The Role of the ED in Suicide Screening and Risk Assessment

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Objectives

- To exam the process to evaluate patients for risk of suicide
- To understand the difference between suicide screening and suicide risk assessment
- To review the next steps after risk assessment including discharge

Subsequent Suicide After ED Visit

- Assess 218,304 patient with 6 year follow up
- 408 completed suicides compared to cohort
  - 31.2 / 100,000 pts
  - Twice the rate of patients who did not come to the ED
- Completed suicides associated with
  - Male
  - Overdose
  - Suicidal Ideation
- Recommend psych evaluation before discharge

Suicide Identification

- Overt
- Suspected
  - Any overdose
  - Accidental gunshot wound
  - Wrist laceration
  - Automobile crash
  - Fall from height
- Unsuspected
- Completed
- Screened in

Using Primary, Secondary, and Risk Assessment Tools
Suicide Prevention Resource Center: A Consensus Guide for Emergency Departments

Primary Screening Tool - Universal or Selective

Secondary Screening Tool - Decision Support Tool

Comprehensive Suicide Risk Assessment

ED Visits and Suicide Deaths
Health Systems, 8 States, N = 5984 suicides 2000-2010
Within 4 weeks of death, N = 4988 enrolled

<table>
<thead>
<tr>
<th>Deaths</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>Any visit</td>
<td>2488</td>
<td>49.9</td>
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<tr>
<td>ED Mental Health</td>
<td>373</td>
<td>7.5</td>
</tr>
<tr>
<td>ED Chem Dependency</td>
<td>72</td>
<td>1.4</td>
</tr>
<tr>
<td>ED Other</td>
<td>640</td>
<td>12.8</td>
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<tr>
<td>IP Mental Health</td>
<td>232</td>
<td>4.7</td>
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<tr>
<td>OP Mental Health</td>
<td>729</td>
<td>14.6</td>
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Suicide Screening in the ED

- Suicide ideation is on a continuum
  - Difficult to determine "suicide gesture from suicide plan"

- Rating Scales
  - Clinical rating scales cannot predict suicide in the individual
  - Strict cut-off scores should not be used to dictate admission to the hospital
  - 31 tests of risk of suicidal - Few designed for the ED
  - Commonly used - Modified SAD PERSONS scale, Beck Depression Inventory, Risk of Suicide Questionnaire

- How to screen
- What to do when a patient screens in
- SCREENING IS NOT RISK ASSESSMENT

Problems and Solutions of Screening in ED

- Problems
  - Too busy
  - Not part of ED responsibilities
  - This is preventative care not emergency medicine
  - Don’t get paid for this service

- Solutions
  - Self-administered
  - Touch screen computer
  - Mental health worker
  - Controversary in universal screening

American Association for Emergency Psychiatry (AAEP) Position Statement: Suicide Screening

https://www.emergencypsychiatry.org/position-statements (September 2017)

- AAEP promotes timely, compassionate, and effective mental health services for persons with mental illnesses, regardless of their ability to pay, in all crisis and emergency care settings.
- Based on our mission, AAEP supports universal suicide screening of patients in the emergency setting and appropriate funding for screening and indicated services

Occult Suicidality

- Computerized mental health screening panel
- Waiting room patients
  - 11.6% (186) had suicide ideation
  - 2% (31) had suicide plan
  - Missed in 80.6% (25 of 31) charts
- Web based adolescent psych screening
  - Used a Behavioral Assessment
  - Dx of depression, suicide, PTSD, violence
  - 64.6% agreed to screening
  - 10.5% tested positive

Engaging ED Providers in Suicide Prevention

- EDs are busy places & difficult to engage providers in suicide prevention
- Two issues
  - Patient screening in ED
    - Triage, kiosks, self-administered, RN/MD performed
    - Educate staff to think of suicide screening in ED
  - Screen in
    - Needs more assessment
    - Referral to mental health services

Staff Attitudes about Suicide

- Suicidal behavior appears to elicit mostly negative feelings among staff members...
- If not acknowledged and properly handled...may lead to premature discharge.
- “It is important task for staff members is to contain and work through negative feelings towards patients.”
- Key element influencing whether a patient commits suicide
Staff Attitudes

- Anger at the patient
- Patient may provoke others into rejecting them
- Patient is just manipulative
- Denial from patient and family
- Patient’s free will
- Rescue the patient

Evaluation Concerns
Who Does the Psychiatric Evaluation
- ED MD
- In-house psychiatry
- ED mental health worker
- Telepsychiatry
- Community mental health
- Outside contracted mental health worker
- The bottom line is ED physician’s responsibility to ensure correct disposition

Determination of Risk
- All patients who want to harm themselves need admission
- Alcohol and substance intoxicated patients need admission even if they change their mind when they are not clinically intoxicated
- All teenagers with suicide gestures or thoughts need admission
- Maybe not

Suicide Assessment
- No perfect tool with scores
- Suicide Assessment
  - High – admit
  - Medium – consult psych
  - Low – home with follow up
- Use static and dynamic risk factors
- Good documentation

Clinical Rating Scales of Suicide Risk Assessment
- Reviewed Modified Sad Persons, Beck Depression Inventory, Beck Anxiety Inventory, Beck Hopelessness Scale, Beck Score for Suicide Ideation, High-Risk Construct Scale
- 100% Sensitivity and negative predictive value
- Low Specificity and positive predictive value
- Cannot predict suicide and strict cut off scores should not be used.
Barriers and Facilitators of Suicide Risk Assessment in ED

- 92 providers from 2 hosp systems surveyed
- Themes of suicide risk assessment
  - Time
  - Privacy
  - Collaboration and consultation
  - Integration into routine care
- Recommend a collaborative, multidisciplinary approach

ED Risk Assessment

- Static risk factors
- Dynamic risk factors
- Protective factors
- Document thought process
- Provide appropriate discharge process to include safety planning

Static Risk Factors for Suicide

- Age,
- Gender
- Medical problems
- Past attempt
- Family hx of suicide
- Psychiatric illness
- Substance use disorder

ED Decision Support, SPRC

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<thead>
<tr>
<th>1. MENTAL HEALTH</th>
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</thead>
<tbody>
<tr>
<td>2. HISTORY OF SUICIDE ATTEMPT</td>
<td>2. HISTORY OF SUICIDE ATTEMPT</td>
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<tr>
<td>3. FAMILY HISTORY OF SUICIDE</td>
<td>3. FAMILY HISTORY OF SUICIDE</td>
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<tr>
<td>4. CURRENT MEDICATIONS</td>
<td>4. CURRENT MEDICATIONS</td>
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<tr>
<td>5. MEDICATIONS</td>
<td>5. MEDICATIONS</td>
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<td>6. OTHERS</td>
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<td>7. NEXT OF KIN</td>
<td>7. NEXT OF KIN</td>
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<tr>
<td>8. SOCIAL SUPPORT</td>
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ACEP Clinical Guidelines

- Physicians should not use risk assessment tools in isolation
- Low risk may go home
- Appropriate psychiatric assessment, good clinical judgement
- Take into account patient, family and community factors

Evaluation Concerns

Contracts for Safety

- Setting of pre-existing, deep, committed doctor patient relationship
- Pros — deepen commitment, strengthen therapeutic alliance, facilitate communication, lower anxiety, document precautions
- Cons — anger or inhibit client, introduce coercion, false sense of security
- Conclusion — "...Never enough to protect against legal liability and lead to adverse consequences for the clinician and the patient."

Static Risk Factors for Suicide
Dynamic Risk Factors for Suicide

High risk suicide attempt
- Use of highly lethal means (guns-hanging)
- Planned and or rehearsed ahead of time
- Efforts to not be discovered-going to remote site
- Suicide note-putting affairs in order
- Ambivalence about lack of success

Moderate risk
- Use of limited # of medications or substances of abuse
- High likelihood of being discovered or calling for help
- Suicide note overtly manipulative or designed to gain attention

Low risk attempt (gesture)
- Taking a small number of pills
- Attempt in front of another person
- Hasoz that the attempt was not successful or feels "stupid"

Protective Factors
- Support systems
- Pregnancy
- Parenthood
- Religiosity

Role of the ED in Patients Found to Be Suicidal

- Remove risk of self harm
  - Remove weapons, sharp objects,
  - Remove prescriptions
  - Safe environment away from windows, stairwells
- Medical & psychiatric evaluation & treatment
- Determination of risk and need for admission
- ED Interventions
  - Admitted waiting for a bed
  - Plan to discharge

ED Concerns Precautions

- Most suicides are hangings, jumping off the building, cutting with a sharp object or OD
- Look for materials that can be weaponized
- Remove nurse call system bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.
- Remove medications, cleaning supplies and other chemical used in EDs
- Use metal detectors to screen all patients

ED Concerns Elopement of Psychiatric Patients

- Identify patients at high risk for elopement
  - Agitated
  - Schizophrenic
  - Bipolar
  - Involuntary admissions
- Ensure proper monitoring of patients
  - One to one observation
  - Video monitoring
  - Electronic or visual means
  - Cannot use seclusion or restrain for this purpose alone
  - Family members may assist but not responsible
- Code Green/Elopement
  - Notification of security with description of missing patient
  - Immediate search of the unit and surrounding area by unit staff
  - Notification of the patient’s physician

ED Treatment Interventions

- Brief intervention
  - International study of 8 EDS
  - Brief intervention and enhanced follow up
  - Reduced number of deaths
- Enhanced Intervention
  - 18 month study of female Hispanic patients
  - Soap opera video, family therapy, and staff training
  - Reduced suicide re-attempts and ideation
- Rapid response
  - Suicidal adolescents in a pediatric ED
  - Rapid response team psychiatrist & RN with assessment, meds & community follow-up
  - Lower hospitalization rate
Innovative ED Treatments

**Ketamine Use in Suicidal patients**
- 15 suicidal patients received subanesthetic IV dose of ketamine
- 13 of 14 completely free of suicidal ideation at 10 day follow up

**Can the Suicidal Patient Go Home**
- Medical treatment not needed
- No prior suicidal attempt
- Not actively suicidal
- Adult in house with good relationship
- Adult agrees to monitor
- Adult will move guns and medications
- Whom to contact for deterioration
- Follow up arranged
- Agreement to plan and recommendations

What to Document
Suicide Prevention Resource Center: A Consensus Guide for Emergency Departments

- Arrival means and reason
- Account of what happened
- Communication or attempted communication
- Screenings and assessments performed
- Key considerations made for admission or D/C
- Interventions provided onsite
- Patient’s stated preferences regarding treatment
- Actions taken to mitigate concerns
- Lethal means access
- Patient care plan
- Referral given

Discharge Process
Suicide Prevention Resource Center: A Consensus Guide for Emergency Departments

- **(1) Brief Patient Education**
- **(2) Safety Planning**
- **(3) Lethal Means Counseling**
- **(4) Rapid Referral**
- **(5) Caring Contacts**

Discharge Planning Checklist

- Involve the patient as a partner
- Make follow-up appointments
- Review and discuss the Patient Care Plan (discharge plan)
- Discuss barriers
- Provide crisis center phone number
- Discuss limiting access to lethal means
- Provide written instructions and education materials
- Confirm that the patient understands the Patient Care Plan
- Share patient health information with referral providers
- Communicate your concern

Resources

- Brief description
- "How"

Some sections: special note or sample scripts
SAFE VET intervention

- 4 interventions
  - Means restriction
  - Teaching brief problem-solving and coping skills
  - Enhancing social support and identifying emergency contacts
  - Motivational enhancement

Success – 4.4 days to follow up, 69% F/U in 14 days ED visit

Safety Planning: Brief Instructions*

1. **Step 1: Warning signs:**
   - Ask “How will you know when the safety plan will no longer be effective?”
   - List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using patients’ own words.

2. **Step 2: Internal coping strategies:**
   - Ask patients to list several people and social settings, in case the first option is unavailable.
   - Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
   - Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.

3. **Step 3: People who can help:**
   - Ask “Who are the mental health professionals that we should identify for future contact?”
   - Among your family or friends, who do you think you could contact for help during a crisis?

4. **Step 4: Things I can do to help myself:**
   - Components may include: immediate activities, social settings, problem solving and coping skills, and/or actions to address the crisis.

5. **Step 5: Means restriction:**
   - The clinician should ask patients which means they would consider using during a crisis.
   - For methods with low lethality, clinicians may ask veterans to remove or restrict their access.
   - If doubt is expressed about contacting individuals, identify potential obstacles and how to overcome them.

6. **Step 6: Reducing the Potential for Use of Lethal Means**
   - Ask patients to list several people and social settings, in case the first option is unavailable.
   - Ask “How likely do you think you would be able to do this step during a time of crisis?”
   - Ask “What can you do, on your own, if you think of them?”

**SAFETY PLAN**

- **Emergency contacts**
  - VA mental health clinician
  - VA Suicide Prevention Hotline Phone: 1-800-273-8255, push 1
  - VA Suicide Prevention Resource Coordinator Phone
  - Urgent Care Services Address
  - Clinician Pager or Emergency Contact #

**Take Home Points**

- **Why screen?**
  - Effective in identifying those with suicide ideation

- **Who to screen?**
  - All patients or psychiatric presentations

- **When to screen?**
  - Triage or anytime

- **What to do if they say yes?**
  - Need risk assessment
  - Admission, consultation or referral

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Contact Information

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