Invited Commentary

Screening for suicide risk – The need, the possibilities, and a call for resources

Stephen B. Freedman, MDCM, MSc*; Amanda S. Newton, PhD, RN†

In this issue of *CJEM*, Lee and colleagues contribute an important perspective on the risk of suicide death among youth following an emergency department (ED) visit for a mental-health-related concern and the timing of suicide death after such visits.[1] Youth and their families who present to EDs during a mental health crisis are some of the most vulnerable, scared, and stressed patients evaluated in EDs. While recent Canadian literature exists on the risk of death among youth after an ED visit for deliberate self-harm,[2] to our knowledge, this risk has yet to be comprehensively detailed among those with ED visits for non-self-harm-related mental health crises. The study by Lee et al.[1] fills a critical knowledge gap, because ED clinicians are concerned about the risk, safety, and well-being of all youth presenting with mental health concerns.

In their study, Lee and colleagues found that the risk of death by suicide or indeterminate cause was threefold higher for youth with ED mental health visits compared to youth with non-mental, health-related visits. While this seems to present a population in need of a targeted intervention, the challenge is that the median time to suicide death was 5.2 years. These findings are important and should inform a national dialogue on the practice and implications of screening for suicide risk in all ED patients presenting with mental health concerns. Such a discussion is needed to help clarify the role of the ED in relation to the continuum of mental health and social services. What is particularly challenging is, how can the magnitude of risk and timing for suicide, as reported by Lee et al.,[1] be used to guide ED resource utilization and disposition decision-making?

Screening to assess for suicide risk among pediatric mental health patients should be standard ED practice. The premise behind screening is that mental health patients have a self-harm risk that is typically undetected.[3] While the Lee et al.[1] study quantifies the risk in this patient population, a recent study also demonstrated that screening can effectively identify risk in patients with a range of mental health concerns.[3] A core tenet of screening is that the practice employs a standardized and validated tool to allow clinicians to rule-in and rule-out immediate risk among ED patients.[4] The goal is to quickly identify those youth who require a more in-depth clinical assessment by a trained mental healthcare professional regarding intent and means for self-harm and potential death by suicide. U.S.-based organizations have rapidly endorsed the importance of screening all mental health patients and are mandating or providing resources to facilitate this practice.[5,6] The same level of action has yet to occur in Canada; to date, no formal recommendations or guidelines on screening in an ED setting exist. What is now needed is investment in understanding the mid- and longer-term impacts of ED-based screening. This includes studies of its impact on access and time to mental health and social services, healthcare costs and resources, and, most importantly, the number of deaths by suicide.

Community-based mental health and/or social services must be available and accessible to youth who intentionally harm themselves, as well as those without self-harm complaints yet screen positive and, thus, might also be at risk of death by suicide. Over two-thirds of youth who come to an ED for a mental health

From the *Sections of Pediatric Emergency Medicine and Gastroenterology, Alberta Children's Hospital, Alberta Children's Hospital Research Institute, Cumming School of Medicine, University of Calgary, Calgary, AB; and the †Department of Pediatrics, Faculty of Medicine & Dentistry , University of Alberta, Edmonton.

Correspondence to: Stephen B. Freedman, Alberta Children's Hospital, C4-634 28 Oki Drive NW, Calgary, AB, T3B 6A8; E-mail: Stephen.freedman@ahs.ca

 CJEM 2020;22(3):269–270 DOI 10.1017/cem.2020.39

emergency will be discharged home[7]; this is also true for those youth who present to the ED with suicidal ideation and/or self-harming behaviours.[8] Findings from the Lee et al. study suggest that such youth continue to be at risk of death by suicide or indeterminate cause for many years after an index ED visit. As nearly 70% of youth who later died by suicide had been admitted at the initial ED visit, even hospitalization is not a long-term solution for all youth. What the Lee et al. study does not tell us is what the healthcare trajectories were for youth who died by suicide years after an ED visit. Did these youth access healthcare or social services in the year or months preceding their death? Were services and support available but not accessed by youth? Conversely, were services and support not available for youth in their communities?

Many gaps are documented for access to mental health and social services in Canada (see a contemporary commentary[9]), including the concern that the lack of integration of mental health services into provincial healthcare plans continues to perpetuate existing barriers (e.g., financial) to access and treatment.[10] This makes it likely that some youth in the Lee et al. study did not receive the care and services that they needed throughout their lifetime. Identifying at-risk children through early screening and intervention before they present to an ED with significant self-harm behaviours is necessary to alter their trajectories and improve health and well-being outcomes. In an ideal healthcare system, there is a coordinated continuum of mental health promotion, prevention, and intervention services in all communities. This continuum supports youth early on in childhood to develop skills and reduce stigma around mental health, identifies and supports at-risk and vulnerable youth, and ensures that youth are cared for in and by their communities. While this continuum of care extends well beyond the ED setting, clinicians who screen youth in the ED for suicide risk do face an ethical dilemma if they identify at-risk youth but have no available or accessible follow-up services to offer. At this time, improved transitions from acute emergency care to short- and longer-term mental healthcare solutions are necessary in order to increase service engagement after an ED visit and decrease the potential for continued crises (e.g., repeated ED visits). The Lee et al. study[1] should serve as a wake-up call and a reminder that one of our most vulnerable patient populations, youth with mental health concerns, continue to need us, their care providers, to advocate for their access to the post-ED visit care they need and deserve.

Acknowledgements: Dr. Stephen Freedman is supported by the Alberta Children's Hospital Foundation Professorship in Child Health and Wellness.

Keywords: Mental health, pediatrics, psychiatry

Competing interests: None declared.

REFERENCES

1. Lee J, Black T, Meckler G, Doan Q. Outcome of pediatric emergency mental health visits: incidence and timing of suicide. *CJEM* 2020;22(3):321–330.
2. Gardner W, Pajer K, Cloutier P, et al. Health outcomes associated with emergency department visits by adolescents for self-harm: a propensity-matched cohort study. *CMAJ* 2019;191(44):E1207–16.
3. DeVylder JE, Ryan AC, Cwik M, et al. Assessment of selective and universal screening for suicide risk in a pediatric emergency department. *JAMA Netw Open* 2019;2(10): e1914070.
4. Newton AS, Soleimani A, Kirkland SW, Gokiert RJ. A systematic review of instruments to identify mental health and substance use problems among children in the emergency department. *Acad Emerg Med* 2017;24(5):552–68.
5. The Joint Commission. Suicide prevention. 2019. https://www.jointcommission.org/en/resources/patient-safety-topics/suicide-prevention/ (accessed April 7, 2020).
6. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Critical crossroads pediatric mental health care in the emergency department: a care pathway resource toolkit. Rockville, MD: U.S. Department of Health and Human Services; 2019.
7. Santilles G, Axeen S, Lam CN, Menchine M. National trends in mental health-related emergency department visits by children and adults, 2009–2015. *Am J Emerg Med* 2019; epub, doi:10.1016/j.ajem.2019.12.035.
8. Burstein B, Agostino H, Greenfield B. Suicidal attempts and ideation among children and adolescents in US emergency departments, 2007–2015. *JAMA Pediatr* 2019;173(6):598–600.
9. Gratzer D, Goldbloom D. New government, new opportunity, and an old problem with access to mental health care. *Can J Psychiatry* 2017;62(1):8–10.
10. Cawthorpe D. Improving youth mental health supports in Canada. *CMAJ* 2018;190:E1181–2.

https://doi.org/10.1017/cem.2020.39 Published online by Cambridge University Press