

Management of Suicidal Patients in Emergency Departments: Recent Innovations in Care

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VA Center of Excellence for Suicide Research

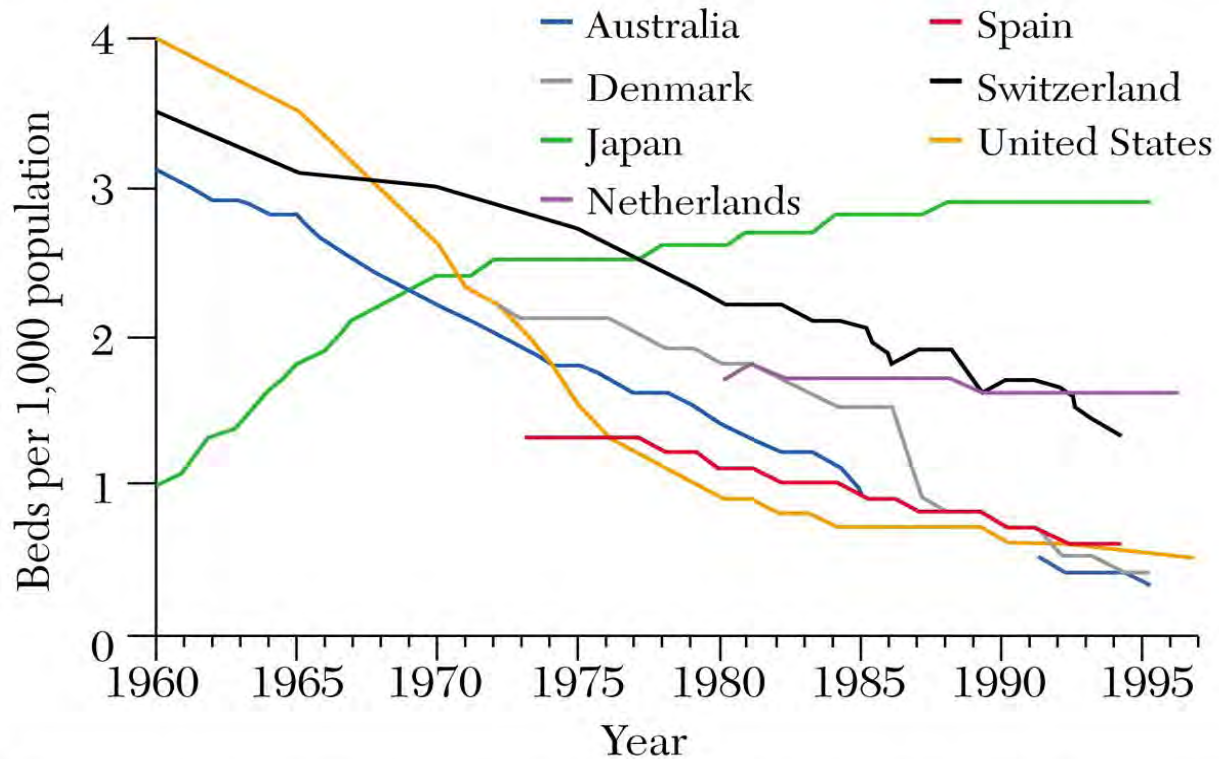
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Disturbing Trends in Mental Health Care Delivery!

Figure 1

Psychiatric inpatient beds per 1,000 population in seven countries, 1960 to 1996¹

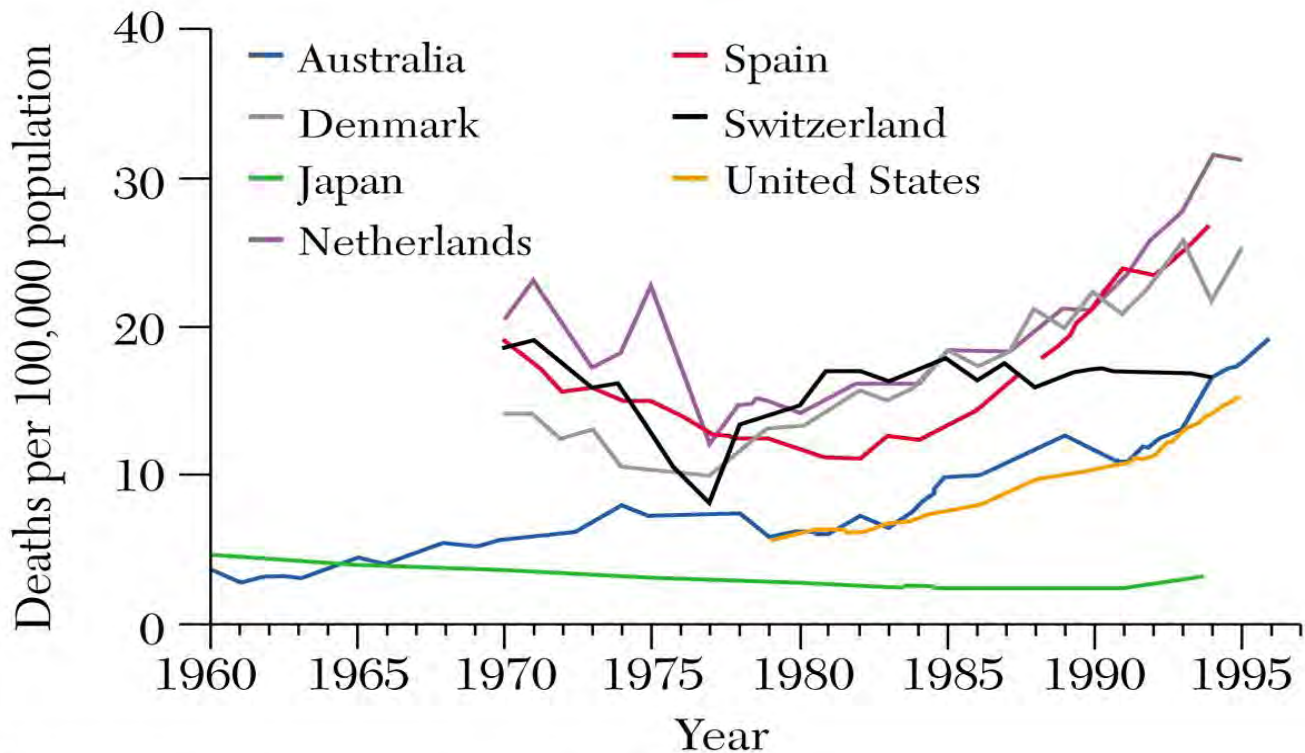


¹ Source: Author's calculations using OECD Health Data 98

How has decreased availability of specialty mental health services played out for patients?

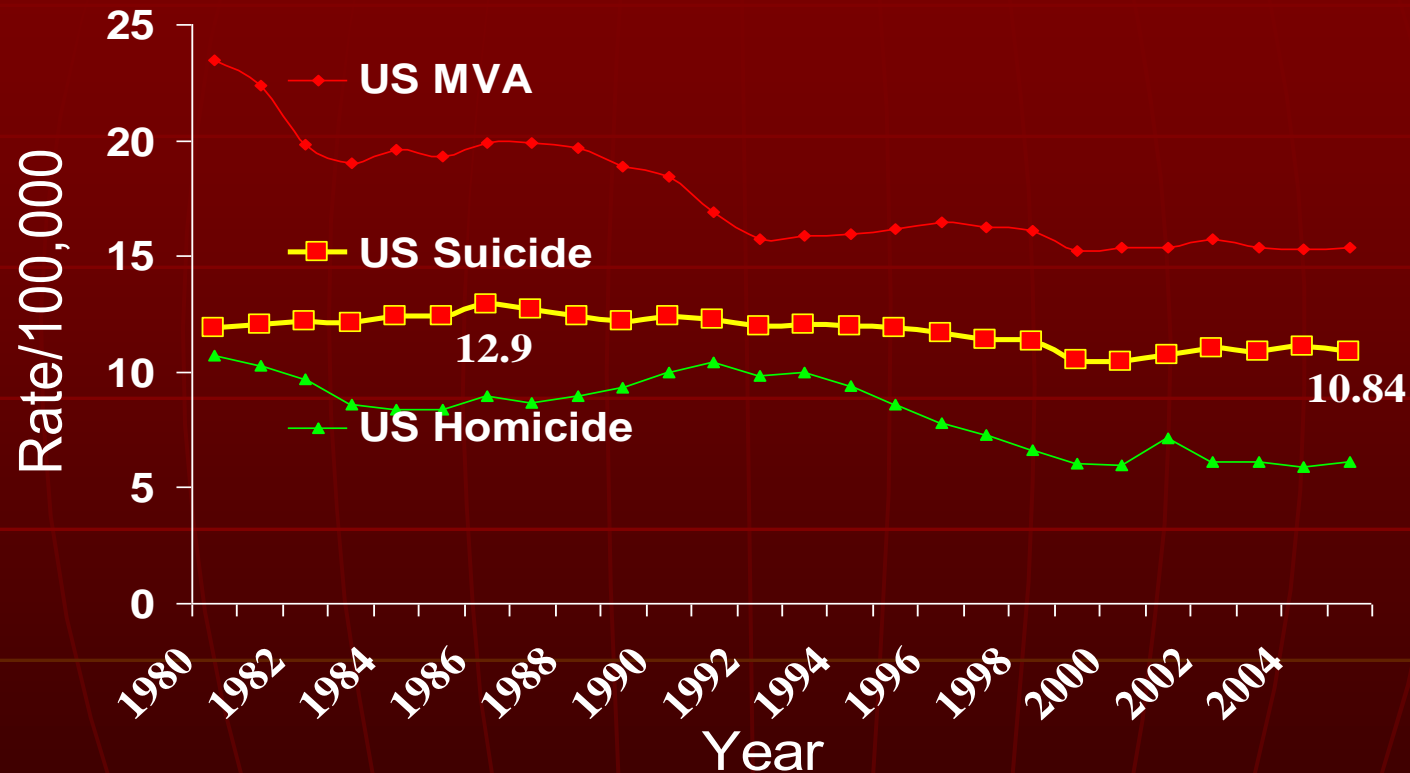
Figure 2

Deaths among persons with mental and substance use disorders per 100,000 population, 1960 to 1996¹



¹ Source: OECD Health Data 98

Suicide: Second or third leading cause of death among young people



Crude rates

http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

“Suicide Epidemic Among Veterans”

A CBS News Investigation Uncovers A Suicide Rate For Veterans Twice That Of Other Americans

NEW YORK, Nov. 13, 2007

“Veterans aged 20 through 24 ... had the highest suicide rate among all veterans, estimated between two and four times higher than civilians the same age. The suicide rate for non-veterans is 8.3 per 100,000, while the rate for veterans was ... between 22.9 and 31.9 per 100,000.”

Based on data from 45 states

How has decreased
availability of specialty
mental health services
played out for
Emergency Medical
Service Providers?

Emergency Department Treatment of Mental Disorders: A Growth Industry

- 100 million ED visits in 2002 [all causes]
- 20% increase in number of visits over prior decade
- **15% decrease in number of ED's over prior decade**
- 6.3% of presentations were for MH
- 7% of these were for suicide attempts = 441K visits

Impact on Emergency Services

- Mood Disorders and Substance Abusers are highest service users, highest suicide risk
- Suicidal presentations 2nd most common
- **Range of severity is extensive: “3 hots & a cot” to near-lethal attempts**
- Most patients are not admitted to the inpatient psychiatric hospital
- Recidivism of discharged patients is common

Suicide Risk in Medical Emergency Care

- Suicidal ideation common in ED patients who present for medical disorders
- Study of 1590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans
- 4 of those 31 attempted suicide within 45 days of ED presentation

Claassen & Larkin, 2005

ED GRIDLOCK

Although escalating patient acuity places a large strain on ED resources, the most important cause of ED overcrowding is insufficient inpatient capacity for ED patients who require hospital admission. Psych beds more scarce than general medical/surgical.

Richardson LD, Asplin BR, Lowe RA. Emergency department crowding as a health policy issue: past development, future directions. *Ann Emerg Med.* 2002; **40**:388–393. doi: 10.1067/mem.2002.128012. [[PubMed](#)]

American Hospital Association. Hospital Statistics. 1999. <http://www.hospitalconnect.com/healthforum/hfstats/downloads.html>

What is the experience
of suicidal patients and
their families who
receive care in
Emergency
Departments?

ED Experience Can Run Counter to Mandate of **Primum Non Nocere**

- More than half of 465 consumers and almost a third of 300 family members felt directly **punished** or **stigmatized** by staff.
- Fewer than 40% of consumers felt that staff listened to them, described the nature of treatments to them, or took their injury seriously.
- Consumers and family members also reported negative experiences involving a perception of **unprofessional staff behavior**, feeling the suicide attempt was not taken seriously, and long wait times.

Emergency Departments as Locus of Care: Why Does Good ED Care Matter?

ED patients who survive suicide attempts are reluctant to engage in follow-up treatment:

- Up to half refuse outpatient treatment at outset
(Rudd et al, 1996)
- Up to 60% of attempters do not attend up to 1 week of treatment after ED discharge

(Jauregui et al, 1999; Piacentini et al, 1995)

Opportunities for improved care of suicidal patients in emergency departments:

- ✓ Improved screening and recognition
- ✓ Improved assessment/ risk stratification
- ✓ Improved provider knowledge and attitudes
- ✓ Improved range of definitive treatment options in ED itself
- ✓ Improved connection after ED discharge
- ✓ Improved aftercare & referral to specialty services

Project 1: A brief educational intervention regarding care of suicidal patients for ED Providers

- ✓Supported by Suicide Prevention Resource Center
- ✓Cooperative effort of the Emergency Research Network in the Empire State (ERNES)
- ✓Providers in four ERNES EDs completed surveys detailing recognition and care of suicidal patients before and after exposure to training materials.
- ✓Providers in one ED served as a comparator group, and completed the pre and post surveys but did not receive the educational materials.
- ✓Pre-post measures of staff attitudes toward suicide and suicide prevention, related practice patterns and perceived skills in suicide assessment.

Project 1:

The intervention consisted of:

- 1) A brightly colored, 11" X 17" poster mounted in the chart room or break room of each ED
- 2) Distribution of an accompanying clinical guide to all ED providers.

The study involved consisted of 3 phases including:

- 1) Completion and collection of baseline surveys (3 weeks)
- 2) Exposure to educational materials (4 weeks)
- 3) Completion and collection of follow-up surveys (3 weeks).

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.



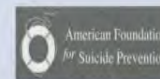
Emergency Nurses
Association



American Association of
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American Foundation for
Suicide Prevention



Suicide Prevention
Resource Center

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.
- ❖ **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?

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

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.

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

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



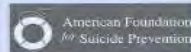
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Project 1: Results

Exposed subjects more readily endorsed:

- ✓ In subjects they're worried about, ED providers "always ask them about risk factors for suicide" (58% to 41%)
- ✓ Providers who were exposed to the poster "always ask directly if [patients they're concerned about] are having suicidal thoughts" (73% to 59%).
- ✓ (51.8%) of intervention site subjects reported they "suspected underlying or concealed suicidal ideation in a patient who presented without a mental health related chief complaint" in the past month, compared to less than one fifth (18.2%) of clinicians in the comparator site ($X^2=9.1$, $p<.003$).
- ✓ A higher proportion of intervention site subjects (74.1%) relative to comparator subjects agreed with the statement "The ED where I work has a very good protocol for managing suicidal patients when they are identified" (52.6%; $X^2=4.0$, $p<.04$).

Project 1: Conclusions

Significant improvements in self-reported practice patterns can be achieved through the simple intervention of hanging a wall poster and distributing a one-page clinical guide to ED clinicians.

Additional Resources: Is Your Patient Suicidal?

Poster:

http://www.sprc.org/library/ER_SuicideRiskPosterVert2.pdf

Suicide Risk: A Guide for ED Evaluation and Triage

<http://www.sprc.org/library/UsingIsYourPatientSuicidal.pdf>

***Project 2:
SAFE VET Demonstration Project
Designed to Enhance Care by:***

Improving the identification of suicidal veterans in VA and Community EDs;

Linking suicidal veterans to appropriate VA services;

Providing a brief ED-based intervention to reduce suicide risk (safety planning) and enhance retention in outpatient treatment.

Ensuring that veterans receive appropriate follow-up care

SAFE VET now being carried out as standard clinical care at 5 VA ED sites across US. More recently added 4 control sites via external research funding.

Contrast the ED Patient with a Suicide Attempt and the ED Patient with a Fracture



ED Patient with apparent fracture

- **Diagnose**-----exam and x ray
- **Treat**---Immobilize and Stabilize-
apply a cast- treat pain
- **Refer** for follow-up

Typical Approach to Suicidal Patients in the ED

- Assess imminent danger—conduct a risk assessment
- Triage---hospitalization vs. discharge to community
- If discharged, refer for treatment
- Is this approach acceptable with other problems presented in the ED?
- **Where's the "Treat"?**

Why don't we have the equivalent of a cast available for suicide risk?



Slide courtesy of Dr. Barbara Stanley

SAFE VET Demonstration Project incorporates aspects of two recent VA- wide initiatives

Stanley & Brown 2008 developed a brief behavioral intervention, Safety Planning Intervention, that incorporates elements of four evidence-based suicide risk reduction strategies: 1) means restriction, 2) teaching brief problem solving and coping skills (including distraction), 3) enhancing social support and identifying emergency contacts, and 4) motivational enhancement.

SAFE VET Demonstration Project incorporates aspects of two recent VA-wide initiatives

- New Position: Acute Services Coordinator
- ED-based but spans episode of care
- Works in conjunction with clinical staff
- Intervention includes operationalized risk assessment and safety planning
- Able to follow discharged patients until successfully linked to outpatient care
- Works in tandem with SPC
- Handles MODERATE risk patients in community

Intervention Steps 1 and 2:

1. Suicide Status Categorical Rating
 - ✓ Rating of current suicide status assigned to each individual
 - ✓ Concise and consistent manner of communicating current suicide status
2. Safety Planning
 - ✓ Several key components designed to help individuals cope with suicidal feelings and urges in order to avert a suicidal crisis
 - ✓ Hierarchically-arranged list of coping strategies identified for use during a suicidal crisis or when suicidal urges emerge over anticipated period between ED discharge and intake at VA

Step 3. Motivational Enhancement & Problem Solving

- ✓ Psychoeducation to address the importance of treatment and to correct any misconceptions regarding treatment
- ✓ Problem-solving to address any anticipated barriers to engaging in treatment
- ✓ Encouragement to attend outpatient therapy
- ✓ Motivational enhancement strategies to help:
 - ✓ Increase motivation to utilize the safety plan as developed
 - ✓ Attend ongoing treatment and next level of care

Follow-Up Protocol:

- Weekly contact for the first two weeks and biweekly contact for the next ten weeks
- Contact by phone, mail or email
- Content consists of:
 - Friendly support
 - Brief risk assessment
 - Safety plan review
 - Problem solving with respect to obstacles to treatment engagement