

REVIEW ARTICLE

Ethics

Assessing psychiatric safety in suicidal emergency department patients

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Abstract

We provide a review of the assessment of suicidal emergency department patients and includes a legal and ethical perspective. Screening tools and psychiatric consultation are important adjuncts to the ED evaluation of potentially suicidal patients. Suicide risk should be assessed, and if positive, an appropriate and safe disposition should be arranged. The aim of this article is to review these assessment tools and consider ethical issues, such as patient autonomy, accountability of the emergency physician, and consultant to Emergency Medical Treatment and Labor Act (EMTALA) as well as confidentiality, privacy, and social issues.

KEYWORDS

ED, psychiatry, suicide

1 | INTRODUCTION

Suicide is a major public health concern and results in an estimated 800,000 deaths annually. With a prevalence of 10.8 per 100,000 persons, suicide is the 11th leading cause of death in the United States.¹ Suicide is the second leading cause of death for individuals age 10–34.² The US Centers for Disease Control and Prevention Youth Risk Behavior Survey estimates that 8500 out of every 100,000 adolescents attempt suicide. Nationwide, >2 million young people attempt suicide annually, and 90% of suicide attempts among youth are unknown to parents.³ The World Health Organization has established a health initiative to increase awareness and reduce suicides worldwide.⁴

Approximately 8% of all adult emergency department patients have had recent suicidal ideation or behavior, but many of them will not tell providers unless asked.^{5,6} It is estimated that 1.5 million adolescents and countless US veterans rely on the ED as their usual source of medical care.⁴ Thus the ED assessment of suicidal ideation is important to ensuring the appropriate treatment and disposition for patients in need. Our objective is to provide an ethical perspective for assessing patients presenting to the ED with mental health complaints, focusing on suicidality. We address common ethical issues, methods of assessment once identified, and disposition options.

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2 | ASSESSMENT: SCREENING TOOLS AND TYPES OF PSYCHIATRIC CONSULTATION FOR IDENTIFIED PATIENTS

According to the Joint Commission's Sentinel Event database, analysis of 1089 suicides among patients receiving services in a staffed around-the-clock care setting or within 72 hours of discharge (including the ED), the most common root cause documented was shortcomings in psychiatric assessment.⁷ With the single strongest known risk factor for suicide being a recent suicide attempt, ED point-of-care screening is a key suicide prevention strategy. Approximately 1% of all adults and adolescents who visit an ED because of deliberate self-injury will die by suicide within 3 months of their index visit. Retrospective studies report that 15% of all suicide victims have visited the ED for deliberate self-injury within the year before their suicide.⁸

In the ED, medical providers often do not detect suicide ideation in their patients (including children and adolescents) who eventually die by suicide, despite the fact that most of them received health care services in the year before death, usually for reasons unrelated to suicide or mental health.⁹ Research also shows that asking about suicide does not prompt it, and potentially has quite the opposite effect, which is why medical provider vigilance in assessing suicide risk remains vitally important across the age spectrum. Moreover, research suggests that nearly 90% of those who die by suicide have experienced serious mental illness such as bipolar disorder, major depression, schizophrenia, and substance use disorders.^{10–12} Thus, psychiatric disorders and previous suicide attempts are intertwined and do increase suicide risk.¹³

2.1 | Identification of suicidal patients

Currently, the Joint Commission requires that ED providers screen all patients who present with a behavioral health chief complaint for suicidal ideation using a brief, standardized, evidence-supported screening tool.^{14,15} This mandate could be fulfilled by targeting patients with emotional or behavioral disorders and presenting symptoms or by screening everyone (universal screening) regardless of chief complaint. Neither capture method for suicide screening and assessment has been shown yet to reduce mortality since the mandate began in February 2016. Thus, the balance of benefits and harms cannot be determined for universal suicide-risk screening of patients, and further research may be beneficial.¹⁶ Moreover, most evidence for treatment effectiveness is in high-risk populations who were not discovered through screening, such as persons who presented to an ED because of a suicide attempt. In addition a universal screening program not designed to fit an ED's workflow may not function effectively, and often, patients will not answer questions honestly.

Although asking a patient about suicidal ideation or plans does not trigger suicidal behavior, details elicited in direct conversation may be useful for risk stratification in the ED. Gaining collateral information, first responder insights, and eliciting concerns of friends and family at the scene and in triage is crucial and may prevent premature

discharge.¹⁷ Emergency physicians should be diligent in obtaining collateral information, even if it is not immediately accessible, such as by calling the emergency contact for the patient. Although obtaining informed consent from patients for contacting collateral sources is part of a best practices approach, if the patient refuses to allow contact to be made, clinicians can still gather collateral information without the patient's express permission if they believe the patient is a danger to self or others under the Health Insurance Portability and Accountability Act (HIPAA).¹⁸ These factors must be considered alongside the early data suggesting screening does identify people with occult suicidal ideation^{6,19} without negatively affecting ED flow.²⁰

Initial screening identifies populations that might be at risk, along with those that have suicidal ideation. Screening at this level is easy to do with existing personnel. Although cost-effectiveness analyses are pending, the monetary investment to screen for suicide is most likely quite minimal.¹⁶ A secondary, more time-consuming screen is then needed, requiring more resources than are available in some settings. In addition, there need to be resources for follow-up in the community or by tele-psychiatry. Although this sounds daunting, several institutions have created effective programs.²¹

2.2 | Suicide risk assessment

Risk assessment is critical for determination of need for emergent mental health consultation and subsequent treatment options. Individual risk factors have limited ability to predict suicide in an individual at a particular time. A large proportion of Americans have one of these risk factors, but only a small proportion will attempt suicide, and even fewer will die by it.²² A recent study, however, found that having a suicide plan and a history of past attempts has a high sensitivity for identifying risk of suicide in the 6 weeks following hospital discharge.²³ Thus, an ED suicide risk assessment may, therefore, enable identification of patients with suicidal ideation and facilitate initiation of appropriate treatment. Although risk assessment is an inexact science, the goal is to assess the patient's history, current mental state, home environment, and specific suicidal thoughts or behaviors.

The lowest-risk patients in the clinical context of suicide may be those without a serious suicide plan, prior suicide attempt, history of serious mental illness or substance use disorder, a normal mental status (without high levels of emotional distress), and no access to lethal means.²⁴ Experienced clinicians can identify these patients.

The Suicide Prevention Resource Center ED Guide, developed with input from multidisciplinary experts and national emergency medicine organizations, supports providers' decisions to forgo consultation in low-risk cases. Specifically, the guide includes a 6-question decision support tool that can be used to document medical decision making and explain if a mental health consultation is indicated (Table 1).²⁵

Many suicidal ED patients need a comprehensive risk assessment to inform decision making about treatment and disposition.

The Joint Commission recently published guidelines, including recommendation NPSG 15.01.01, EP 2: BHC: "Screen all individuals seen for suicidal ideation using a validated screening tool for the

TABLE 1 ED evaluation of suicide risk

1. Plan: have you been thinking about how you might kill yourself?
2. Intent: do you have any intention of killing yourself?
3. Past attempt: have you ever tried to kill yourself?
4. Mental health history: have you ever had treatment for mental health problems? Do you have a mental health issue that affects your activities of daily life?
5. Substance use: Has drinking or drug use been an issue for you? At least once in the past month, have you had ≥ 5 (male) or ≥ 4 drinks on one occasion?
6. Irritability/agitation/aggression: recently, have you been feeling anxious or agitated? Have you been getting into fights? Is the patient irritable, agitated or aggressive?

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>

TABLE 2 Resources for initial suicide ideation screening

American College of Emergency Physicians ICAR ² E	www.acep.org/icar2e Online tool: http://acep.org/patient-care/iCar2e/
ED SAFE Patient Safety Screener	http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf
Suicide Prevention Resource Center Patient Safety Screener	http://zerosuicide.spr.org/toolkit/identify/screening-and-assessing-suicide-risk

management of suicidal patients."²⁶ This document also provided examples of validated screening tools that can be used (Table 2). The Suicide Assessment 5-step Evaluation and Triage (SAFE-T) (Table 3), is a free assessment tool, available in various formats, including pocket card and mobile applications. It guides primary and behavioral health care providers through a stepwise evaluation of a patient's risks, protective factors and specifics of suicidal thoughts or plans to estimate overall risk.^{27,28} Even when the emergency physician is not completing the comprehensive assessment, the SAFE-T domains provide useful reminders about specific questions to ask patients.

The Columbia-Suicide Severity Rating Scale (C-SSR) can be used for in-depth screening and assessment for adults and adolescents. A screening version is available that truncates the three-page evidence-supported scale for use in ambulatory settings.²⁹ There is also an electronic Columbia-Suicide Severity Rating Scale (eC-SSRS) version that is a computer-automated, patient-reported C-SSRS iteration in which the user's response to a question triggers the appropriate follow-up questions (if any). With the eC-SSRS, use of the scale is not limited to patients or subjects having to sit with a person who asks them the questions; instead, they can complete the assessment on their own, not only in the ED, but also from their homes or during emergency medical services transport to the ED. Bottom line, suicide may be preventable and asking the right questions to probe and protect those at risk is a critical first step to stopping it.

TABLE 3 Suicide assessment five-step evaluation and triage (SAFE-T)

1. Identify risk factors	Suicidal behavior, psychiatric disorders, key symptoms, family history, precipitants, stressors, interpersonal, change in treatment, access to firearms
2. Identify protective factors	Ability to cope with stress, religious beliefs, frustration tolerance, responsibility to children/pets, positive therapeutic relationships, social supports, regular church attendance
3. Conduct suicide inquiry	Ideation, plan, behaviors, intent, explore reasons to die versus reasons to live
4. Determine risk level and intervention	High—admission generally indicated Moderate—admission may be necessary Low—outpatient referral
5. Document	Risk levels and rationale: treatment plan to address/reduce current risk

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) Substance Abuse and Mental Health Services Administration. 2009. Available at: https://www.integration.samhsa.gov/images/res/SAFE_T.pdf. Accessed October 29, 2018.
Suicide Safe. Substance Abuse and Mental Health Services Administration. 2015. Available at: <http://store.samhsa.gov/apps/suicidesafe/>. Accessed October 29, 2018.

TABLE 4 Resources for evaluation of suicidal risk

SAFE-T	https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432
Columbia-Suicide Screening Severity Rating	http://cssrs.columbia.edu/
Ask Suicide-Screening Questions (ASQ)	https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml
Beck Scale for Suicidal Ideation	https://www.commondataelements.ninds.nih.gov/doc/noc/beck_depression_inventory_noc_link.pdf

2.3 | What happens if patients screen positive?

In the ED setting, one of the biggest barriers to screening is uncertainty about how to manage the patients who screen positive effectively and efficiently. Before screening for suicide risk, the ED will need to have a plan in place to manage those who screen positive. Patients who are found to be at risk (positive screens) should undergo in-depth psychiatry consultation conducted by a trained clinician (RN, LCSW, NP/PA, or psychiatrist—possibly via telemedicine), depending on the available local resources, to determine whether a more comprehensive mental health evaluation is warranted. Any patient who screens positive, regardless of ED disposition, should undergo a secondary suicidal risk evaluation (Table 4) reviewed by an emergency physician as the final

authority to determine the proper and immediate course of treatment. All patients screened and comprehensively assessed should be given suicide resources that detail suicide prevention interventions considered to be evidence-supported best practice.

3 | LEGAL AND ETHICAL ISSUES

3.1 | Autonomy of the patient

While patient autonomy is respected as a fundamental bioethical principle, responses to suicidal behavior appropriately emphasize the principle of beneficence over autonomy. If a patient is suicidal, it is the provider's primary duty to ensure their safety, including detaining the patient for psychiatric treatment. Involuntary mental health treatment is indicated for actively suicidal patients, who are presumed to lack decision making capacity.³⁰⁻³² Although this practice may seem contradictory to the value we place on patient autonomy, mental health treatment is likely the best way to restore a patient's autonomy. An ethical dilemma may arise in cases of uncertain suicide risk, when patient autonomy must be weighed against patient and public safety. In such cases, a thorough history and psychiatric assessment is warranted, likely to include psychiatric consultation.

3.2 | Accountability of the physician: emergency medicine and psychiatry, EMTALA

Health care providers face significant ethical challenges of professional responsibility for clinical decisions, issues related to therapeutic relationships, and organizational factors when caring for patients who are potentially suicidal.³³ ED providers are often challenged by a lack of complete health information, limited time to obtain history from the patient, a lack of privacy, and multiple distractions during assessment and treatment.

A multi-factorial approach to suicide prevention is essential to reducing the incidence of suicide. In the ED, providers should use appropriate resources to assess the risk of suicide. Although there are various clinical decision support tools to estimate suicide risk, no tool reliably predicts future behavior for all patients. Ultimately, the responsibility for assessment and disposition of a patient with suicidal ideation lies with the treating provider. The emergency physician and a consulting psychiatrist, both of whom have expertise in assessment and disposition of patients with mental illness, share this responsibility and corresponding liability. In addition to clinical assessment, assessment of nonclinical factors including social support from family and friends, financial resources, legal resources, housing, transportation, and employment are also important for safe discharge planning.³⁴ Discharged patients should receive appropriate outpatient resources for mental illness, drug treatment, and other medical and social issues in addition to risk reduction strategies such as counseling on access to lethal means.³⁵

The Emergency Medical Treatment and Labor Act (EMTALA) requires a medical screening examination for all patients presenting to an ED. In addition, EMTALA specifies conditions for transfer of patients to other institutions, a common necessity for suicidal patients who are transferred for involuntary psychiatric care at another institution. Appropriate transfer measures include³⁶:

1. Patient's condition has been stabilized;
2. Patient needs treatment that is available at the receiving facility;
3. Benefits of transfer outweigh risks;
4. Receiving facility agrees to accept patient;
5. Medical records accompany patient;
6. Transfer occurs by qualified personnel and equipment.

Although lawsuits regarding EMTALA violations for patients with mental health conditions are rare,³⁷ Bitterman describes a significant exception.³⁸

3.3 | Confidentiality and privacy

Confidentiality and privacy are central values in medical practice. Although privacy is considered the intrinsic right of the individual patient, the right of confidentiality is the responsibility of the physician to protect as the patient makes vulnerable disclosures in the therapeutic relationship. There are three broad categories of exceptions to maintaining a patient's confidentiality, where a physician is obligated to divulge information³⁹:

1. Patient is a danger to themselves;
2. Patient is a danger to others;
3. Concern for child, elder, or dependent-adult abuse.

Each of these mandated steps to safeguard the patient or others can justify disclosure of the patient's private health information, but only to the individuals and to the degree required to address the exceptions identified. Given the nature of these exceptions, psychiatric emergencies often encompass tensions among ethical responsibilities to respect the patient's privacy, to pursue the most beneficent care plan, and to protect the patient and others. One classic example of this is the Tarasoff decision of the Supreme Court of California in 1976, when it was judged that mental health professionals have a duty to warn individuals who are being threatened with bodily harm by a patient.⁴⁰ This is interpreted by most as, if a patient specifically mentions a desire to harm a particular person, and the patient is released to the general public, the professional has a duty to warn the individual named, usually by means of contacting law enforcement.

Patients with psychiatric conditions are particularly vulnerable to the harms of confidentiality breaches, given the social stigma and consequences of mental illness. For this reason, particular vigilance to safeguard the privacy of these patients is important.

3.4 | Social issues

Social isolation, financial hardship, and other proximate socioeconomic stressors are well-established risk factors for suicide, making homeless patients a particularly at-risk population.⁴¹ Emergency physicians are familiar with other reasons homeless patients make suicidal statements, such as a desire for shelter, a comfortable environment, or attention. Anchoring on the patient's inadequate living arrangements could de-emphasize other presenting suicide risk factors and potentially further marginalize an already vulnerable patient. Ethically, providing for a homeless patient's emergent mental health care must be guided by the principles of beneficence and justice along with virtuous caring for the patient's well-being.

Welcoming patients' candor about the role that homelessness may be playing in their ED presentation with mental health symptoms is a prudent and ethical step in assessing their safe disposition. Although an inpatient psychiatry unit may not be any more appropriate than an inpatient medical/surgical floor or a homeless shelter for a patient simply in need of shelter, emergency physicians should work with patients to identify an appropriate and safe disposition through available resources. A psychiatric consultation may help differentiate malingering from serious mental illness. Additional practical considerations are required to achieve an ethical and safe discharge for homeless patients.

Although mental health risk stratification may be equitable, discharging an at-risk mental health patient must be done safely with consideration of sufficient access to shelter, food, water, transportation, and medications. Environmental stressors such as ambient temperature at the time of discharge may carry morally significant weight in safeguarding the patient's well-being. For example, in the state of New York, the Governor has a standing executive order requiring hospitals to provide shelter to homeless patients when the temperature falls below 32°F.⁴²

3.5 | Payment issues

With hospital readmission as an important quality indicator, the 2010 Affordable Care Act developed the Hospital Readmissions Reduction Program, which requires reduced payments from Medicare and Medicaid to hospitals with excess readmissions for certain medical diagnoses.⁴³ Although this program did not target psychiatric readmissions, these occur at much higher rates and are increasingly scrutinized from both a quality and cost standpoint. Many of the risk factors for readmission that are peripheral to the primary medical diagnosis of patients are the primary risk factors for psychiatric hospitalization, including mental illness diagnosis, substance use, and a poor socioeconomic situation.⁴⁴ An additional challenge is the recognition that recent hospitalization is a risk factor for suicide in patients presenting with mental health complaints.⁴⁵

Although reimbursement considerations are important for both institutions and individual patients, physicians should not recommend admission of psychiatric conditions based primarily on reimbursement

considerations. Rather, emergency physicians should be vigilant to safeguard patients against any undue financial considerations influencing or coercing the patient's disposition.

4 | SPECIAL POPULATIONS

4.1 | Alcohol intoxication and substance use disorder

Alcohol intoxication is frequently associated with stated suicidality. Both acute and chronic alcohol use raise the risk of suicide. More than a third of suicide victims drink alcohol before death,⁴⁶ and adults with a substance use disorder often attempt suicide after thinking seriously about it and planning.⁴⁷ Clinical sobriety, although not well defined, and cognitive capacity for executive functioning are prerequisites for meaningful patient participation in the assessment process. Although a particular blood or breath alcohol level has not been correlated with the timing of a valid psychiatric evaluation in the literature, it is important to ensure that the patient is clinically sober to assess mental status and suicide risk. The lack of active intoxicants in the blood and qualitative detection of other substances on urine testing may help identify the existence of a substance use disorder or medical noncompliance that may have clinical implications. It is appropriate to observe intoxicated patients until sober enough to participate in a comprehensive suicide risk assessment.

The acute use of several other agents such as opioids, benzodiazepines, cocaine, and others can alter cognition leading to delirium and therefore altered capacity. The presence or absence of these agents can often be determined using standard drug screens. Although the legal definition of intoxication for these agents is lacking, a thorough assessment of vital signs and cognition to determine the presence or absence of delirium is indicated. The acute use of these substances (single agent or combinations) may be short-lived and therefore require repeat assessments. There is growing evidence that substance use disorder or withdrawal can also alter decision-making capacity.⁴⁸⁻⁵¹

4.2 | Psychosis

Psychiatric conditions are important to include in the assessment of suicide risk. A diagnosed psychiatric condition should be considered and assessed, but does not necessarily rule out appropriate decisional capacity.

Patients presenting with acute psychosis pose important clinical and ethical issues. Patients may present with psychosis due to a primary mental health condition, an underlying medical etiology, or intoxication with a substance, such as alcohol or illicit drugs.

Assessment of decisional capacity is essential to the psychiatric assessment and establishment of suicide risk and ability to participate in medical decision making. Decisional capacity is the ability of the patient to make a decision regarding medical treatment. Decisional capacity may be affected by a wide variety of cognitive and affective

functions, including attention, intellect, memory, judgment, insight, language, emotion, and calculation. Appropriate decisional capacity for medical decision making includes the following elements^{52,53}:

1. The ability to receive information
2. The ability to process and understand information
3. The ability to deliberate
4. The ability to make and articulate a choice

Patients with acute psychosis do not have appropriate decisional capacity to make medical decisions. Patients with acute psychosis should receive appropriate medical management, which may include medical management of agitation, or restraints to ensure safety of the patient and staff. Although suicide risk may be assessed in the acute phase, the risk assessment is not accurate until the psychosis is appropriately treated and the patient has full decisional capacity. In some cases, this can be accomplished in the ED (such as acute drug intoxication), but in most cases, this requires psychiatric hospitalization and treatment. Early intervention treatment for psychosis has been shown to reduce suicidality.⁵⁴

5 | DISPOSITION

The disposition options for psychiatric patients presenting to the ED include admission, discharge, transfer, boarding, or observation. The disposition decision influences the patient's length of stay in the ED. Prolongation of ED length of stay is associated with multiple patient factors, including age over 40 and especially over 60, lack of health insurance, elevated alcohol level, diagnostic imaging, restraint use, a chief complaint of substance use, and a discharge diagnosis of a substance use disorder.⁵⁵ The disposition decision also affects patient rights to refuse further treatment. This is why the assessment of psychiatric patients in the ED is so important and weighty.

Patients may be admitted either involuntarily or voluntarily. Patients who are involuntarily admitted, including those under court order, lose their rights to refuse further treatment unless their involuntary status changes or expires. Some states include mandatory reporting to firearms registries of patients who are admitted involuntarily.⁵⁶ Patients who are voluntarily admitted may refuse further treatment and have their request to be discharged honored, which is sometimes referred to as being discharged against medical advice.

On discharge, the emergency physician should ensure that proper follow-up has been established and give clear instructions for reasons to return to the ED. A safety plan, offering counseling on access to lethal means, safety planning, means restriction, and follow-up phone calls should also be considered.⁵⁷ Interventions during the ED visit, such as involvement of a mental health advocate, may improve patient perception of their experience and correlate with improved adherence to follow-up.⁵⁸

Exacerbations of chronic medical conditions requiring admission are often determined efficiently for medical patients, but determining the need for admission of psychiatric patients and then finally get-

ting them to an inpatient bed is considerably less efficient and more stressful for health care workers and patients. Applying the accepted definition of boarding for psychiatric patients (length of stay >4 hours beyond the time when medical clearance occurs), psychiatric boarding is extremely variable but occurs in most EDs.⁵⁹ Data from the National Hospital Ambulatory Medical Care Survey (2008) demonstrated an 11.5% rate of boarding for all ED patients, compared to a 21.5% rate for psychiatric patients, and boarding times were found to be 2.78 hours longer for psychiatric patients.⁶⁰ Moreover, boarded psychiatric patients are more likely to experience medication errors and adverse events.⁶¹ From an ethical standpoint, the fact that psychiatric patients are more likely to experience prolonged ED length of stay and longer boarding times is concerning, but of even greater concern is the disparity in these times related to specific groups of psychiatric patients. Older adults (age >65) were particularly at risk for prolonged length of stay (median length of stay = 16.2 hours), long boarding times, and increased risk of adverse events.⁶² Several studies have demonstrated that uninsured or self-pay psychiatric patients have a higher rate of boarding, longer length of stay, and that insurance status independently predicts a greater likelihood of boarding.^{60,63} Clearly the goal of providing equitable emergency care to all those presenting to our EDs and providing a safety net for the underserved is at odds with current disparities in distribution of psychiatric care and in psychiatric boarding. These obstacles conflict with the moral principle of justice proposed by Beauchamp and Childress.⁶⁴

Transferring psychiatric patients to other facilities to decrease the ED's burden should also be considered from the patient's point of view. Several studies demonstrate a much longer ED length of stay for patients transferred.^{65,66} Data obtained from the Healthcare Cost and Utilization Project 2010 Nationwide ED Sample indicate that transfers were more likely for uninsured psychiatric patients (odds ratio [OR] = 2.26) than for privately insured patients.⁶⁷ Transfers should be done in the context of usual referral patterns, which can vary depending on the site.

6 | CONCLUSIONS

Suicide remains a major cause of death particularly at younger ages and suicide ideation and behavior are a significant contribution to ED visits. A number of screening tools and processes used to identify these patients and their suicide risk are reviewed as well as the indications for emergent mental health consultation. Ethical and legal considerations regarding autonomy, accountability, EMTALA, confidentiality, privacy, and patient transfers are important. Suicidal patients as well as those who are intoxicated or psychotic may lack capacity and require involuntary treatment. Determining safe and appropriate disposition may prolong the length of stay as consideration is given to decide whether the patient can be discharged with close follow up, observed, transferred, boarded, or admitted. Further study is needed to help provide optimal care to these mental health patients with suicide thoughts and behaviors.

CONFLICTS OF INTEREST

The authors have no conflict of interest to disclose.

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