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Incorporating the Emergency Department in the Blueprint for Youth Suicide Prevention

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More than 4 in 5 people who died by suicide saw a health care practitioner in the last year and 24% did not have a mental health–related diagnosis.[1] The urgency to improve how suicide is managed is especially great for children and adolescents in the US. The adolescent period is a time in which the death rate by suicide greatly increases.[2] Furthermore, during the COVID-19 pandemic, mental health worsened, and death by suicide increased in adolescents and children. One less-tapped health care setting for preventing suicide completion is the emergency department (ED), which serves to supplement, and, in some cases, supplant the care provided in primary care, subspecialty clinics, and hospitals. For patients with self-injury, the ED can serve 2 purposes, both to manage the physical injury and begin to heal the mental injury.[1,3]

In this study, Kemal et al[4] used the Healthcare Cost and Utilization Project's state ED and inpatient databases of Arkansas, Florida, Iowa, Maryland, Nebraska, New York, Vermont, and Wisconsin from 2019 to retrospectively analyze patients aged 5 to 18 years with self-inflicted injury by diagnosis code to understand ED utilization 90 days before and after the self-inflicted injury. Overall, they found that 24.2% had an ED encounter before a self-inflicted injury, and 26.7% had an encounter after injury.[4]

The findings by Kemal et al[4] support calls from the American Academy of Pediatrics and Bright Futures for universal screening for suicide in all clinical settings, which includes the ED.[5] Ideally, if a patient reports suicidality, they would undergo an evidence-based suicide risk assessment and have a management plan created, since the screening, assessment, and effective management of suicidal ideation can reduce future attempts.[5,6] In some states, such as Illinois, universal screening for suicide may extend even into schools.

Far too many people die by suicide, and a reduction in suicide in adolescence is reflected throughout the lifetime.[2] Previous efforts have focused on targeted screening in settings such as the clinic or medical home, but it is important to expand both efforts for depression and suicide screening. Many children in the preadolescent and adolescent phase may only visit their medical practitioner once a year for a well-child check and thus have limited exposure to screening in their medical home. Screening patients outside of the medical home will increase opportunities to identify those at risk for death by suicide. Furthermore, this study by Kemal et al[4] found that rural and publicly insured patients were more likely to exclusively use the ED for care.[4] This study by Kemal et al[4] supports the national call to increase access to primary care (which are the de facto mental health care practitioners) and medical homes for people living in rural settings and people with public insurance.

The study by Kemal et al[4] had a few limitations due to its observational study design and available data. The study excluded people who died by suicide, which biased results toward populations less likely to die by suicide (eg, female patients). The dataset did not include gender or more granular racial and ethnic groups, which limited interpretation for certain populations at high risk for suicide, including lesbian, gay, bisexual, transgender, queer, and other individuals and individuals identifying as multiple races or ethnicities and American Indian individuals. Furthermore, whether interactions or effect modification existed by sex, race and ethnicity, or other characteristics is unknown.

While recommended by guidelines, future studies are needed to understand how to effectively implement systematic screening for suicidality in settings outside the medical home, such as the ED, urgent care settings, subspecialist clinics, schools, and at home via telehealth. Furthermore, additional work to implement and strengthen the downstream management for patients who report suicidality is necessary. On the backbone of effective universal screening, suicide and self-inflicted injury prevention is possible. The change will require creative multiprong approaches that include bolstering protective factors, effective harm reduction strategies, improvement in access to care with mental health care practitioners, and training practitioners on effective management.

ARTICLE INFORMATION

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