resources
Brief patient education	Goal: Instill hope of recovery, reduce shame and stigma Include: Diagnosis, home care, follow-up instructions, warning signs for return to ED or call to crisis line Use teach-back techniques and provide written version with community resources	"After an Attempt" brochures for ED providers, patients, and family members (available from Substance Abuse and Mental Health Services Administration in English and Spanish[42-44]: http://store.samhsa.gov/home) "With Help Comes Hope" support Web site: http://lifelineforattemptsurvivors.org/
Safety planning	Structured plan to identify coping strategies and contacts	One-page printable template: http://www.suicidesafetyplan.com Free mobile applications include MY3 and Suicide Safe
Lethal means counseling	Goal: Reduce patient access to lethal methods (eg, guns, toxic medications) Discuss options for safe storage with others or in home	Detailed recommendations for clinicians: http://www.hsph.harvard.edu/means-matter/recommendations/clinicians/ Supported by American College of Emergency Physicians[45]
Rapid referral	Follow-up appointment within 7 days (ideally ≤24 h) Troubleshoot barriers (eg, transportation) to facilitate follow-up	Template for developing community resource list available in Suicide Prevention Resource Center ED Guide[8] Services locator (therapists and support groups): http://www.suicidepreventionlifeline.org/learn/therapy.aspx
Caring contacts (after discharge)	Brief communications (letter, telephone, text, e-mail) to promote treatment adherence and feeling of connectedness May be automated or made by nonclinical staff	Toolkit for telephone call system: http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html Sample messages available in Suicide Prevention Resource Center ED Guide[8]

*Each of the above should also include crisis line information: 1-800-273-8255 and http://www.suicidepreventionlifeline.org/ (online chat available).

determine whether a mental health consultation is required and whether the patient needs hospitalization. Brief ED interventions—including counseling about reducing access to firearms and toxic medications—may be both feasible and effective, depending on the ED environment and resources. Suicide remains a leading cause of death in the United States, but ED providers have an opportunity to ease emotional pain and save lives.

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REFERENCES

1. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm: systematic review. *Br J Psychiatry*. 2002;181:193-199.
2. Ilgen MA, Walton MA, Cunningham RM, et al. Recent suicidal ideation among patients in an inner city emergency department. *Suicide Life Threat Behav*. 2009;39:508-517.
3. Claassen CA, Larkin GL. Occult suicidality in an emergency department population. *Br J Psychiatry*. 2005;186:352-353.
4. Joint Commission on Accreditation of Healthcare Organizations. Hospital national patient safety goal 15.01.01. 2015. Available at: http://www.jointcommission.org/assets/1/6/2015_NPSG_BHC.pdf. Accessed May 27, 2015.
5. Suicide Prevention Resource Center. Emergency departments: a key setting for suicide prevention (Research to Practice Webinar). 2015. Available at: http://www.sprc.org/sites/sprc.org/files/event_materials/June_2015_R2P_EDs_Presentation.pdf. Accessed June 26, 2015.
6. Betz ME, Arias SA, Miller M, et al. Change in emergency department providers' beliefs and practices after use of new protocols for suicidal patients. *Psychiatr Serv*. 2015;66:625-631.
7. Suicide Attempt Survivors Task Force. *The Way Forward: Pathways to Hope, Recovery, and Wellness With Insights From Lived Experience*. Washington, DC: National Action Alliance for Suicide Prevention, Suicide Attempt Survivors Task Force; 2014. Available at: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf. Accessed September 2015.
8. Capoccia L, Labre M. *Caring for Adult Patients With Suicide Risk: A Consensus-Based Guide for Emergency Departments*. Waltham, MA: Education Development Center, Inc, Suicide Resource Prevention Center; 2015. Available at: http://www.sprc.org/ed-guide. Accessed July 23, 2015.
9. Betz ME, Sullivan AF, Manton AP, et al. Knowledge, attitudes and practices of emergency department providers in the care of suicidal patients. *Depress Anxiety*. 2012;30:1005-1012.
10. Sood TR, McStay CM. Evaluation of the psychiatric patient. *Emerg Med Clin North Am*. 2009;27:669-683, ix.
11. Good B, Walsh RM, Alexander G, et al. Assessment of the acute psychiatric patient in the emergency department: legal cases and caveats. *West J Emerg Med*. 2014;15:312-317.
12. Colpe LJ, Pringle BA. Data for building a national suicide prevention strategy: what we have and what we need. *Am J Prev Med*. 2014;47:S130-S136.
13. Mills PD, Watts BV, DeRosier JM, et al. Suicide attempts and completions in the emergency department in Veterans Affairs hospitals. *Emerg Med J*. 2012;29:399-403.
14. Sentinel Event Alert, Issue 46: A follow-up report on preventing suicide: focus on medical/surgical units and the emergency department. Vol 46: Joint Commission; 2010. Available at: http://www.jointcommission.org/sentinel_event_alert_issue_46_a_follow-up_report_on_preventing_suicide_focus_on_medicalsurgical_units_and_the_emergency_department/. Accessed September 2015.
15. Illinois Hospital Association, Behavioral Health Steering Committee Best Practices Task Force. Best practices for the treatment of patients with mental and substance use illnesses in the emergency department. 2007. Available at: http://www.ihatoday.org/uploadDocs/1/bestpractices.pdf. Accessed July 23, 2015.
16. Coburn VA, Mycyk MB. Physical and chemical restraints. *Emerg Med Clin North Am*. 2009;27:655-667, ix.
17. Lukens TW, Wolf SJ, Edlow JA, et al. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Ann Emerg Med*. 2006;47:79-99.
18. Fortu JMT, Kim IK, Cooper A, et al. Psychiatric patients in the pediatric emergency department undergoing routine urine toxicology screens for medical clearance: results and use. *Pediatr Emerg Care*. 2009;25:387-392.
19. Parmar P, Goolsby CA, Udompanyanan K, et al. Value of mandatory screening studies in emergency department patients cleared for psychiatric admission. *West J Emerg Med*. 2012;13:388-393.
20. Korn CS, Currier GW, Henderson SO. "Medical clearance" of psychiatric patients without medical complaints in the emergency department. *J Emerg Med*. 2000;18:173-176.
21. Donofrio JJ, Santillanes G, McCammack BD, et al. Clinical utility of screening laboratory tests in pediatric psychiatric patients presenting to the emergency department for medical clearance. *Ann Emerg Med*. 2014;63:666-675.e663.
22. Kaplan MS, Huguet N, McFarland BH, et al. Use of alcohol before suicide in the United States. *Ann Epidemiol*. 2014;24:588-592.e581-582.
23. *Results From the 2012 National Survey on Drug Use and Health: Mental Health Findings*. Rockville, MD: Substance Abuse & Mental Health Services Administration, US Dept of Health & Human Services; 2013.
24. Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) Substance Abuse and Mental Health Services Administration. 2009. Available at: http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432. Accessed January 2, 2015.

25. Suicide Safe. Substance Abuse and Mental Health Services Administration. 2015. Available at: http://store.samhsa.gov/apps/suicidesafe/. Accessed May 27, 2015.
26. National Alliance on Mental Illness. Emergency department resource toolkit. 2015. Available at: http://www2.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/ContentManagement/ContentDisplay.cfm&ContentID=24452. Accessed May 27, 2015.
27. Stanley B, Brown GK. Safety planning intervention: a brief intervention to mitigate suicide risk. *Cogn Behav Pract*. 2012;19:256-264.
28. Granboulan V, Roudot-Thoraval F, Lemerle S, et al. Predictive factors of post-discharge follow-up care among adolescent suicide attempters. *Acta Psychiatr Scand*. 2001;104:31-36.
29. Kruesi MJP, Grossman J, Pennington JM, et al. Suicide and violence prevention: parent education in the emergency department. *J Am Acad Child Adolesc Psychiatry*. 1999;38:250-255.
30. Walters H, Kulkarni M, Forman J, et al. Feasibility and acceptability of interventions to delay gun access in VA mental health settings. *Gen Hosp Psychiatry*. 2012;34:692-698.
31. Deisenhammer EA, Ing CM, Strauss R, et al. The duration of the suicidal process: how much time is left for intervention between consideration and accomplishment of a suicide attempt? *J Clin Psychiatr*. 2009;70:19-24.
32. Drum DJ, Brownson C, Denmark AB, et al. New data on the nature of suicidal crises in college students: shifting the paradigm. *Prof Psychol Res Pr*. 2009;40:213-222.
33. Spicer RS, Miller TR. Suicide acts in 8 states: incidence and case fatality rates by demographics and method. *Am J Public Health*. 2000;90:1885-1891.
34. Miller M, Azrael D, Hemenway D. The epidemiology of case fatality rates for suicide in the Northeast. *Ann Emerg Med*. 2004;43:723-730.
35. Barber CW, Miller MJ. Reducing a suicidal person's access to lethal means of suicide: a research agenda. *Am J Prev Med*. 2014;47:S264-S272.
36. Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. *JAMA*. 2005;293:707-714.
37. Shenassa ED, Rogers ML, Spalding KL, et al. Safer storage of firearms at home and risk of suicide: a study of protective factors in a nationally representative sample. *J Epidemiol Community Health*. 2004;58:841-848.
38. Weinberger SE, Hoyt DB, Lawrence HC III, et al. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. *Ann Intern Med*. 2015;162:513-516.
39. Kuehn BM. Battle over Florida legislation casts a chill over gun inquiries. *JAMA*. 2015;313:1893-1895.
40. *Online Handbook: Civil Commitment*. Arlington, VA: American Psychiatric Association; 2010.
41. Brown GK, Green KL. A review of evidence-based follow-up care for suicide prevention: where do we go from here? *Am J Prev Med*. 2014;47:S209-S215.
42. Substance Abuse and Mental Health Services Administration; US Department of Health and Human Services. After an attempt: a guide for medical providers in the emergency department taking care of suicide attempt survivors. 2006. Available at: https://store.samhsa.gov/shin/content/SMA08-4359/SMA08-4359.pdf. Accessed July 7, 2015.
43. Substance Abuse and Mental Health Services Administration; US Department of Health and Human Services. After an attempt: a guide for taking care of yourself after your treatment in the emergency department. 2006. Available at: https://store.samhsa.gov/shin/content/SMA08-4355/SMA08-4355.pdf. Accessed July 7, 2015.
44. Substance Abuse and Mental Health Services Administration; US Department of Health and Human Services. National suicide prevention lifeline: after an attempt: a guide for taking care of your family member after treatment in the emergency department. 2006. Available at: https://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf. Accessed July 7, 2015.
45. American College of Emergency Physicians. Firearm safety and injury prevention. 2013. Available at: http://www.acep.org/Clinical--Practice-Management/Firearm-Safety-and-Injury-Prevention/. Accessed July 23, 2015.
46. Petrik ML, Gutierrez PM, Berlin JS, et al. Barriers and facilitators of suicide risk assessment in emergency departments: a qualitative study of provider perspectives. *Gen Hosp Psychiatry*. 2015;37:581-586.
47. Davidson CL, Olson-Madden JH, Betz ME, et al. Emergency department identification, assessment, and management of the suicidal patient. In: Koslow PR, Ruiz P, Nemeroff CB, eds. *A Concise Guide to Understanding Suicide*. Cambridge, United Kingdom: Cambridge University Press; 2014:244-255.
48. Bryan CJ, Rudd MD. Advances in the assessment of suicide risk. *J Clin Psychol*. 2006;62:185-200.
49. Joiner TE, Walker RL, Rudd MD, et al. Scientizing and routinizing the assessment of suicidality in outpatient practice. *Prof Psychol Res Pr*. 1999;30:447-453.