SPRC SUICIDE PREVENTION RESOURCE CENTER

Working with Emergency Departments: New Tools and Grantee Models

EDC SAMHSA

Agenda

- Rationale for Suicide Prevention in the Emergency Department
- Models and Tools
  - Oklahoma—WyAngela Knight Singh
  - White Mountain Apache/Johns Hopkins U—Mary Cwik, Novalene Goklish
  - National Suicide Prevention Lifeline Outreach Toolkit—Patrick Cook
- Discussion

SUICIDE PREVENTION IN THE EMERGENCY DEPARTMENT

Emergency Department

- 1 in 10 suicides are by people seen in an ED within 2 months of dying--many never assessed for suicide risk.
- 10% of ED patients have suicide ideation—most don't spontaneously disclose

Emergency Department—Status Quo

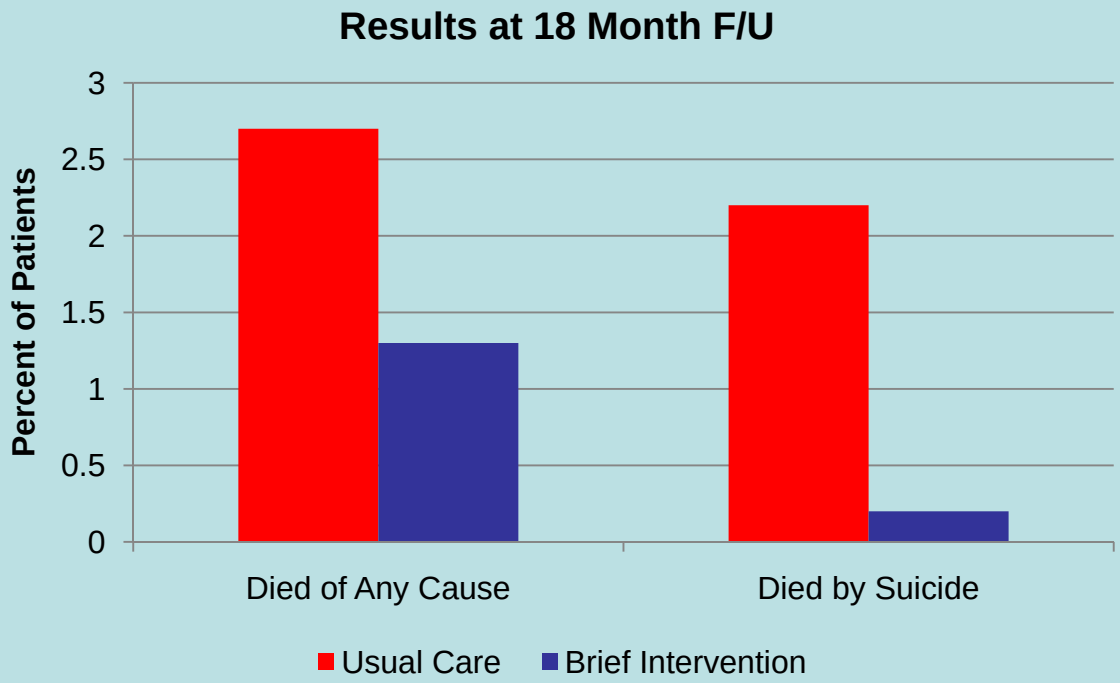
Kemball et al (2008)

- 165 ED patients with suicidal ideation self-identified on a computer screening
- Physician and nurse were informed
- Six month f/u
  - 10% were transferred to psychiatric services
  - Only 25% had any notation in the chart re suicide risk
  - 4 were seen again in the ED with suicide attempts—none were there for mental health problems on the index visit

Kemball R, Gasgarth R, Johnson B, Patil M, Houry D. Unrecognized suicidal ideation in ED patients: are we missing an opportunity. Am J of Emerg Med. (2008) 26, 701-705.

❖ Fleischmann et al (2008)

- Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)
- Brief (1 hour) intervention as close to attempt as possible
- 9 F/u contacts (phone calls or visits) over 18 months



Emergency Department

- Look for signs of acute suicide risk

Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of Acute Suicide Risk

- Talking about suicide
- Seeking lethal means
- Purposeless
- Anxiety or agitation
- Insomnia
- Substance abuse
- Hopelessness
- Social withdrawal
- Anger
- Recklessness
- Mood changes

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

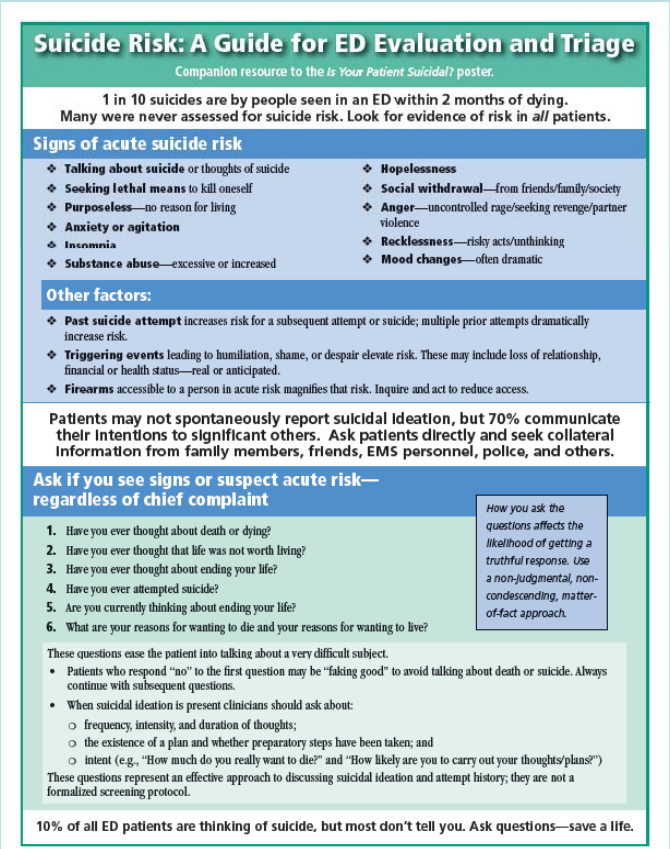
National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57392). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.

Emergency Department

- **Screen:**
  - **Universally or selectively**
  - **Paper/pencil, computer, or by clinician**



Suicide Risk: A Guide for ED Evaluation and Triage

Companion resource to the *Is Your Patient Suicidal?* poster.

1 in 10 suicides are by people seen in an ED within 2 months of dying.
Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of acute suicide risk

- **Talking about suicide** or thoughts of suicide
- **Seeking lethal means** to kill oneself
- **Purposeless**—no reason for living
- **Anxiety or agitation**
- **Insomnia**
- **Substance abuse**—excessive or increased
- **Hopelessness**
- **Social withdrawal**—from friends/family/society
- **Anger**—uncontrolled rage/seeking revenge/partner violence
- **Recklessness**—risky acts/unthinking
- **Mood changes**—often dramatic

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
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Ask if you see signs or suspect acute risk—regardless of chief complaint

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6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions ease the patient into talking about a very difficult subject.

- Patients who respond "no" to the first question may be "faking good" to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
  - frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans?")

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

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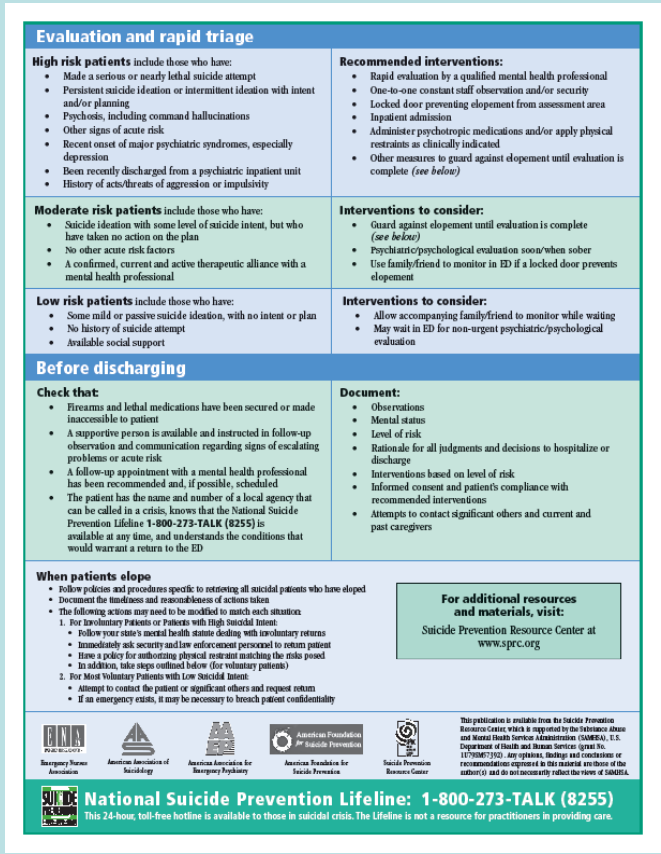

Evaluation and rapid triage

High risk patients include those who have:
- Made a serious or nearly lethal suicide attempt
- Persistent suicide ideation or intermittent ideation with intent and/or planning
- Psychosis, including command hallucinations
- Other signs of acute risk
- Recent onset of major psychiatric syndromes, especially depression
- Been recently discharged from a psychiatric inpatient unit
- History of acts/threats of aggression or impulsivity

Recommended interventions:
- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete *(see below)*

Moderate risk patients include those who have:
- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current and active therapeutic alliance with a mental health professional

Interventions to consider:
- Guard against elopement until evaluation is complete *(see below)*
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend to monitor in ED if a locked door prevents elopement

Low risk patients include those who have:
- Some mild or passive suicide ideation, with no intent or plan
- No history of suicide attempt
- Available social support

Interventions to consider:
- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation

Before discharging

Check that:
- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED

Document:
- Observations
- Mental status
- Level of risk
- Rationale for all judgments and decisions to hospitalize or discharge
- Interventions based on level of risk
- Informed consent and patient's compliance with recommended interventions
- Attempts to contact significant others and current and past caregivers

When patients elope
- Follow policies and procedures specific to retrieving all suicidal patients who have eloped
- Document the timeliness and reasonableness of actions taken
- The following actions may need to be modified to match each situation:
  1. For Involuntary Patients or Patients with High Suicidal Intent:
     - Follow your state's mental health statute dealing with involuntary returns
     - Immediately ask security and law enforcement personnel to return patient
     - Have a policy for authorizing physical restraint matching the risks posed
     - In addition, take steps outlined below (for voluntary patients)
  2. For Most Voluntary Patients with Low Suicidal Intent:
     - Attempt to contact the patient or significant others and request return
     - If an emergency exists, it may be necessary to breach patient confidentiality

For additional resources and materials, visit:
Suicide Prevention Resource Center at www.sprc.org

Emergency Nurses Association · American Association of Suicidology · American Association for Emergency Psychiatry · American Foundation for Suicide Prevention · Suicide Prevention Resource Center

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Emergency Department

Evaluation and rapid triage

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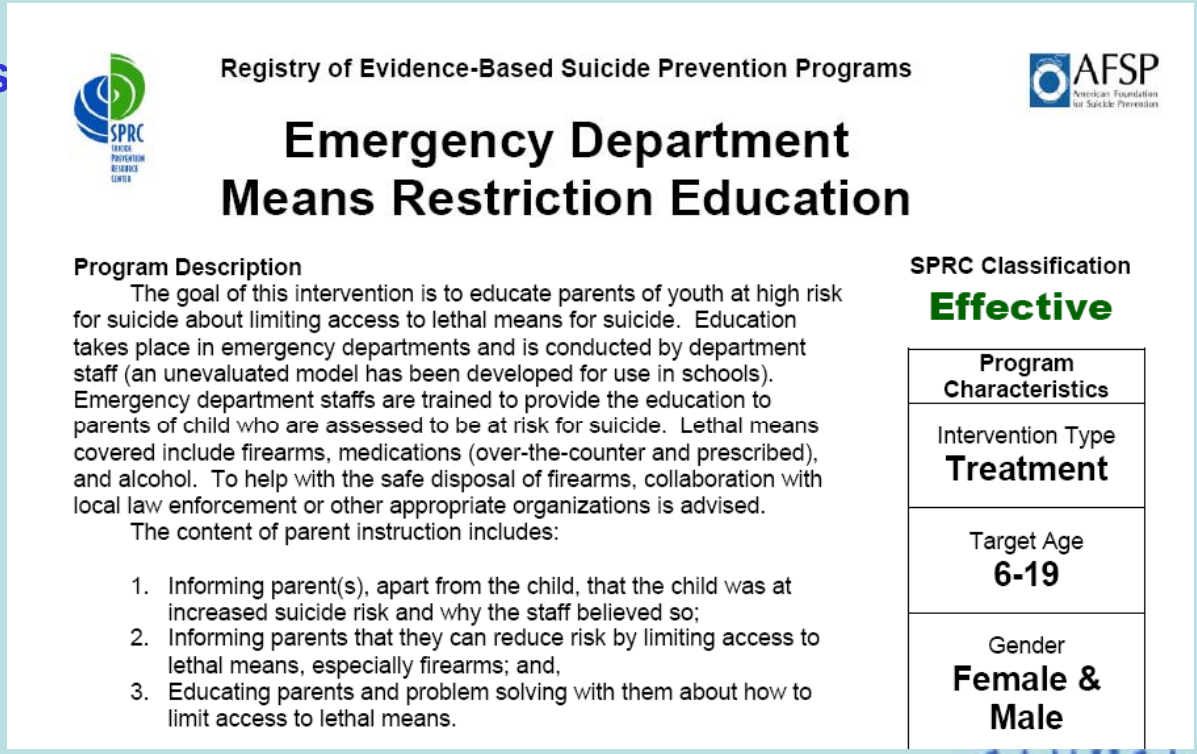
Moderate risk patients include those who have: • Suicide ideation with some level of suicide intent, but who have taken no action on the plan • No other acute risk factors • A confirmed, current and active therapeutic alliance with a mental health professional	**Interventions to consider:** • Guard against elopement until evaluation is complete *(see below)* • Psychiatric/psychological evaluation soon/when sober • Use family/friend to monitor in ED if a locked door prevents elopement
Low risk patients include those who have: • Some mild or passive suicide ideation, with no intent or plan • No history of suicide attempt • Available social support	**Interventions to consider:** • Allow accompanying family/friend to monitor while waiting • May wait in ED for non-urgent psychiatric/psychological evaluation

Emergency Departments

❖ Brief Interventions

- Motivational interviewing
- Safety planning; support planning
- Means restriction
- Follow up contacts



Registry of Evidence-Based Suicide Prevention Programs

Emergency Department Means Restriction Education

Program Description

The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools). Emergency department staffs are trained to provide the education to parents of child who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.

The content of parent instruction includes:

1. Informing parent(s), apart from the child, that the child was at increased suicide risk and why the staff believed so;
2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and,
3. Educating parents and problem solving with them about how to limit access to lethal means.

SPRC Classification

Effective

Program Characteristics
Intervention Type **Treatment**
Target Age **6-19**
Gender **Female & Male**

Before discharging

Check that:

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- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED