

Suicide Risk Assessment and Prevention in the Acute Care General Hospital Setting

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Guidance

Executive Summary

Suicide is a nationwide problem. According to data from the Centers for Disease Control and Prevention, 44,193 suicides occurred in the United States in 2015, making it the 10th leading cause of death overall. This is an average of 121 deaths by suicide per day, or one every 12 minutes. Suicide is the second leading cause of death among individuals age 15 to 24 years, the third leading cause of death among children age 5 to 14 years, and the fourth leading cause of death among adults age 25 to 44 years. (CDC)

Patients who seek care in an emergency department (ED) or general hospital primarily because of suicidal ideation or injuries from a suicide attempt may volunteer the fact that they are suicidal. Others may seek care for injuries sustained in a suicide attempt without disclosing that the injuries resulted from a suicide attempt (e.g., a broken limb from jumping). Yet others may present for unrelated physical or behavioral health reasons but may also be at risk for suicide.

When the patient's reason for presenting does not obviously relate to suicide, suicide risk may go unrecognized, particularly if providers do not ask screening questions. This represents a lost opportunity to intervene, whether or not the patient's reason for presenting relates to suicidality. Even when suicide risk is recognized, it is often challenging to determine which disposition is most appropriate or how to plan effectively to keep the patient safe.

Although clinicians cannot predict which patients will attempt suicide, they can implement strategies to prevent inpatient suicides, such as assessing patients for suicide risk and adopting measures to reduce the likelihood that a patient will attempt suicide. These prevention measures include closer monitoring of the patient, removing from the patient's room any structures and materials that the patient could use to attempt suicide, increasing staff awareness of suicide prevention strategies, and effectively communicating with caregivers about a patient's risk.

Risk managers must ensure that proper policies and procedures are in place for suicide assessment and prevention. Although preventing death is the driving force behind healthcare facilities' efforts, these initiatives also help ensure compliance with regulatory and accrediting requirements as well as minimize the possibility of claims and lawsuits for preventable suicides of patients in healthcare facilities and immediately after discharge.

This guidance article explores the assessment and management of risks inherent in treating suicidal patients in the acute care hospital setting, such as in the ED, the intensive care unit (ICU), or a medical-surgical unit. Although suicide assessment and prevention principles may be similar in other healthcare settings, such as psychiatric units or facilities, the primary focus of this guidance article is on suicide prevention in the general acute care setting.

Action Recommendations

- Work with behavioral health providers, community agencies, and the government to map resources for patients at risk for suicide, and consider how to fill gaps.
- Establish a multidisciplinary team responsible for developing and implementing policies and educating staff.
- Select the most appropriate screening tools for the organization and its patient populations, and establish protocols for more in-depth assessments when screening tools identify at-risk patients.
- Minimize environmental concerns in triage areas by equipping them for emergency assistance and eliminating items that could be used for self-harm.
- Set up post-triage patient areas in the ED to make patient monitoring feasible and minimize opportunities for self-harm.
- Plan for suicidal-patient management in the ED with measures such as direct observation, appropriate use of security personnel, and minimized boarding of patients.
- Train staff in identifying, screening, and assessing at-risk patients and in understanding and using the safety and security measures in place.
- Include inpatient care settings such as the ICU and medical-surgical units in planning for suicide screening, assessment, and prevention.
- Develop a discharge or crisis plan prior to suicidal patients actually being discharged.

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The Issue in Focus

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Suicide is a nationwide problem. According to data from the Centers for Disease Control and Prevention, 44,193 suicides occurred in the United States in 2015, making it the 10th leading cause of death overall. This is an average of 121 deaths by suicide per day, or one every 12 minutes. Suicide is the second leading cause of death among individuals age 15 to 24 years, the third leading cause of death among children age 5 to 14 years, and the fourth leading cause of death among adults age 25 to 44 years. (CDC) The data on suicidal behavior are even more striking. According to 2008–2009 statistics, 8.3 million individuals in the United States reported having suicidal thoughts and more than 1 million Americans reported attempting suicide. (Crosby et al.)

Patients at Risk for Suicide in for Hospitals and Emergency Departments

A dearth of need-appropriate, accessible resources for patients with behavioral health needs, including suicidality, causes great difficulties for patients and healthcare organizations across the continuum of care. Historical efforts moved many people with behavioral health conditions out of institutions and into less restrictive settings. However, some people still need inpatient beds but cannot get them because the demand exceeds the supply. (Raphelson) In 2016, fewer than 12 state psychiatric beds were available per 100,000 population—the lowest number per capita since the United States stopped considering mental illness a crime in the 1850s (Fuller et al.). In some areas, outpatient services exist but have months-long waiting lists. Costs to patients and social determinants of health (e.g., transportation difficulties) are other potential barriers to access.

All of this has had a tremendous effect on healthcare delivery. Acute care hospitals and in particular the emergency department (ED) have become the de facto provider of behavioral healthcare for many patients, causing an increase in the numbers of patients with psychiatric needs presenting to EDs. One study found that in a nationwide comparison of visits by four-year groupings, rates for suicide attempt and self-injury ED visits more than doubled from 1993–1996 to 2005–2008 (Ting et al.). The trend continues to escalate; the number of ED visits for suicidal ideation increased by 415% from 2006 to 2014 (Moore et al.).

Patients who seek care in an ED or general hospital primarily because of suicidal ideation or injuries from a suicide attempt may volunteer this information. Others may seek care for injuries sustained in a suicide attempt without disclosing that the injuries resulted from a suicide attempt (e.g., a broken limb from jumping). Yet others may present for unrelated physical or behavioral health reasons but may also be at risk for suicide. In a study of nearly 6,000 people who died by suicide, 83% received healthcare services in the year before death, but most such contacts with the healthcare system were not associated with a mental health diagnosis code (Ahmedani et al.).

When the patient's reason for presenting does not obviously relate to suicide, suicide risk may go unrecognized, particularly if providers do not ask screening questions. Researchers sent surveys to all level I and level II trauma centers in the United States, asking about their screening procedures and interventions. Only 49% of respondents routinely screened patients for suicide risk. (Love and Zatzick) This represents a lost opportunity to intervene, whether or not the patient's reason for presenting relates to suicidality. Even when suicide risk is recognized, it is often challenging to determine which disposition is most appropriate or how to plan effectively to keep the patient safe.

The relatively recent influx of patients with psychiatric needs into the acute care setting, regardless of how they present, revealed a system that was ill prepared for the challenges it faces. For example, EDs often have insufficient resources to invest in capital redesigns to make the spaces safer and to provide additional training to staff. Since most providers do not have a behavioral health background, they believe they lack the knowledge and expertise to best provide care for the psychiatric patient population. In addition, some of these providers have negative attitudes toward psychiatric patients in general and express frustration with patients who repeatedly present with suicidal behavior. Overall, staff exhibit frustration with the organization and a feeling of helplessness at the perceived failure of the mental health system. (Manton)

Risk Factors for Suicide

Although researchers have identified risk factors for suicide in the general population, there are fewer data on risk factors for the hospital population. In the general population, risk factors for both those younger and older than age 30 include the following (CRICO/RMF):

- ▮ Family history of suicide
- ▮ Male gender
- ▮ History of suicide attempts
- ▮ Native American
- ▮ Mood disorders

One control group study of people who committed suicide after psychiatric hospitalization found these individuals were more likely to have the following characteristics (Bickley et al.):

- ▮ Recent significant illness onset
- ▮ Comorbid psychiatric diagnosis
- ▮ History of self-harm
- ▮ Recent adverse life event, particularly relationship break up
- ▮ Age 40 or older

- Nonadherence to prescribed medication
- Reported depressive symptoms or hopelessness
- Nonparticipation in aftercare

Applying the same risk factors for suicide in the general population to hospitalized patients may yield false positives. Even patients at risk for suicide in general hospitals may have a different profile from at-risk patients in psychiatric hospitals. Typical differences between acute psychiatric suicidal patients and general hospital suicidal patients can be categorized as follows (Tishler and Reiss):

- Psychiatric patients
 - Young males with psychiatric diagnosis
 - Admitted with recent suicide attempt or ideation
 - History of mental illness, substance abuse, or previous suicide attempts
- General hospital unit suicidal patients
 - Older males
 - No history of psychiatric or suicidal behavior
 - Pain, depression, or physical distress
 - Often experiencing new onset of a chronic disease or a recent major life stressor

Suicide Attempts during or Shortly after a Hospital Stay or ED Visit

Suicide attempts during or shortly after a hospital stay or ED visit are a relatively low-frequency but high-severity concern. In ECRI Institute PSO's *Deep Dive: Meeting Patients' Behavioral Health Needs in Acute Care*, analysts examined 2,364 relevant events involving patients with behavioral health needs. Of those, 183 (7.7%) involved patient self-harm, and 19 (0.8%) specifically involved a suicide attempt. The following case presents one example (ECRI Institute PSO):

The patient's primary nurse assessed the adolescent patient, identifying suicidal ideation. When the nurse asked how the patient planned on killing himself, he stated, "I can't tell you because you have what I want to kill myself with." The nurse asked the sitter (a paramedic) to move closer to the bedside while she went to inform the charge nurse. The patient grabbed the sitter's scissors and placed them with the blade on his own neck. A code was called, and a team with clinical and security staff and a police officer responded, trying to talk the patient down. The patient refused to move the scissors. The patient lunged at the police officer and attempted to grab his gun. The patient still refused to move or hand over the scissors. The patient was tased, and the scissors were recovered.

Joint Commission states that in 2017, suicide was the fourth most frequently reported sentinel event—following unintended retention of foreign bodies, falls, and wrong-patient, wrong-site, or wrong-procedure surgery (Joint Commission "Summary Data"). Although some think of suicide as being primarily an ED problem, many suicides occur in other nonpsychiatric locations of acute care hospitals. In an earlier Sentinel Event Alert, the agency stated that of the 827 suicides reported between 1995 and 2010 (Joint Commission "A Follow-Up"):

- 14.0% took place in non-behavioral health units in acute care general hospitals (e.g., medical-surgical units, intensive care units [ICUs]),
- 8.0% took place in the ED, and
- 2.4% took place in other nonpsychiatric settings (e.g., home care, long-term care).

Two analyses of suicides and suicide attempts on hospital or other healthcare facility grounds show the difficulty of predicting and preventing suicide and the complexity of the problem—and underscore the need for a multifactorial approach. These findings also yield patient safety lessons.

Researchers examined 43 root-cause analyses (RCAs) of suicides and suicide attempts in medical-surgical units and 7 RCAs of similar events in ICUs in Veterans Health Administration facilities over about 13 years. The most common methods of suicide were cutting, overdose, and hanging. Alcohol detoxification and chest pain were the most frequent admitting diagnoses. Common root causes included poor communication among providers and services (particularly inadequate care planning and communication of suicide risk); need for staff training in suicide assessment; need for improvement in suicide risk assessment; and patient stress owing to medical problems, pain, or behavioral health needs. (Mills et al.)

Another health system analyzed the eight suicide attempts that occurred among medical-surgical patients at two of its hospitals over 13 years. The researchers matched each of the eight patients with four patients of the same age and sex who were admitted to the same unit who did not attempt suicide. All of the patients who attempted suicide had experienced a stressor shortly before their suicide attempt: three experienced poorly controlled pain, two each experienced anxiety or agitation, and one each experienced delirium, insomnia, and psychosocial difficulties (e.g., at home or work). (Shekunov et al.)

Most attempted suicide soon after admission. Four patients overdosed on medications brought from home, two cut their wrists, one attempted self-strangulation using a blood pressure cuff, and one swallowed objects (e.g., intravenous [IV] catheter clip, glove). Only two of the eight patients expressed suicidal ideation on admission, and none expressed suicidal intent shortly before his or her attempt. Four patients were seen by a psychiatrist during their hospitalization but before their suicide attempt, and all four denied having suicidal ideation during the psychiatric interview. (Shekunov et al.)

Suicide after discharge is also a challenge. Examining 96 RCAs of suicide within three months of medical hospitalization at a Veterans Affairs (VA) facility, researchers found that 43% of root causes related to management of known suicide risk, 29% related to decisions about monitoring suicide risk, and 28% related to inadequate patient engagement in treatment. Common concerns were failure of medical teams to provide behavioral health treatment and lack of standardized processes for assessing behavioral health needs in patients with serious physical health conditions. In addition, patients declined recommended behavioral health interventions in 26% of cases and left against medical advice in 16% of cases. (Riblet et al.)

Claims and Lawsuits

Healthcare facilities, including behavioral health hospitals, acute care hospitals with and without behavioral health departments, and long-term care facilities, have been held liable in patient suicides under many negligence theories. Indeed, lawsuits related to patient suicides are the largest single category of suits and lead to the most expensive settlements and verdicts against psychiatrists (Melonas and McNary). Other healthcare providers such as nonpsychiatric physicians, psychologists, social workers, and nurses may also risk being held liable for a patient suicide, adding to liability exposure.

Hospitals can be liable for the negligence of employees under the theory of *respondeat superior*, or "let the master answer." Additionally, hospitals may be vicariously liable for the professional negligence of independent licensed professionals who provide patient care at the facility if the hospital had direction or control over the professional.

The American Psychiatric Association identified common complaint allegations against professionals for inpatient suicides, including the following (Jabbarpour and Jayaram):

- Failure to predict or diagnose the suicide
- Failure to control, supervise, or restrain the patient
- Failure to take proper tests and evaluations of the patient to establish suicidal intent
- Failure to medicate properly
- Failure to provide adequate monitoring
- Failure to take an adequate history
- Inadequate supervision or failure to remove dangerous objects, such as a patient's belt
- Failure to provide a safe and secure environment for the patient

Generally, lawsuits allege that healthcare facilities or healthcare workers have neglected their duty to prevent patients from harming themselves by failing to adequately assess patients or failing to implement an appropriate plan for patients who have been assessed as suicidal. For a negligence case to proceed in court, the plaintiffs must be able to show that the incident was foreseeable. (Melonas and McNary)

Although a provider cannot be expected to predict whether a patient will commit suicide, the provider would be expected to implement certain measures to prevent harm to the patient if the patient is identified as being at risk of suicide. In short, if the risk of suicide is foreseeable, the provider would be expected to take action to protect the patient from self-harm.

Regulations and Standards

CMS Conditions of Participation

Suicide prevention is addressed by the Centers for Medicare and Medicaid Services' (CMS) Conditions of Participation (CoPs). Applicable provisions include CoPs related to the governing body, patient rights, privacy and safety, the nursing service, restraints and seclusion, the physical environment, and first aid and resuscitation.

Notably, CMS recently updated its interpretive guidelines for 42 CFR § 482.13(c)(2) ("The patient has the right to receive care in a safe setting") and 42 CFR § 482.41(a) ("The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured"). Risks include those arising from ligatures, sharps, accessible light fixtures, breakable windows, medications, harmful substances, plastic bags, oxygen tubing, and bell cords. (CMS)

The interpretive guidelines state that all hospitals must conduct environmental risk assessments that are appropriate to the care environment and patient population. "That does not mean that a unit which does not typically care for patients with psychiatric conditions is not expected to conduct environmental risk assessments," the guidelines clarify. "It means that the risk assessment must be appropriate to the unit and should consider the possibility that the unit may sometimes care for patients at risk for harm to self or others." Hospital staff must be trained to identify environmental safety risks. (CMS)

The guidelines emphasize that the focus on ligature-resistant and ligature-free environments is aimed mainly at psychiatric units and psychiatric hospitals. The guidelines specify that this focus does not apply to nonpsychiatric units of acute care hospitals that may nonetheless care for patients at risk of self-harm or harm to others (e.g., medical-surgical units, EDs, ICUs). (CMS)

However, CMS states that nonpsychiatric settings where patients with psychiatric conditions may be cared for must identify and protect patients at risk for harm to self or others and mitigate environmental safety risks. "The protection would be that of utilizing safety measures such as 1:1 monitoring with continuous visual observation, removal of sharp objects from the room/area, or removal of equipment that can be used as a weapon," CMS writes. Access to hazardous nonclinical locations (e.g., electrical rooms; rooms housing the heating, ventilation, and air-conditioning system) must be secured. (CMS)

Acknowledging that not all risks can be eliminated, CMS expects hospitals to "demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines." The interpretive guidelines do not require a specific type of assessment, instead stating that the assessment should be appropriate to the care setting, patient population, and staff competency.

Hospital risk managers should also be aware of state requirements affecting their suicide prevention and reporting efforts.

Joint Commission Standards

In its most recent Sentinel Event Alert on suicide (see [Resource List](#)), Joint Commission lists applicable requirements across its accreditation programs. Requirements for hospitals relate to the following (Joint Commission, "Detecting and Treating Suicide Ideation"; Joint Commission, "National Patient Safety Goals"):

- Identifying patients at risk for suicide (National Patient Safety Goal, NPSG.15.01.01)
- Maintaining a "safe, functional environment" (Environment of care, EC.02.06.01)
- Boarding patients who are waiting for behavioral healthcare (Provision of care, treatment, services, PC.01.01.01, element of performance 24)
- Assessing and reassessing patients (PC.01.02.01)
- Assessing the needs of patients seeking care for behavioral health disorders (PC.01.02.13)
- Having a process to address patients' needs after transfer or discharge (PC.04.01.01)

The NPSG on identifying patients at risk for suicide "applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals," according to Joint Commission. As of this writing, Joint Commission had recently sought input on proposed revisions to this NPSG that would broaden one element of performance—addressing minimization of suicide means in the physical environment—to apply to all hospitals. A Joint Commission BoosterPak and standards interpretation resources (see [Resource List](#)) address common concerns and questions regarding standards related to suicide.

ECRI INSTITUTE RESOURCES

[Getting the Most Out of Root-Cause Analyses](#)

[Duty to Warn or Protect Third Parties](#)

Joint Commission also expects accredited hospitals to "identify and respond appropriately to all sentinel events." The agency specifically considers suicide in an around-the-clock care setting or within 72 hours of discharge, including discharge from the ED, to be a sentinel event. Joint Commission requires accredited organizations to review all sentinel events and notes that all sentinel events are subject to review by the accreditor. Appropriate response to a sentinel event includes completing a "comprehensive systematic analysis." (Joint Commission "Sentinel Event Policy") For more information on Joint Commission's sentinel event policy, see the guidance article [Getting the Most Out of Root-Cause Analyses](#).

Tarasoff Doctrine

Risk managers should ensure that caregivers understand how the *Tarasoff* doctrine applies to suicidal patients. The *Tarasoff* doctrine states that caregivers have a duty to warn and protect potential victims of violence if a patient indicates suicidal or homicidal intent. This legal doctrine stems from a California Supreme Court ruling that therapists are obliged to use reasonable care to protect potential victims from danger if an individual indicates his or her intentions to perpetrate a violent act. Given that specific criteria for duty to warn are governed by individual state laws, legal counsel must be consulted to determine the necessary steps to follow in these cases. The *Tarasoff* doctrine is discussed in more detail in the guidance article [Duty to Warn or Protect Third Parties](#).

Action Plan

 [Make a Plan: Suicide Risk Assessment and Prevention](#)

Download this customizable document to track your implementation of these action recommendations.

Map Resources and Fill Gaps

Action Recommendation: Work with behavioral health providers, community agencies, and the government to map resources for patients at risk for suicide, and consider how to fill gaps.

To better serve patients at risk for suicide, a community is likely to need access to a range of behavioral health services and supports, beyond simply outpatient counseling, general EDs, and inpatient psychiatric beds. Hospitals and health systems can help their communities plan pathways to care for behavioral health needs in general, including suicide risk specifically. This may involve offering options that serve a range of acuity levels, facilitate management of medical comorbidities, and improve accessibility and timeliness of care.

An initial step may be to collaborate with behavioral health providers and community and government agencies to map behavioral health resources and identify opportunities. Organizations should identify mismatches between availability—in terms of services, capacity, and hours of availability—and need. Analysis of utilization patterns may help identify other barriers to access and utilization.

The American Hospital Association's report on behavioral health challenges in general hospitals (see [Resource List](#)) recommends that hospital leaders spur the development of a regional or community-wide plan for meeting and coordinating behavioral health needs. Hospitals should develop a formal plan delineating their role in behavioral health and their relationships with other providers, community agencies, and government, the report states. The report includes case studies showing how hospitals have addressed behavioral health challenges and links to case studies illustrating collaborative efforts to improve behavioral health, including suicide-related outcomes, among hospitals and their communities. The Centers for Disease Control and Prevention's technical package on preventing suicide (see [Resource List](#)) offers additional big-picture strategies for communities and health systems.

Communities may develop crisis intervention resources, such as hotlines, crisis intervention training for law enforcement and community-based behavioral health workers, mobile crisis units, counseling, residential services, and crisis stabilization units (Joint Commission "Alleviating ED Boarding"). Leaders and champions in acute care settings should consider whether adequate crisis intervention resources are available outside normal business hours.

Hospitals and health systems may take a variety of steps to address gaps. Examples include developing new service lines (e.g., psychiatric ED), expanding behavioral health capabilities within the general hospital or ED, improving care coordination with behavioral health providers and community-based services, and building bridges with organizations that support social determinants of health (e.g., housing, employment).

Efforts to improve care coordination include enhanced care management. This involves ED staff coordinating appointments and following up with patients after discharge. Other models leverage the efforts of community health workers, patient navigators, health coaches, or peer support specialists to help coordinate care for patients with behavioral health needs. (Laderman et al.)

Communities may also evaluate whether the services and supports they provide are culturally appropriate. One community adapted a brief suicide intervention for youth from the White Mountain Apache Tribe. Suicide rates are three to four times as high among 15- to 24-year-old American Indian/Native Alaskan youth as among other U.S. youth in the same age range. The intervention was delivered in a home or other private setting for patients who had recently visited an ED after a suicide attempt. The intervention lasted a total of two to four hours over one or two visits. Culturally relevant materials (e.g., workbook, intervention manual, video with Apache actors and community Elders) were developed, and Apache community mental health workers performed the intervention.

Results indicated significant decreases in negative thinking, depressive symptoms, and suicidal ideation compared with baseline. Use of outpatient treatment increased, and ED visits for behavioral health reasons decreased. Participants had positive attitudes toward counseling and were highly satisfied with the intervention. (Cwik et al.)

Establish a Multidisciplinary Team

Action Recommendation: Establish a multidisciplinary team responsible for developing and implementing policies and educating staff.

Acute care organizations should consider establishing a multidisciplinary team or teams to develop and monitor approaches to identifying and managing suicide risk. Some hospitals may choose to have one such team to coordinate approaches across the facility, possibly with additional teams to carry out work in specific departments. In other hospitals, teams may be primarily department-specific, but because patients often move from one unit to another, there should be some system for cross-departmental communication and planning.

Team members may include representatives from administration, physician leadership, management, frontline nursing staff, security, facilities and building management, case management, psychiatry, psychology, social work, and specific departments. Those teams should develop organizational and departmental policies on the assessment and management principles they adopt.

No single set of recommendations regarding the proper care and treatment of the suicidal patient in every possible acute care setting exists. Each hospital is unique in its ability to provide suicide prevention and management interventions in its populations, based upon resources available both inside and outside the organization. In addition, more restrictive measures may be appropriate in certain areas of an acute care hospital than others, given the level of risk provided by their populations and the resources to prevent the risk.

To determine which units may need department-specific teams, organizations should determine the areas at highest risk for suicidal activity by patients. Those teams can develop departmental policies and work processes that align with organizational policies and integrate with policies and work processes of other units. They may also educate staff on their expectations and requirements (see the discussion [Build Staff Competencies](#) for more guidance).

Screen and Assess Patients

Action Recommendation: Select the most appropriate screening tools for the organization and its patient populations, and establish protocols for more in-depth assessments when screening tools identify at-risk patients.

Although many organizations have adopted standardized suicide screening or assessment tools in at least some areas of the hospital, no research has found any formalized assessment tool to have predictive validity, and no tool has been created that can "predict" suicide. (Simon) Screening is not designed to "predict" who is at risk for suicide; rather, it can help staff identify which patients require a more in-depth comprehensive suicide risk assessment done by a qualified provider.

Patients who attempt suicide in general acute care settings do not necessarily have the same risk factors as members of the general population or psychiatric patients who commit suicide. This underscores the importance of considering the potential for suicide risk in every patient and not assuming that risk is limited to certain groups—or relying exclusively on risk factors.

Support for universal screening, at least in certain settings, is growing. Joint Commission's most recent Sentinel Event Alert suggests that emergency care, primary care, and behavioral health clinicians "screen all patients for suicide ideation" with an evidence-based tool, review all patients' family and personal histories for risk factors, and review screening results before patients leave (Joint Commission "Detecting and Treating Suicide Ideation").

Research on suicide risk assessments in EDs also supports the benefits of universal screening. In the ED-SAFE study, eight hospitals that did not have psychiatric EDs evaluated universal suicide and self-harm risk screening in the ED. The study progressed through three phases: In the first phase, each hospital implemented (for all patients presenting to the ED) treatment as usual; in the second phase, each hospital used universal suicide and self-harm risk screening for all patients; and in the third phase, each implemented universal screening for all patients plus an intervention. The intervention consisted of secondary suicide risk screening by the emergency physician, a safety plan and informational resources, and multiple post-ED phone calls to the patient and to a significant other identified by the patient. The phone calls were based on the CLASP (Coping Long Term with Active Suicide Program) protocol. (Miller et al., "Suicide prevention"; Miller et al., "The coping")

The percentage of patients with documented screening for suicide or self-harm risk rose from 26% during the treatment-as-usual phase of the study to 73% during the universal-screening-only phase, to 84% during the final phase, universal screening plus intervention. The percentage of patients who acknowledged suicidal or intentional self-harm ideation or behavior also increased, from 2.9% during treatment as usual to 5.2% during universal screening only, to 5.7% during universal screening plus intervention. Universal screening "was feasible and led to a nearly twofold increase in risk detection," the authors wrote, concluding that the impact of universal suicide screening on public health could be "tremendous." (Boudreaux et al.)

The brief intervention played an important role. The ED-SAFE study also examined outcomes for 1,376 adult ED patients who either had attempted suicide or had active suicidal ideation within the past week. The percentage of patients who attempted suicide over the 52-week follow-up period did not differ between the first phase (treatment as usual) and the second phase (universal screening only). However, addition of the brief intervention (during the third phase) appeared to have an impact. Only 18% of patients in the screening-plus-intervention group attempted suicide during follow-up, compared with 23% in the treatment-as-usual group, for a relative risk reduction of 20%. The total number of suicide attempts was 30% lower in the screening-plus-intervention group than in the treatment-as-usual group. (Miller et al., "Suicide prevention") See [Resource List](#) for information on accessing the materials used in the ED-SAFE study.

Processes and tools for screening and assessment should be appropriate to the setting and patient population. For example, the American Academy of Pediatrics (AAP) has published a two-part clinical report addressing the evaluation and management of pediatric patients with acute behavioral health needs. The first part discusses clinical challenges and strategies in treating children who present with a behavioral health issue as their primary complaint, including evaluation of patients who have revealed suicidal ideation or who have attempted suicide and determination of the appropriate level of care. (Chun et al. "Evaluation and Management: Part I") The second part of the AAP clinical report discusses clinical challenges that arise when pediatric patients have a primarily medical or unclear presentation possibly along with behavioral health needs. (Chun et al. "Evaluation and Management: Part II") See [Resource List](#) for information on accessing Parts I and II.

Universal screening may increase detection of suicide risk in medical inpatients and other settings as well. A study reported on results from the first six months after implementation of universal screening for suicide risk in the ED, inpatient units, and outpatient clinics of a safety-net hospital system. The rate of positive screens was 6.3% in the ED, 2.1% in the clinics, and 1.6% in the inpatient units, representing nearly 13,000 positive screens. (Roaten et al.)

The hospital's multidisciplinary team(s) should determine the best screening tools for the organization, a particular department, or a particular population, depending on what is most appropriate for patient safety and what best meets regulatory requirements. Attempt whenever possible to integrate the tools into existing electronic medical record systems. Organizations should also ensure adequate training on the use of a tool in high-volume areas; if a standardized facility-wide tool will be implemented, all affected staff should be trained. The team should also establish a protocol for obtaining a more in-depth comprehensive suicide risk assessment when a suicide risk screening tool identifies a patient who may be at risk for suicide.

In acute care settings, leaders and managers may wish to identify and address providers' concerns about, as well as factors that facilitate or impede, screening and assessment. For example, researchers asked ED providers from two hospital systems about suicide risk assessment in the ED. Themes that emerged included a need for more time with patients, challenges in facilitating patient privacy, patient nonparticipation, communication-related facilitators (e.g., nonjudgmental language and tone) and barriers (e.g., difficulty communicating with colleagues across silos), desire for assessment protocols, and a desire for more behavioral health resources, even among those who currently collaborated with other disciplines during assessment. (Petrik et al.)

Several resources are available to help acute care organizations improve suicide screening and assessment. The Suicide Prevention Resource Center offers a guide for EDs that includes a wealth of tools and other resources. The Emergency Nurses Association (ENA) offers a clinical practice guideline on suicide risk assessment. Guidelines from the VA address evaluation and treatment of patients at risk in a range of healthcare settings. The Substance Abuse and Mental Health Services Administration offers a mobile app based on the SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) tool. See [Resource List](#) for information on accessing these and other resources.

After clinicians determine that a patient is at risk, another challenge is determining an appropriate disposition and level of treatment. An American College of Emergency Physicians clinical policy that addresses key issues regarding patients who present to the ED with acute psychiatric symptoms states that clinicians should not rely on suicide risk assessment tools alone when determining disposition because no tools are yet able to accurately determine risk. Instead, the clinical policy recommends conducting a psychiatric assessment; considering patient, family, and community factors; and using clinical judgment. (ACEP)

Many general acute care settings have limited or no access to psychiatrists, and nonpsychiatric physicians may be uncertain how to assess risk and choose an appropriate disposition. A tool to assess suicide risk designed for EDs and medical-surgical units "performed at a remarkably high level" in recognizing a patient's risk for committing suicide within 24 hours and identifying an appropriate level of intervention (routine, specialized, highly specialized, or secured) compared with interview by a psychiatrist. Questions addressing risk level asked about issues including



pain, coping, level of upset, desire to live or die, and psychiatric history. Questions addressing the level of intervention asked about issues including the need for psychiatric evaluation, environmental modifications, observation, referral, and discharge education. (Desjardins et al.) Hospitals and EDs that have little or no access to psychiatric support may consider evaluating how clinicians determine disposition and treatment level for patients at risk for suicide.

Minimize Environmental Concerns in Triage Areas

Action Recommendation: Minimize environmental concerns in triage areas by equipping them for emergency assistance and eliminating items that could be used for self-harm.

Ask ECRI

A member asked for information on construction standards in hospitals, particularly related to windows and the risks they present to behavioral health patients. [See our response.](#)

Due to privacy concerns, the location where the triage nurse performs the initial assessment of the new ED patient should be secluded, such as in a separate room within the ED. This area usually includes only the nurse and the patient and often will have many hazards that a suicidal patient could use for harm if left there unmonitored. In addition, no matter where the triage is performed, often patients will possess items or have parts in their clothing that could be used for self-harm. The triage nurse should take steps to ensure the safety of the patient by removing such items.

The triage room should be equipped with an emergency assistance notification system tied to security assistance. Environmental hazards (e.g., sharp items, plastic trash can liners, medications) in the triage area should be minimized as much as possible. Patients with suspected strong suicidal intent should be closely monitored while in a secluded triage room.

During triage, ensure the safety of all patients determined to be at risk of suicide by removing items that could be used in self-harm, including disrobing the patient and providing a hospital gown, if appropriate. If a gown is not provided, perform a search of the patient's possessions for medications, weapons, and other paraphernalia. Items such as the following should be removed from the patient (Cardell et al.):

- Guns
- Knives
- Scissors
- Metal soda cans
- Nail files or nail clippers
- Sewing or crochet items
- Tweezers
- Perfume bottles
- Any glass items
- Belts
- Shoe laces
- Medications

Evaluate ED Patient Areas for Environmental Safety

Action Recommendation: Set up post-triage patient areas in the ED to make patient monitoring feasible and minimize opportunities for self-harm.

After triage, if the facility does not have a specific psychiatric emergency unit, the ED patient is usually moved to either a specially designed safe room in the regular ED or a regular bay in the ED. Both settings have potential risks. Design elements of the safe room may provide opportunities for self-harm, and both options have multiple hazardous medical items that could be used for self-harm. Also, suicidal patients are at risk for elopement from the ED when left unobserved.

Patients at risk of suicide in the ED should be located away from department exits to prevent elopement. In addition, patients should be located close to dedicated restrooms specifically designed to reduce the risk of patients causing harm to themselves or others (e.g., removal of weight-supporting ligatures).

In addition, video surveillance, with cameras enclosed in tamper-proof housing and with audio capability, may be used to monitor patient activity remotely. Note, however, that remote video monitoring does not replace in-person monitoring by staff in close proximity when warranted.

Dedicated Safe Rooms for Psychiatric Patients

Some organizations may have dedicated safe rooms for psychiatric patients. These rooms should be equipped with tamper-proof hardware and an observation window with window coverings managed from outside the room. All removable objects or medical equipment, in-wall gases, and cupboards should be protected with doors that can be quickly secured. Televisions, if used, should be mounted behind protective glazing. Walls, ceilings, and doors should be hardened to prevent penetration, and access in and out of the room or suite should be controlled. (IAHSS)

In EDs that do not have safe rooms, at-risk patients housed in general areas warrant additional precautions. In mixed psychiatric/general use areas, medical equipment or other unsafe items should be removed or secured before the area is used. Items that cannot be removed should be monitored closely, including the following (Cardell et al.):

- Call light cords
- Lines and electrical cords on medical equipment
- Blinds or curtain cords
- Intravenous tubing
- Eating utensils

- Plastic storage bags

Manage Suicidal Patients in the ED

Action Recommendation: Plan for suicidal-patient management in the ED with measures such as direct observation, appropriate use of security personnel, and minimized boarding of patients.

One-to-One (1:1) Observation Staff or Sitters

Most acute care hospitals use some form of additional hospital staff to perform a 1:1 observation for patients at risk for suicide. These are typically "sitters," patient care technicians, or security personnel. The limited data available questions the effectiveness of 1:1 personnel in preventing psychiatric crises (Harding). Nonetheless, the use of properly trained 1:1 staff has advantages in patient care and environmental management. For example, 1:1 staff can, in their scope as described below, maintain and assess for a safe environment free of items to harm the patient and help prevent the patient from injuring him- or herself when using the bathroom. In addition, the use of 1:1 staff might be determined to be the standard of care if a lawsuit or claim developed after an event.

Ideally, 1:1 observation staff assigned to patients at risk for suicide should have some training in understanding psychiatric patients and their role in maintaining patient safety. As the constant eyes and ears observing the patient, a trained 1:1 staff member can help to better mitigate the risks associated with inpatient care of a suicidal patient.

Organizations should develop specific training for 1:1 observation staff appropriate to their scope and role. The training should include safety measures to take when caring for a patient with suicide risk (see the discussion [Manage Suicidal Patients in Medical-Surgical and Critical Care Units](#)); how to perform and document any environmental room checks, if requested; and how to get assistance if a crisis develops. Consider using 1:1 observation staff to help maintain a safe environment, such as by conducting environmental safety checks of the room during each shift.

Security personnel. Most hospitals have security personnel assigned to the ED to assist with crises that may occur. Some organizations assign someone from security as the 1:1 observation staff member for patients with suicide risk in lieu of a patient care technician or sitter both in the ED and on inpatient units. Although security staff have a role in ensuring the safety and security of patients with other psychiatric conditions, their use with patients with suicide risk should be more limited. Their role is to prevent harm as appropriate within their scope of duties. They cannot perform nursing assessments or any assistive roles that nonsecurity 1:1 observation staff members can. In addition, acting as a 1:1 observation staff member may take security personnel away from other pressing issues elsewhere in the hospital and thus can be an inappropriate use of resources. Hospitals should carefully consider whether using security in these roles is appropriate for their organization.

Boarding Patients

As EDs face the challenge of increasing numbers of psychiatric patients with difficult placement opportunities, ED crowding also increases. This leads to boarding of patients with psychiatric conditions for longer periods of time. While the patients remain in the ED, their medical and psychological needs must be addressed. Suicides by ED patients who were awaiting transfer to another appropriate facility have been noted. (Joint Commission "Standards FAQ") Thus, ensuring appropriate and continued care for patients with suicide risk who are boarded while awaiting transfer is key.

EDs should develop a process and plan for the care of behavioral health patients held for extended periods of time in the ED while awaiting transfer. The plan and its relevant processes should include considerations such as the following (Abraham and Gutbezah):

- A physician or other provider to remain responsible for medical oversight of the patient for the duration of the stay
- A physical environment that is appropriate to the needs of the patient
- Appropriate physician or provider orders (which may include medications) to address the patient's needs
- Continuation of staff observation levels as appropriate to the condition

Build Staff Competencies

Action Recommendation: Train staff in identifying, screening, and assessing at-risk patients and in understanding and using the safety and security measures in place.

Several sources have advocated for additional training for ED and other hospital staff on caring for psychiatric patients. An ENA white paper outlines many challenges that EDs face in providing care to patients at risk of suicide as well as other psychiatric conditions. Among the challenges are a lack of specific training and knowledge of safety practices, frustration at repeat suicidal patients in the ED, and helplessness regarding the perceived failures of the behavioral health system. (Manton)

Specific training for any staff who may repeatedly care for patients with suicide risk can help them in several ways. Understanding assessment and safety measures can help to overcome concerns about their inability to treat the patient. Likewise, knowing the organization has a cogent and logical procedure for managing these patients can help overcome feelings of helplessness.

For ED triage nursing staff, organizations should provide training on the following:

- The triage system adopted in the department, including information regarding triage relevant for possible psychiatric conditions
- Behavioral cues or statements indicative of suicidal thoughts, plans, and behaviors of patients without a current psychiatric diagnosis
- Behavioral cues or statements of patients indicating increasing suicidality
- Safety measures to take when triaging a patient with suicide risk (see the earlier discussion [Minimize Environmental Concerns in Triage Areas](#))
- Considerations or actions for personal safety when dealing with potentially violent patients
- Effective communication strategies to assess and interview patients who have or may have psychiatric conditions
- Identification of common physical conditions that may present as psychiatric behaviors (e.g., medication-induced dementia)

Nurses who care for patients with suicide risk in the ED and on inpatient units require additional training even if sitters or other 1:1 staff are used. This training should cover the following:

- General overview of the suicidal and psychiatric patient (to overcome possible biases against them)
- The need to perform an appropriate suicide screening assessment for patients at risk for suicide each shift

- Safety measures to take when caring for a patient with suicide risk (see the earlier discussions [Minimize Environmental Concerns in Triage Areas](#) and [Evaluate ED Patient Areas for Environmental Safety](#))
- Behavioral cues or statements indicative of suicidal thoughts, plans, and behaviors for patients not previously assessed to be at risk of suicide
- Behavioral cues or statements of patients indicating increasing suicidality
- How to get assistance in a deepening crisis
- Appropriate medical record documentation for suicidal patients, including the following:
 - Assessment of behavior and mood
 - Direct quotations of suicidal intent
 - Removal of hazardous materials
 - Continuous observation
 - Other actions to keep patient safe
 - Notification of physician if any issues require it

Organizations might consider devising multiple interventions to support a variety of learning styles and present multiple opportunities for practice. Learning modalities that may be used, alone or in combination, include lectures, workshops, group discussion and interaction, videos, interaction with standardized patients (portrayed by actors), interaction with virtual patients, modeling, and role-playing.

Manage Suicidal Patients in Medical-Surgical and Critical Care Units

Action Recommendation: Include inpatient care settings such as the ICU and medical-surgical units in planning for suicide screening, assessment, and prevention.

Issues Specific to ICU Settings

After discharge from the ED, many suicidal patients are admitted to an ICU. On arrival, their medical conditions frequently require them to be intubated, sedated, and medically or chemically restrained, and as a result, these patients are not actively suicidal. As their condition improves, however, and they become oriented to their surroundings and their condition, suicidal impulses may return. Some ICU settings may be so focused on the physical needs of the patient that these psychiatric issues may be overlooked, increasing the patient's risk of suicide in the ICU setting.

Organizations should create an order set for use in the ICU for patients who are admitted to the ICU after a suicide attempt and are intubated and sedated. The order set, which is initiated when the patient is extubated, should include the following (Adams):

- Moving the patient as close to the nurses' station as possible
- 1:1 observation (not by ICU staff unless the nursing ratio for the patient is 1:1)
- Removal of any hazardous items in the room (see the list in the discussion [ED Bays without Safe Rooms](#))
- Suicide screening assessment by the nursing staff once per shift
- Use of disposable servingware and utensils for meals

A similar order set should be created for use in ICUs for patients at suicide risk who are admitted without intubation (Adams). ICU staff should be trained as noted in the earlier discussion [Build Staff Competencies](#).

Issues Specific to Medical-Surgical Unit Settings

Patients in medical-surgical units may also be at risk for suicide. If enough patients with dual severe psychiatric and medical diagnoses are seen, some hospitals build "safe rooms" for a medical-surgical unit to provide a safer environmental structure to prevent harm to psychiatric patients, similar to those seen in the ED. Most notably, these rooms have medical equipment stored behind walls, shatter-resistant windows, and special plumbing fixtures in the bathrooms to prevent self-harm. In the absence of available safe rooms, special precautions must be used when using a standard room with a patient identified as being at risk for suicide.

Any personal items that could be used for self-harm should be removed or prevented from entering the room; medical equipment that could be used for self-harm should be removed or closely monitored. Meals should be served on disposable serving ware with plastic utensils. Staff should inspect any item brought in by visitors to be used by the patient, and observation should continue throughout visits. (Adams)

If the patient is admitted to a standard patient room without safety features in the bathroom, the patient must shower and use the bathroom facilities with the door open and a staff member present. If any allowances are made for patient privacy, such as the staff member being present behind a partially closed door, caution must be used to ensure that the patient is not engaging in self-harm behavior. The patient should be restricted to the room or, if clinically indicated, allowed on the unit only with close observation. (Adams)

Patient safety is also at risk in transfers. Staff who may escort patients off the unit for testing may not be aware of the suicidality of the patient. This has been a cause of inpatient suicides when a patient elopes from the escort and engages in self-harm behavior. Ensure that the suicide risk of patients is communicated to transport staff during handoffs and to the receiving unit. (Adams) Nursing staff on units where patients at risk for suicide are frequently admitted should have specific training as described in the earlier discussion [Build Staff Competencies](#).

Plan a Safe Discharge

Action Recommendation: Develop a discharge or crisis plan prior to suicidal patients actually being discharged.

A final high-risk area for managing patients at risk of suicide is after discharge. One study of postdischarge suicide found that the majority (55%) of postdischarge suicides took place during the first week; nearly half (49%) of those deaths occurred before the first follow-up appointment. Involvement of the family system and aftercare services for those discharged can help reduce the possibility of suicide. (Bickley et al.; Joint Commission "Standards BoosterPak")

Ask ECRI

A member asked for information to provide to hospital staff on discharging patients identified as a suicide risk from a medical care unit. [See our response.](#)

No matter the setting, any patient who during the admission is identified as being at high risk of suicide should have social work or case management involved as soon as possible to ensure that appropriate follow-up care can be arranged. A discharge or crisis plan should be developed prior to a suicidal patient's discharge. This plan should be shared and discussed with the patient and the patient's family or other appropriate contact for the patient in meetings prior to discharge. Also, if possible, provide this plan to the patient's primary care provider and other clinicians who will be following up with the patient after discharge.

The following steps should be included in the development of the discharge or crisis plan (Jabbarpour and Jayaram; Bickley et al.):

- Identify risk factors that might increase the likelihood of suicide postdischarge, such as relapse of mental illness or substance abuse use, noncompliance, or discontinuance of medication.
- Outline the responses by the patient, family, and outpatient system if there is a crisis. Provide the patient and the patient's caregivers with the national suicide prevention number (1-800-273-TALK [8255]) or information on local crisis hotlines.
- Explain medications to be taken in clear and understandable language for the patient. Limit the amount of medications to a nonlethal amount.
- Provide follow-up appointment information with a clear and concise explanation of who to follow up with (and their phone number) and where the appointment is.
- Plan for the involvement and education of family members and significant others.

The organization should conduct a final discharge meeting with the patient and any appropriate family support members or significant others. The meeting should include a reaffirmation of discharge plans, continuing needs, community resources, and an emergency plan.

Nursing staff should conduct and document a final suicide risk assessment immediately prior to the discharge. The assessment should cover access to weapons, living situation, and availability of family or personal support systems. Patients or family members should verify that any firearms or lethal medications in the home have been secured or made inaccessible to the patient. Harvard T.H. Chan School of Public Health's "Means Matter" website (see Resource List) offers helpful information and resources for addressing suicide means. The patient's ability and capability to adhere to a management plan and to collaborate with support systems should also be assessed.

All of these preventive steps should be documented carefully in the patient record. Any unsuccessful attempts to engage family or significant others in discharge planning should also be documented. Suicide Prevention Resource Center's consensus guide for EDs (see Resource List) discusses how to document the ED visit and which elements to document.

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Resource List

ECRI Institute Resources

- [Guidance: Duty to Warn or Protect Third Parties](#)
- [Guidance: Getting the Most Out of Root-Cause Analyses](#)
- [Make a Plan: Suicide Risk Assessment and Prevention](#)
- [Ready, Set, Go: Suicide Risk Assessment and Prevention](#)
- [Self-Assessment: Behavioral Health: Environmental Assessment](#)
- [Self-Assessment: Behavioral Health: Patient Safety](#)
- [Self-Assessment: Behavioral Health: Patients' Rights](#)
- [Self-Assessment: Behavioral Health: Policies and Procedures](#)
- [Self-Assessment: Behavioral Health: Staff Competency and Credentialing](#)

Additional Resources

American Academy of Pediatrics

- Evaluation and management of children and adolescents with acute mental health or behavioral problems
 - [Part I: common clinical challenges of patients with mental health and/or behavioral emergencies](#)
 - [Part II: recognition of clinically challenging mental health related conditions presenting with medical or uncertain symptoms](#)
- [Suicide and suicide attempts in adolescents](#)

American Hospital Association

- [Behavioral health challenges in the general hospital: practical help for hospital leaders](#)

American Psychiatric Association

- [Practice guideline for the assessment and treatment of patients with suicidal behaviors](#)

Centers for Disease Control and Prevention

- [Preventing suicide: a technical package of policy, programs, and practices](#)

CRICO/Risk Management Foundation of the Harvard Medical Institutions

- [Emergency/crisis coverage of a suicidal patient: decision support outline](#)
- [Guidelines for identification, assessment, and treatment planning for suicidality](#)

Emergency Medicine Network

- [ED-SAFE materials \(Emergency Department Safety Assessment and Follow-up Evaluation\)](#)

Emergency Nurses Association

- [Suicide risk assessment clinical practice guideline](#)

Facility Guidelines Institute

- [Design guide for the built environment of behavioral health facilities](#)
- [Guidelines for design and construction of hospitals](#)

Harvard T.H. Chan School of Public Health



- Means Matter website

International Association for Healthcare Security & Safety

- IAHSS design guidelines

Joint Commission

- BoosterPak: Suicide risk
- Detecting and treating suicide ideation in all settings (Sentinel Event Alert 56)
- Standards interpretation questions addressing suicide
- 2019 National Patient Safety Goals

National Action Alliance for Suicide Prevention

- Recommended standard care for people with suicide risk: making health care suicide safe

Pennsylvania Patient Safety Authority

- Failures in the diagnostic process when assessing suicidal intent

Substance Abuse and Mental Health Services Administration

- Suicide Safe mobile app (based on SAFE-T evaluation and triage tool)

Suicide Prevention Resource Center

- Caring for adult patients with suicide risk: a consensus guide for emergency departments
- Interventions for suicide risk
- Zero Suicide toolkit

U.S. Department of Veterans Affairs VA/DoD Clinical Practice Guidelines

- VA/Department of Defense clinical practice guideline for assessment and management of patients at risk for suicide

U.S. Preventive Services Task Force

- Suicide risk in adolescents, adults and older adults: screening

U.S. Surgeon General

- National strategy for suicide prevention: goals and objectives for action, 2012

Citation

ECRI. Suicide risk assessment and prevention in the acute care general hospital setting. Health Syst Risk Manage 2019 Jan 29. <https://www.ecri.org/components/HRC/Pages/MenH1.aspx>

Classifications

CARE SETTINGS

Emergency Care | Chronic Disease Hospital | General Acute Care Hospital | Long Term Care Hospital | Military General Acute Care Hospital | Military General Acute Care Hospital. Operational (Transportable) | Psychiatric Hospital | Rehabilitation Hospital | Special Hospital | Clinic/Center | Emergency Care

EDUCATION AND SOCIOLOGY

Legal Services

REGULATIONS OR COMPLIANCE

Hospital Design and Construction | Nursing Assessment | Maintenance and Engineering, Hospital | Maintenance and Engineering, Hospital | Maintenance and Engineering, Hospital

PERSONS

Health Personnel | Case Managers | Case Managers

SPECIALTIES

Behavioral Neurology & Neuropsychiatry

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