PSNet
PATIENT SAFETY NETWORK

Suicide Prevention

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Introduction

Suicide is one of the leading causes of death in the United States, accounting for nearly 50,000 deaths in 2022, a 36% rise since 2000.[1] In addition, over 13 million Americans experience suicidal thoughts each year,[2] and many of those people attempt suicide, which can have long-term physical and emotional impacts on that individual, their friends and family, and the community at large. Despite the widespread impact of suicide, it remains a preventable tragedy, especially when suicidal ideation is identified early and support can be given. The healthcare system provides a valuable opportunity to identify people with suicidality, given that the majority of people who die by suicide have interacted with the healthcare system in the weeks or months leading up to their deaths.[3] In addition, healthcare providers are uniquely trained and positioned to identify warning signs and connect at-risk individuals with resources.

Given this crucial role that healthcare providers can play in suicide prevention, screening patients for suicide risk and supporting patients with identified risk have received increased attention in recent years. The Joint Commission included suicide prevention in its list of National Patient Safety Goals in 2018 and made suicide during a stay in the hospital, or within three days of discharge, a sentinel event.[4] Despite the attention, implementation of screening and follow up procedures is inconsistent. To address this, in 2024, the Joint Commission widened the window in the sentinel event definition from three days after discharge to seven days.[5] This essay will discuss how suicide screening can be successfully integrated into regular care in both inpatient and outpatient settings, as well as best practices for assisting a patient with identified risk for suicide. Using these tools and strategies can help identify individuals in need early, enabling them to receive timely, targeted interventions that can prevent suicide attempts and ultimately save lives.

Choosing a Screening Tool

While the fundamental process of identifying and managing suicide risk remains consistent across healthcare settings, the specific tools employed often differ based on the setting—particularly in terms of length, complexity, and ease of administration. In the fast-paced emergency department (ED) environment, providers require tools that are brief and straightforward to administer, such as the Columbia-Suicide

Severity Rating Scale (C-SSRS) Screener or the Patient Safety Screener, which allow for rapid risk screening with minimal impact on care delivery.[6,7] In primary care and outpatient clinics, where appointments may allow for a more comprehensive evaluation, screening is often conducted using slightly longer, yet still efficient, tools like the Patient Health Questionnaire-9 (PHQ-9), which is a measure of depression that has an item that screens for thoughts of intentional self-harm.[8] Depression screeners like the PHQ-9 can be used in combination with suicide-specific screeners, like those mentioned above. Together, these instruments are designed to detect signs of suicidal ideation in patients who might not present with overt mental health concerns.

Specialized settings, such as pediatric settings and OBGYN offices, use screening tools to meet the specific needs of their patient populations. For example, pediatricians can use age-appropriate adaptations of tools like the Ask Suicide Screening Questions (ASQ)[9] to engage children and adolescents effectively, ensuring that the language and format are accessible. Similarly, OBGYN practices routinely integrate the Edinburgh Postnatal Depression Scale (EPDS) during postpartum visits to monitor both depressive symptoms and suicidal ideation. Similar to the PHQ-9, the EPDS can be paired with a suicide-specific screener to improve risk detection. By selecting the specific screening tools tailored to the unique patient and care delivery needs in each setting—such as through brevity in an ED or tailored assessment in specialized care—healthcare organizations can ensure that interventions to prevent suicide can target those identified as at risk.

Choosing a Screening Approach

Once the appropriate screening tool has been selected, healthcare organizations must determine whether to implement a universal or targeted screening approach. In general outpatient settings, such as primary care clinics, universal screening may be relatively easy to implement, because depression screening is already widely implemented. The suicide-related item within a screener like the PHQ-9 can be used, or, even better, a suicide-specific screener, like the C-SSRS Screener, can be added to the routine depression screening. By screening all patients, providers can identify individuals experiencing suicidal ideation who might otherwise go undetected since many at-risk individuals do not present with obvious mental health concerns.[10] This proactive approach is particularly beneficial given that many people who die by suicide have interacted with the healthcare system in the months leading up to their death.[3] However, universal screening can be time-consuming and may result in a high number of positives, requiring additional resources for follow-up assessments and mental health referrals that may be challenging to arrange.

In contrast, inpatient units and emergency departments often employ a more targeted approach, prioritizing screening for patients with known risk factors, such as psychiatric conditions, substance use disorders, or recent self-harm, due to time constraints and the urgent nature of care in those settings. This method allows providers to focus their resources on individuals with the highest likelihood of suicide risk while minimizing lower-priority assessments. However, a major drawback of targeted screening is that it relies on providers recognizing risk factors upfront, which may lead to missed opportunities if a patient’s suicidal thoughts are not immediately evident. Recent studies have explored the use of universal screening in the ED and found that it can be implemented successfully and can catch nearly double the number of patients as a targeted approach.[11]

Best Practices for Conducting Screening and Assessment

The next step is to effectively implement and conduct the screenings once the appropriate tool and population has been selected. Providers should be properly trained in how to administer screening tools with consistency and fidelity, and that includes creating a safe and open environment for patients to engage in the process and share their concerns honestly. Healthcare providers should be comfortable having discussions about suicidal thoughts and behaviors using non-judgmental and compassionate language to reduce stigma and build trust.[12] For example, after completing the screening, a provider might say, "Thank you for sharing your feelings—it takes a lot of courage, and I appreciate your trust. I want to understand your experience better so we can work together to help you feel safer and supported." Providers can also pay close attention to both verbal and non-verbal cues—such as hesitations, changes in tone, or body language— which can provide vital insights into a patient's mental state. If possible, conducting screenings in private settings can enhance patient comfort, and clear explanations of confidentiality policies—including the limits, such as the duty to report imminent risk—can help patients feel secure in sharing their concerns. Using these strategies will not only improve the accuracy of the screening process but also empower patients to seek help. Continuous training and adherence to these guidelines ensure that every screening session is an opportunity for early intervention, ultimately contributing to the prevention of suicide and the enhancement of overall patient well-being.

Responding to Positive Screenings

Immediately after a patient screens positive for suicide risk, the response should be tailored both to the healthcare setting and to the severity of the risk. In inpatient settings, where patients are already under close supervision, for those deemed at high or imminent risk, providers can immediately secure the area by removing potentially harmful objects and equipment and consider assigning a dedicated observer. In these controlled settings, the severity of suicide risk dictates whether rapid suicide risk mitigation efforts and/or more comprehensive mental health assessments are warranted.[13,14] In outpatient settings, the response is also adjusted based on the risk level, but the response methods differ slightly due to the difference in access to acute care resources. Patients with lower severity may receive a calming discussion and an initial safety plan, along with referrals for mental health services, while those exhibiting higher severity may be immediately directed to local crisis intervention services or, in the direst scenarios, taken to the emergency department.[15,16] This tailored approach ensures that each patient receives an appropriate level of care based on both their environment and their individual risk profile.

In the inpatient environment, the discharge and referral process is essential to maintaining patient safety, as suicide rates spike in the days after discharge.[17] Effective discharge planning involves confirming that a robust safety plan is in place,[18] providing clear crisis resources, and ensuring that patients are connected with mental health services through warm handoffs to outpatient care. Scheduling rapid follow-up visit appointments before discharge helps bridge the gap between inpatient and outpatient care providers, ensuring that the patient continues to receive support during this vulnerable transition period. The National Action Alliance for Suicide Prevention recommends that patients are contacted within 24 hours of discharge and again within 7 days after discharge, in whatever mode the patient prefers (e.g., phone, text, face-to-face).[19] These follow-up recommendations will help hospitals avoid suicide sentinel events, especially

given the recently expanded post-discharge window.5

Barriers and Facilitators to Suicide Prevention

While the need for effective suicide prevention and established protocols is clear, numerous barriers can hinder healthcare organizations from successfully identifying suicide risk and preventing suicide. Resource constraints, such as the nationwide shortage of mental health professionals and follow-up services, can significantly impact the effectiveness of suicide prevention efforts after discharge.[20] Additional obstacles include time constraints during clinical visits that limit thorough assessments, legal and liability concerns that may deter providers from engaging in thorough suicide risk discussions, and the challenges posed by fragmented communication between providers in different care settings. These systemic issues can result in inconsistent application of screening protocols and delays in implementing timely interventions, further compromising patient safety.

To address these challenges and improve their ability to identify and manage suicide risk, healthcare organizations can invest in comprehensive training programs that equip staff with the skills to identify warning signs, confidently use validated screening tools, and implement timely interventions with fidelity. While the shortage of mental health professionals is not easily remedied, healthcare organizations can leverage existing resources as effectively as possible by using telehealth to connect patients with mental health professionals across the country, maintaining up-to-date lists of community-based resources, and by cross-training staff to better assist patients with mental health concerns.

Conclusion

Throughout this essay, various approaches have been discussed—from selecting the right screening tools to tailoring screening based on the setting and patient population with a universal or targeted approach. Yet, amid these technical details, the core of effective suicide prevention lies in creating a supportive, non-judgmental environment where patients feel understood and valued. By maintaining empathy and using trauma-informed care approaches, healthcare providers can break down the barriers of stigma and ensure that every patient receives the personalized care they need, thereby increasing the chances of early detection and timely intervention. As healthcare organizations continue to refine their screening and intervention practices, keeping compassion at the forefront will ensure that these efforts are not merely procedural but truly transformative, empowering patients to seek help and supporting them throughout their journey toward well-being.

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