Suicide Assessment in the Emergency Department

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Abstract

The Joint Commission requires hospitals to conduct suicide assessments in emergency departments (ED) as part of their certification process (Joint Commission, 2007a). However, assessment and management of suicidal patients are rarely a part of ED nurses’ orientation. This paper outlines how to conduct a suicide assessment using Shea’s (1998) Chronological Assessment of Suicidal Events (CASE) strategy. It emphasizes the importance of conducting suicide assessments in the ED. Additionally, guidelines are provided to give nurses a framework for managing suicidal patients in EDs. An example of an ED suicide assessment is provided using the S.O.A.P. format.
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Suicide Assessment in the Emergency Department

Statistics on Emergency Department (ED) utilization across the United States uncovers a staggering increase in patient visits. Pitts, Niska, Xu and Burt (2008) compiled information showing the total number of visits by individuals seeking emergency care was 119 million in 2006. This was a 32% increase over the 90 million ED visits reported in 1996. During the same period, the number of hospitals offering ED services dropped from approximately 4000 to 3800. This has created increased waiting times, crowding, and ambulance diversions; all combining to lower quality of care (Pitts et al., 2008). Increased ED demand affects patients with mental illness. This population uses ED services during times of crisis, especially those suffering from acute suicidal ideation and intent (Giordano & Stichler, 2009). Increased ED utilization translates into a greater number of patient triages. ED nurses are not only confronted with the task of assessing for suicide ideation, but also must arrange for the care of suicidal patients as they await transfer to psychiatric hospitals. Additionally, few nurses receive training to assess for suicide or have suicide training available as part of their ED orientation (McAllister, Billett, Moyle & Zimmer-Gembeck, 2009).

Suicide assessment in the emergency department of hospitals moved to the forefront when the Joint Commission initiated sentinel event reporting in 1995. This has become an integral part of implementing the Joint Commission's corporate mission to improve safety and healthcare in hospitals. A sentinel event is the unexpected loss of life, serious bodily injury, undue emotional stress or the possibility of such an event happening to a hospitalized patient. The occurrence of a sentinel event commences upon the patient’s entry into the hospital and ends 72 hours post discharge. Hospitals report sentinel events because these events are an opportunity to learn from mistakes. Additionally, changes in hospital guidelines may prevent these events in
the future. Joint Commission Resources (2007b) statistics reveal that suicide is the second most
commonly reviewed sentinel event. There is uncertainty surrounding the number of suicides that
occur in hospitals each year. The Joint Commission (2009) statistics for sentinel events indicate
that 785 hospital suicides met criteria for evaluation over the past 14 years. A widely cited
statistic indicates that 5% to 6% of all suicides occur in hospitals - totaling 1500 death per year
(Bush, K., Clark, D., Fawcett, J., & Kravitz, H., 1993). Another, more recent study conducted by
Ballard et al. (2008) concluded hospital suicide statistics were lacking because of the variability
in suicide reporting.

The Joint Commission (2007a) states a need for hospitals to develop guidelines for
assessing and preventing suicides. There is a focus on how ED nurses and clinicians assess
patients for suicidal ideation. Further consideration centers on patient transfers to other facilities
or discharged to the community. Additionally, comprehensive assessment, documentation and
referral of suicidal patients provides for safety as well as thwarting one of the most common
reasons for psychiatric malpractice suits – patient suicide (Simon, 2006).

The purpose of this paper is fourfold: a) to emphasize the importance of conducting
suicide assessments in the ED; b) to outline how to conduct a suicide assessment and the key
elements to be included; c) to provide an overview of guidelines for nurses who conduct suicide
assessments in the ED; and d) to provide an example of ED suicide assessment documentation.

**Suicide Assessment in EDs**

The Joint Commission (2010) National Patient Safety Goal-NPSG.15.01.01 requires
accredited hospitals to conduct a suicide assessment for certain patients. *The Suicide Risk
Reduction – Frequently Asked Questions* page on the Joint Commission (2008) web site provides
clarity for NPSG 15.01.01 as it relates to EDs. The requirements stipulate that a suicide
assessments must occur when a patient enters the ED with a primary psychiatric diagnosis, including substance abuse. Additionally, conducting a suicide assessment is optional for patients with a preexisting psychiatric diagnosis when entering the ED with an emergent physical illness or injury. An example of this would be a patient who enters the ED primarily for treatment of an injury such as a broken leg; the psychiatric diagnosis would be subordinate to the injury. On the other hand, when the patient suffers from mental illness and requires relocation to a psychiatric unit or hospital, a suicide assessment must be conducted, and appropriate safety precautions must be applied to prevent patient self-harm while pending transfer. The Joint Commission has documented cases of suicide while patients were awaiting transfer from EDs to psychiatric hospitals. Finally, patients and their families must be given resources that will help them through future suicidal episodes, such as crisis hotline telephone numbers. These resources provide patients and their families with the necessary information to seek care through primary psychiatric care providers, mental health organizations, internet web sites and 24 hour suicide crisis hotlines. Arresting suicide ideation before it becomes a crisis prevents suicide attempts, future ED visits, and ultimately, completed suicide and death.

The ED plays a prominent role in preventing suicides by providing around-the-clock access for patients without primary care providers, those without health insurance, and the mentally ill during times of crisis (Folse, Eich, Hall & Ruppman, 2006; Giordano & Stichler, 2009). The Emergency Medical Treatment and Active Labor Act [EMTALA] (1994) require EDs to provide emergency care to everyone regardless of ability to pay. The mental health crisis of suicide ideation or attempt qualifies the patient for services under this law. Additionally, if the suicidal emergency occurs after primary care business hours, then the ED may be the patient's only source of help (Folse et al, 2006). Researchers Mitchell, Garland, Dean, Panzak, and Taylor
(2005) identify the ED as the "ideal environment" when assessing suicide because ED nurses and clinicians have become accustomed to working through and finding a solution to traumatic events (p. 303).

It is imperative for the ED nurse is to determine whether suicide ideation is present and if so, respond in a manner to provide patients safety. The assessment must be thorough enough to recognize the thoughts and behaviors of the suicidal patient while effectively using ED time and resources (Shea, 1998). Suicidal patients are usually escorted to the ED by family, friends or the police because the patients are too depressed, anxious or agitated to seek help on their own. Once inside the ED, these patients' suicidal ideation and behavior may escalate. They are at greater risk of suicide inside the ED than when at home or on the street just minutes before arrival (Pompilli et al, 2009). Therefore one-to-one constant observation may be required to prevent patient self-harm before, during and after the suicide assessment.

Evidence-based practice guidelines for suicide assessment, documentation, boarding and transfers reduce the likelihood of a potential lawsuit (Simpson, 2004). According to Shuman (2006) the unpredictable and unpreventable nature of suicide does not preclude liability. The ED clinician has a duty to provide psychiatric care and keep the suicidal patient from self harm. An ED clinician's breach of duty enabling a patient to complete suicide can result in a malpractice action based on negligence. Shuman also points out that a breach of duty occurs when the clinician fails to provide care and support to the standard of a reasonable person. The clinician acts as a reasonable person when he or she takes all necessary steps to prevent suicide. This may include assigning a trained hospital staff member to monitor the patient at all times (Brock, Gurekas, Gelines & Rollin, 2009). Another standard of care called "customary practice" does not protect the clinician from malpractice claims because the level of care is not always
sufficient in each case (Shuman, 2006, p. 517). For example, the ED clinician’s customary practice may be to board a suicidal patient in a quiet and secluded room at the end of the hall. If the patient completes suicide in this location and a malpractice action ensues, then the court may find the clinician breeched his or her duty to protect the patient from suicide. A reasonable clinician would have placed the patient in a room within sight of the nurses’ station and assigned a trained ED staff member to sit with the patient.

An ED patient assessment may establish a state of acute suicide risk. Environmental safeguards may be required to protect the patient from completing suicide (Cardell, Bratcher & Quinnett, 2009). Brock et al (2009) recommended providing a “secure room” in the ED (p. 19). The room cannot include items that can be used by the patient to complete suicide. It must also be constructed to allow for easy observation of the patient by a nurse or security guard. Clinical judgment evaluates the individual patient’s suicide risk and adds comforts such as a chair, table or TV for patients at lesser risk. Cardell et al. (2009) suggested that patients actively search for resources needed to complete suicide in the healthcare environment. Nurses and clinicians need to be able to identify and remove objects of self harm in the ED. These include breakable glass that can be used for cutting or IV tubing used as a method for strangulation. Actively working to establish environmental safeguards reduces the risk for suicide in the ED.

**Conducting a Suicide Assessment in the ED**

The Joint Commission (2009) requires suicide assessment in the ED for hospital certification. The purpose of this requirement is to fulfill the Joint Commission’s hospital patient safety goal by reducing the sentinel event of inpatient suicides. Each hospital develops guidelines for suicide assessment. The suggested format is to conduct an initial suicide screen and then proceed with a more in depth assessment for those patients with more complex symptoms. The
Suicide Assessment in the Emergency Department

The goal is for protection of all patients; especially those actively engaged in self-harm thoughts and behaviors.

Suicidal patients benefit from suicide assessment training for ED nurses, but ED nurses spend most of their time caring for patients with biomedical injury, illness, and disease. Suicide assessment training, which is not typically part of their orientation to the ED, gives the nurse additional skills (McAllister, Billett, Moyle & Zimmer-Gembeck, 2009). Additionally, these skills can be applied to the psychosocial/psychiatric dilemma of the suicidal patient. When nurses learn how to evaluate and care for suicidal patients, they gain a better understanding for the experience of the patient's suicidal ideation. According to Sun, Long, Boore and Tsao (2006), empathy is the foundation of the patient-nurse therapeutic relationship. The well-trained ED nurse can help the patient feel more hopeful and less suicidal.

Congenial patient-staff interactions are essential for suicide assessments. Patients often become agitated and confrontational with staff during a long wait for evaluation by a nurse or clinician. Timely ED assessments reduce the risk of unfavorable outcomes, including escalating suicide ideation, or even suicide attempts. (Blank, Santoro, Maynard, Provost, & Keyes, 2007). Additionally, many patients that have to wait too long may leave the hospital without a suicide assessment. An ED visit becomes a life-saving event when the entire staff works to assess and reduce the risk of suicide (Giordano & Stichler, 2009).

Simon (2008) points out that patients, friends and family members may all contribute information about the patient's psychiatric condition and behavior. Patients admitted to the ED are not always forthcoming with their suicidal ideation, intent or plan. They are often frightened, with feelings of shame, and may deny or minimize their suicidal behavior, thoughts, and feelings. These factors can make accurate suicide assessments and patient safety interventions, more
difficult for the ED nurse and clinician. Simon (2008) concludes that suicide risk factors such as past attempts, substance abuse, eating disorders, physical illness and depression provide important clinical information in determining the seriousness of the suicidal ideation/intent.

Allen, Carpenter, Sheets, Miccio and Ross (2003) found that 68% of psychiatric patients feel they are "out of control" upon admission to the ED (p. 45). A second noteworthy finding is that 25% of patients entering the ED have symptoms of depression, suicidal thoughts, or have made a suicide attempt. These researchers also established that patients feel safe when nurses and clinicians help them with mental illness. Shea (1998) points out that building a therapeutic relationship with a suicidal patient enhances the gathering of information during the suicide assessment.

**Chronological Assessment of Suicide Events (CASE)**

Shea (1998) developed CASE using three questioning techniques to investigate four different time frames in the patient’s history to draw out the patient’s suicidal behavior and thinking. The CASE method provides comprehensive detail about suicide in an easy to remember format. Simon (2008) acknowledges CASE as a "practical interviewing strategy for eliciting valid suicide ideation, especially with the guarded suicidal patient" (p. 517).

**Behavioral incident.** The first questioning technique mentioned by Shea (1998) is “Behavioral Incident” (p. 59) developed by Gerald Pascal (1983). These questions are straightforward in their design and the responses by the patient paint a complete step by step illustration of behavior during a suicidal episode. These questions allow the patient to express thoughts and feelings about suicide. An example of Shea’s behavioral incident question might be, “Did you put the razor blade to your wrist?” or “How many pills did you store up?” (Shea, 1998, p. 59). These questions ask the patient about their suicidal behavior clearly and pointedly
allowing the provider to understand and document exactly what occurred. The nurse may establish additional questions relevant to each patient.

**Gentle assumption.** Shea (1998) also recommended a second questioning technique, “Gentle Assumption” (p. 60). Pomeroy, Flax and Wheeler (1982) developed the gentle assumption questioning style to help the patient reveal potentially embarrassing or uncomfortable facts. These are open ended questions that require the nurse to make an assumption about the patient’s behavior. Examples of the gentle assumption questions are: “How many jobs have you been fired from?” or “What other ways have you thought of killing yourself?” (Shea, 1998, p. 60). The nurse will develop other questions as needed to disclose information about the patient’s suicidal thoughts.

**Denial of the specific.** The third questioning technique was developed by Shea (Shea, 1998). When a general question is denied, then the nurse asks a specific question. Shea named this technique “Denial of the Specific” (p. 60). For example, the patient denies the general question, “In the past, have you thought of suicide?” The nurse responds with a more specific question such as, “Have you thought of shooting yourself?” or “Have you thought of hanging yourself?” (p. 60). The specific question is likely to elicit a truthful answer. Practicing this technique will enhance the nurse’s ability to uncover information about the patient’s past suicidal thoughts and behaviors.

Shea (1998) identifies four different time periods for the purpose of organizing and categorizing the patient’s suicidal history. At the conclusion of the CASE assessment the clinician has four interlocking puzzle pieces, that when assembled, create a image of the patient’s suicidal history. The four time frames are a) presenting events time frame, b) recent events time frame, c) past events time frame, d) immediate events time frame.
Presenting Events. This period covers the last few hours before the suicidal patient came to the ED. The assessment focuses on the thoughts, feelings and behaviors that precipitated the current suicidal crisis. The goal during this phase of the assessment is to elicit the suicidal ideation, intent and plan.

Recent Events. Now the issue becomes behaviors and thoughts occurring over the past 6 to 8 weeks. This assessment helps determine the magnitude of the patient's suicidal ideation and planning. This assessment discovers how the pattern of suicidal ideation has become a pervasive part of the patient's thought process. It shows the frequency and severity of suicidal thinking. A pattern of suicidal ideation, intent, and plan can illustrate the patient's level of risk for suicide.

Past events. This chronicles suicide attempts prior to 6-8 weeks ago. Shea (1998) cautions against conducting an exhaustive examination of previous attempts in a busy ED. It is always beneficial to use ED time and resources efficiently. The important information to draw from past events is the most serious suicide attempt, the number of attempts and how long ago was the most recent suicide attempt. Assessment of time frames of presenting events, recent events and past events lays a foundation for discovering what the patient is thinking now.

Immediate events. The assessment focuses on the patient's current suicidal state. The goal is to obtain current suicidal ideation, intent and plan. Combining this new information from the first three time frame assessments completes the assessment of suicide risk. Now the nurse and clinician can determine if the patient needs to be referred for inpatient hospitalization or released back to the community with outpatient follow-up. For example, the nurse can ask questions to determine suicidal ideation: “Do you have thoughts of killing yourself right now?” or, “Do you want to hurt yourself right now?” The next line of questioning helps establish
suicidal intent: “What do you have to live for?” and “Why do you want to die?” The final questions reveal a suicidal plan:

“How are you going to kill yourself?” or “Do you have a plan for killing yourself?” If suicide is still on the patient’s mind then what will happen if the patient leaves the ED and returns home. The behavioral incident and gentle assumption questions discover what patient’s suicidal ideation, intent and plans are at the present time. The CASE approach can be a short screening or a comprehensive assessment to determine how the patient experiences suicidal thinking and behavior.

ED Suicide Assessment Guidelines

The Joint Commission leaves the task of development of ED suicide assessment guidelines to individual hospitals. The guidelines aim to protect patients from self-harm. (Joint Commission, 2008). The American Psychiatric Association [APA] (2003) provides guidelines on how to treat and manage suicidal patients. Local cultural values and available resources influence guidelines for hospitals (Brock et al., 2009). Environmental safeguards or one to one close observation must be in place while a suicidal patient is awaiting transfer to a psychiatric hospital (Cardell et al, 2009).

The APA (2003) guidelines for treating suicidal patients are a starting point for developing ED guidelines. Suicidal patients can be divided into two groups using clinical judgment and guidelines. Clinical judgment is a subjective way to make decisions when objective tools are lacking (Simon, 2008). The first group of patient’s are those who are clinically judged to have minimum risk of suicide. They can be released from the ED into the community with recommendations for outpatient follow-up. The second group of patient’s needs to be hospitalized because they are at higher risk for suicide.
Guidelines for Release into the Community

A patient is best served with release into the community with outpatient treatment if his case is illustrated by the following presentation: a) the patient denies current suicidal ideation/intent/plan, b) the method of suicide has low lethality, c) the patient has minimal symptoms of depression and anxiety, d) the patient has good social support and a reason for living (APA, 2003).

Guidelines for Referral and Transfer to a Psychiatric Hospital

The clinical judgment factors for hospitalization are: a) the patient has poor judgment and insight due to mental illness, b) the patient endorses an intense suicide ideation/intent/plan, c) the patient’s expressed method of suicide is highly lethal, c) the patient is depressed, hopeless, anxious or agitated, d) poor social support makes outpatient follow-up unlikely, e) the patient’s illness involves a medical condition (APA, 2003).

Guidelines for Environmental Safeguards

The following need to be considered when setting up and implementing environmental safeguards in an ED setting. Staff needs to be trained in identifying and removing objects that can be used for self-harm, such as objects that can be used for cutting, hanging, asphyxiation, and suffocation. This also involves the removal of poisonous items and limiting access to areas where patients may have the ability to jump. In an ED setting it is difficult to remove all potentially dangerous items and therefore one-to-one constant observation should be implemented with highly suicidal patients (Cardell et al, 2009).

ED Suicide Assessment Documentation

ED suicide assessment must be documented each time a patient is asked about suicide ideation (Simon, 2006). The S.O.A.P. (S) Subjective, (O) Objective, (A) Assessment (P) Plan...
(Hahn, 2008) is a documentation format commonly used in nursing. An example of this would be: (S) This 58 year old, Caucasian, married male was brought to the ER by his wife due to her concern for his safety. Both the patient and his wife, report a worsening of his depression the past several days. This afternoon his wife found him in the bedroom with his loaded handgun. The patient states that about a month ago he lost his employment of 24 years due to a companywide lay off. This caused a feeling that life was not worth living. He lost interest in his hobby of fly fishing, and began to worry about finances. The patient reports experiencing sleeplessness and poor appetite resulting in a weight loss of fifteen pounds. The patient was hospitalized and treated for depression twelve years ago after a suicide attempt that involved cutting his left wrist. He was discharged from the hospital on Zoloft. He stopped taking the medication after 1 year because “I was fine and didn’t have depression.” Today the patient states: “This morning I loaded my gun and was preparing to shoot myself in the head” and “I just want it to end.” (O) The patient is dressed in casual attire. He is disheveled, and poorly groomed. His mood is depressed and his affect is sad. The patient’s thought process is organized and progressive with response latency and quiet voice. Thought content is suicidal with a well developed, lethal plan with a strong intent to die. He denies auditory or visual hallucinations and paranoid thinking. He is oriented to time, place and person. His concentration is fair, insight is adequate and judgment is poor. (A) Currently this patient is at risk for suicide because of his past attempt, increasing depression, well developed lethal plan and a strong intention to die. Due to these factors, I believe this patient could benefit from being admitted to a psychiatric inpatient unit. The treatment will not interfere with his job because he is currently unemployed and he has insurance coverage for mental health services. (P) 1) Admit the patient to the psychiatric inpatient unit for stabilization of suicidal thoughts and depression. 2) Wife will transfer the gun
to their son to eliminate that means of suicide, 3) Outpatient services information is given to patient for use, if needed after discharge from the psychiatric unit, 4) Suicide hotline phone number and web resources is given to the patient and family member.

This is an example of how the CASE suicide assessment progresses from Presenting Events (found this morning by wife with the gun); to Recent Events (loss of job causing thoughts that life is not worth living); to Past Events (suicide attempt by cutting wrist) and finally Immediate Events (the patient states current suicide ideation). This subjective information together with objective findings can be used to make an assessment (Shea, 1998). A treatment plan is formed using clinical judgment (Simon, 2006).

**Implications for Nursing**

The CASE assessment (Shea, 1998) model holds potential for revealing suicide risk in ED patients. This model provides a structured and easy to use format in guiding nurses in conducting a suicide assessment. Some ED nurses benefit from training in performing this assessment. Training and experience will enhance the nurse’s level of skill at developing the nurse-patient relationship (Sun et al, 2006). Patients describe the need for respectful, non-judgmental care while at the ED during a suicide crisis (Allen et al., 2003). The skillful nurse will use assessment findings to provide care according to ED guidelines. Documenting assessment findings will assist the clinician in making the choice between admission to the psychiatric unit and discharge to home. The ED and the hospital benefit from the nurses’ assessment competence by meeting standards for Joint Commission certification. Finally, the skillful nurse keeps the patient safe from self-harm and avoids legal action due to negligence (Simpson, 2004).

**Implications for Research**
The research related to conducting suicide assessments and training in the ED is limited. There are several areas that need further exploration. For example, little is known about ED nurses' feelings and concerns about caring for patients with both physical and psychiatric illness. Further qualitative research may reveal emotional conflict for the nurse caring for these two groups with differing needs. Research on the stress experienced by nurses caring for suicidal patients in the ED may reveal needs for change in standards of practice. Sun et al (2006) showed improved job satisfaction and increased confidence among nurses receiving trained in caring for suicidal patients in Taiwan. Replicating this research in the United States may produce similar results.

Last, there is a dearth of research in the area of time management and resource utilization while caring for the suicidal patient in the ED. For example, little is known about what types of suicide assessment models are the most effective for eliciting suicidal ideation/intent, easiest to use, and time-saving for nurses in a fast paced ED. This information would assist in developing nurses' training programs while also maintaining the Joint Commission's (2010) requirements for a patient safe environment.

Summary

The first contact with health care is often the ED. EDs have shrunk in number and at the same time have experienced growth in number of patient visits. The Joint Commission recognizes that ED is the place where a suicidal crisis can be resolved through proper care and referral. Patients can access EDs 24 hours per day and receive both physical and psychological assessment. Assessments, guidelines, documentation help assure patient safety and avoid legal action due to negligence. Suicide assessment can be performed by ED nurses in collaboration with clinicians. These ED healthcare professionals are skilled at helping patients in crisis. Shea's
(1998) CASE approach is a systematic way to put the suicidal patient at ease and provide information for the risk assessment of suicide. The clinician can act in the patient's best interest by using ED suicide guidelines to make clinical judgments. These informed decisions result in discharge of the patient into the community or transfer to a psychiatric unit and overall are life saving.

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