Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

SPRC Emergency Department Consensus Panel Study Results Review and Project Update

Lisa Capoccia, Suicide Prevention Resource Center

Scott Formica, Social Science Research and Evaluation

Wednesday May 21, 2014

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Technical Orientation Slide

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What we'll cover

- ✓ Project recap
- ✓ Results of Consensus Panel Study 2
  - Technical results
  - Qualitative results
- ✓ Project next steps
- ✓ Discussion, Q & A
- ✓ Closing remarks

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Poll

Did you participate in Study 2?

Study 2:

- *ran from February to March 2014*
- *was administered by Scott Formica, with SSRE*
- *administered in SurveyMonkey*

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Project Goal: Develop a consensus-based ED provider guide for use with patients with suicidal ideation or suspected suicide risk who may be appropriate to discharge

Key Components of Provider Guide	Source			
	RAND Expert Lens Study 1	SSRE Study 2	Key Informants	Research Literature
1. Decision Support Guide: Discharge or Consult?	X	X	X	X
2. Interventions & Discharge Planning		X	X	X
3. Patient-Centered Care, Documentation, Provider Tools		X	X	X

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Consensus Panel Studies

Study 1: July – August 2013
Focus:
• Rate 13 items for usefulness in making disposition decisions for patients with suicidal ideation (i.e., discharge or MH consult)
Purpose:
• Inform the development of a draft decision support guide

Study 2: February – March 2014
Focus:
• Evaluate the draft decision support guide • Rate interventions and discharge planning strategies
Purpose:
• To affirm decision support guide approach • To highlight key interventions and discharge planning practices for the provider guide

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Results

Scott Formica, M.A.
Researcher
Social Science Research and Evaluation, Inc.

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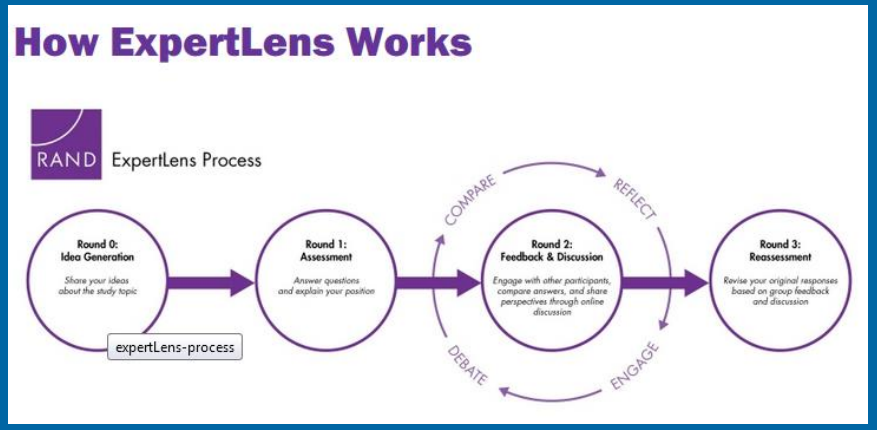
Building Consensus

- ✓ 61 panel members
- ✓ Remote
- ✓ Feedback loop & discussion
- ✓ Anonymous
- ✓ Approximately 6 weeks
- ✓ RAND Corporation and Social Science Research and Evaluation (SSRE)



RAND Corporation image

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Participation

70% participation

- Consensus Panel Members Invited to Participate: 61
- Participated in at least one round of study: 50 (82%)
- Participated in round three: 43 (70%)

Affiliation	Number (%)
Physicians (non-MH)	10 (29%)
Psychologists	9 (26%)
Clinical researcher	7 (21%)
Suicide prevention professional	7 (21%)
Psychiatrists	6 (18%)
Social workers	4 (12%)
Nurse (non-MH)	3 (9%)
Psychiatric nurse	3 (9%)
Federal agency representative	2 (6%)
Policy expert	1 (3%)
Suicide attempt survivor	1 (3%)
Suicide loss survivor	1(3%)

Percentages exceed 100% due to multiple affiliations by panelists.

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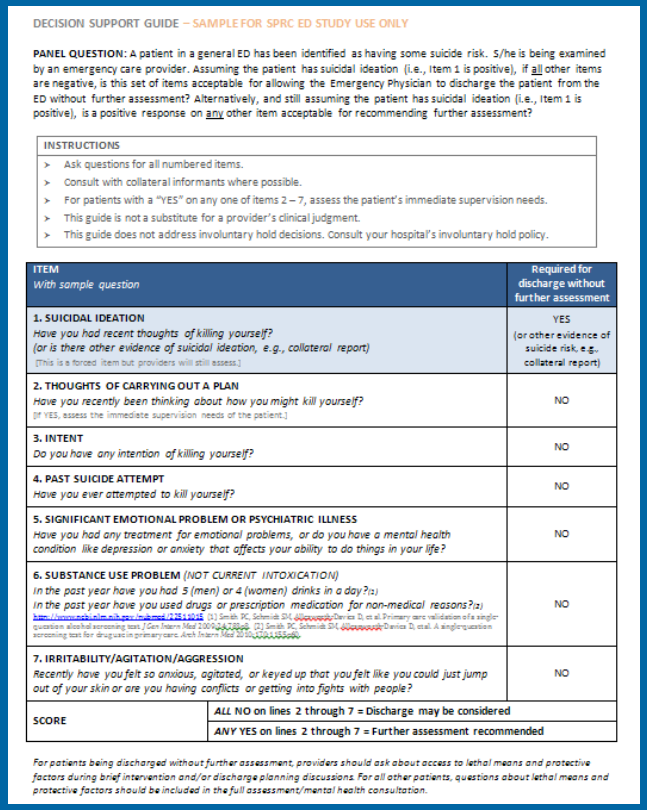
Study handouts

Decision Support Guide



DECISION SUPPORT GUIDE – SAMPLE FOR SPRC ED STUDY USE ONLY

PANEL QUESTION: A patient in a general ED has been identified as having some suicide risk. S/he is being examined by an emergency care provider. Assuming the patient has suicidal ideation (i.e., Item 1 is positive), if all other items are negative, is this set of items acceptable for allowing the Emergency Physician to discharge the patient from the ED without further assessment? Alternatively, and still assuming the patient has suicidal ideation (i.e., Item 1 is positive), is a positive response on any other item acceptable for recommending further assessment?

INSTRUCTIONS

- Ask questions for all numbered items.
- Consult with collateral informants where possible.
- For patients with a "YES" on any one of items 2 – 7, assess the patient's immediate supervision needs.
- This guide is not a substitute for a provider's clinical judgment.
- This guide does not address involuntary hold decisions. Consult your hospital's involuntary hold policy.

ITEM *With sample question*	Required for discharge without further assessment
1. SUICIDAL IDEATION *Have you had recent thoughts of killing yourself?* *(or is there other evidence of suicidal ideation, e.g., collateral report)* [This is a forced item but providers will still assess.]	YES (or other evidence of suicide risk, e.g., collateral report)
2. THOUGHTS OF CARRYING OUT A PLAN *Have you recently been thinking about how you might kill yourself?* [If YES, assess the immediate supervision needs of the patient.]	NO
3. INTENT *Do you have any intention of killing yourself?*	NO
4. PAST SUICIDE ATTEMPT *Have you ever attempted to kill yourself?*	NO
5. SIGNIFICANT EMOTIONAL PROBLEM OR PSYCHIATRIC ILLNESS *Have you had any treatment for emotional problems, or do you have a mental health condition like depression or anxiety that affects your ability to do things in your life?*	NO
6. SUBSTANCE USE PROBLEM *(NOT CURRENT INTOXICATION)* *In the past year have you had 5 (men) or 4 (women) drinks in a day?*(2) *In the past year have you used drugs or prescription medication for non-medical reasons?*(2) http://www.ncbi.nlm.nih.gov/pubmed/23110161 (1) Smith PC, Schmidt SM, Allensworth-Davies D, et al. Primary care validation of a single-question alcohol screening test. J Gen Intern Med 2009;24(7):783-8. (2) Smith PC, Schmidt SM, Allensworth-Davies D, et al. A single-question screening test for drug use in primary care. Arch Intern Med 2010;170(13):1155-60.	NO
7. IRRITABILITY/AGITATION/AGGRESSION *Recently have you felt so anxious, agitated, or keyed up that you felt like you could just jump out of your skin or are you having conflicts or getting into fights with people?*	NO
SCORE	***ALL* NO on lines 2 through 7 = Discharge may be considered**
	***ANY* YES on lines 2 through 7 = Further assessment recommended**

For patients being discharged without further assessment, providers should ask about access to lethal means and protective factors during brief intervention and/or discharge planning discussions. For all other patients, questions about lethal means and protective factors should be included in the full assessment/mental health consultation.

Interventions List

ED STUDY INTERVENTION DESCRIPTIONS

Note: This document is a handout for the SPRC ED Consensus Panel study, and is not intended for dissemination outside of this study or as a provider resource. Results from the study will inform the development of a provider resource which will contain restructured information on some or all of the interventions below. The listings under "Examples," "Related publications," and "Selected outcomes" are not exhaustive. If you would like more information about any of these interventions email lcapoccia@edc.org.

1. BRIEF PATIENT EDUCATION

Patient education for suicidal patients involves communication with the patient and informal caregivers (i.e., friends, family), if present and with the patient's consent, to discuss the patient's condition, risk and protective factors (e.g., engagement in outpatient mental health care), signs of worsening condition and how to respond, home care, medication adherence, and expectations for follow-up care. Patient education often happens as part of discharge planning instructions. Written discharge instructions should be seen as a complement to, and not a replacement for, verbal instructions.

Examples

- Continuity of Care for Suicide Prevention: The Role of Emergency Departments (bottom of page 2)
- *After an Attempt* brochure series for patients who attempted suicide, versions for patients and friends/family

Related publications

- Emergency Nurses Association, 2013. Safe Discharge from the Emergency Setting Position Statement
- Knesper, 2011. Continuity of Care for Suicide Prevention and Research
- Szpiro, et al., 2008. Patient Education in the Emergency Department: A Systematic Review of Interventions and Outcomes
- Fleischmann et al., 2008. Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries
- Taylor & Cameron, 2000. Discharge Instructions for Emergency Department Patients: What Should We Provide?

Selected outcomes

- Patient education combined with follow-up contacts resulted in fewer deaths from suicide up to 18 months later (Fleischmann et al., 2008)
- Multiple experimental and quasi-experimental studies have demonstrated statistically significant improvements in learning in intervention groups compared with controls (Szpiro et al., 2008)

2. PATIENT-AMINISTERED SAFETY PLANNING

Patient-administered safety planning is a process in which patients develop a prioritized list of coping strategies and sources of support to use during a suicidal crisis or to prevent a crisis from developing. The plan is brief, in the patient's own words, and easy to read. Topics addressed in most safety plans include warning signs, internal coping strategies, distracting oneself from the crisis, family members or friends who can provide support, professionals and agencies to contact for help, and making the environment safe. Safety plans have traditionally been done using pen and paper, but there are at least two mobile apps for safety planning currently available.

Examples

- Mobile apps: MY3 and Safety Plan
- Self-administered paper version adapted by the ED-SAFE Study from the Veteran Version developed by Barbara Stanley, Greg Brown, and the Department of Veterans Affairs. E-mail lcapoccia@edc.org to request

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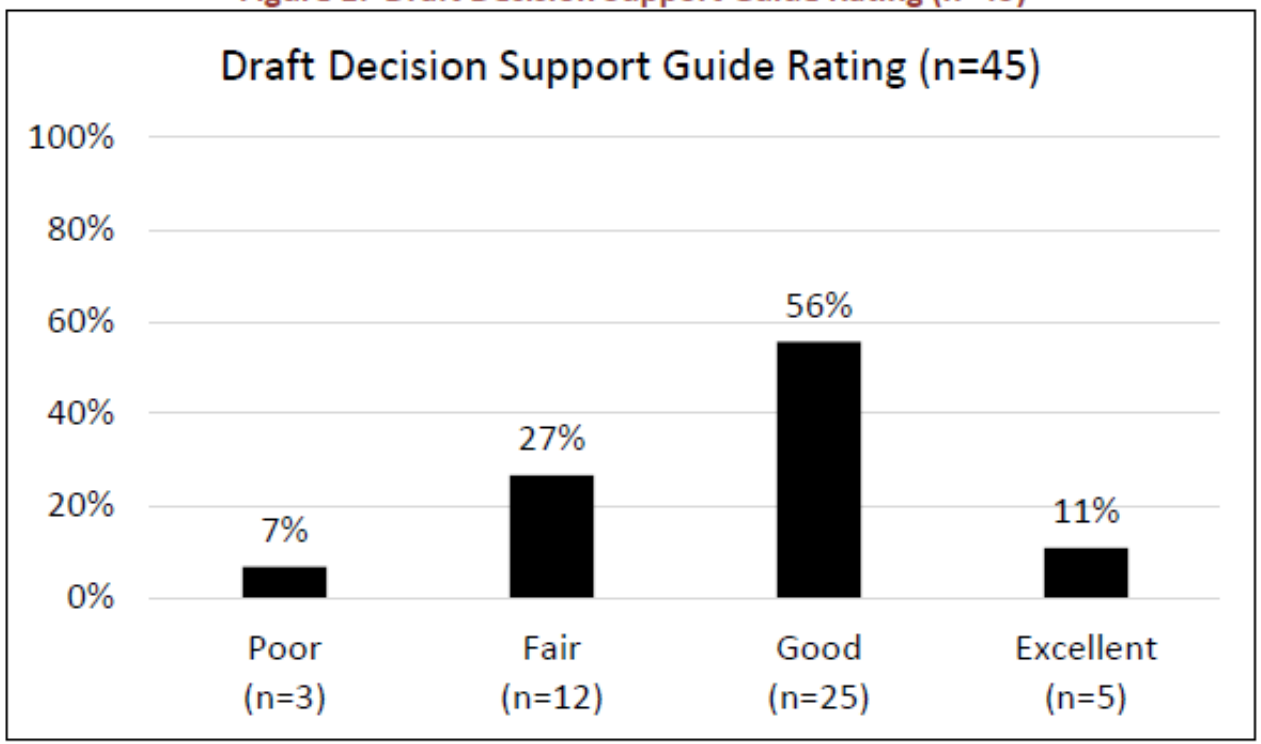
Decision Support Guide Rating

How would you rate this for the purpose of helping ED providers determine which suicidal patients may be appropriate to discharge without further assessment?

67% "good" or "excellent"

Figure 1: Draft Decision Support Guide Rating (n=45)



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Suggested changes

- ✓ Clarify target patient group (not universal screening)
- ✓ Consult other sources: collateral contacts, medical record
- ✓ Improve distinction between current intoxication and substance use disorder
- ✓ Revisit sample question for serious mental illness
- ✓ Placement of lethal means questions and interventions
- ✓ Using the term “recent” for timeframes
- ✓ Simplify scoring
- ✓ Reference risk assessment

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Interventions and Criteria

Interventions / Strategies for ED Settings

1. Brief patient education
2. Patient-administered safety planning
3. Clinician-administered safety planning
4. Lethal means counseling
5. Crisis center helpline information
6. Brief motivational interviewing
7. Telepsychiatry
8. Rapid follow-up/referral
9. Subsequent contact or caring contacts

Rating Criteria

1. Clinically Useful
2. Facilitates Continuity of Care
3. Feasible
4. Patient-Centered

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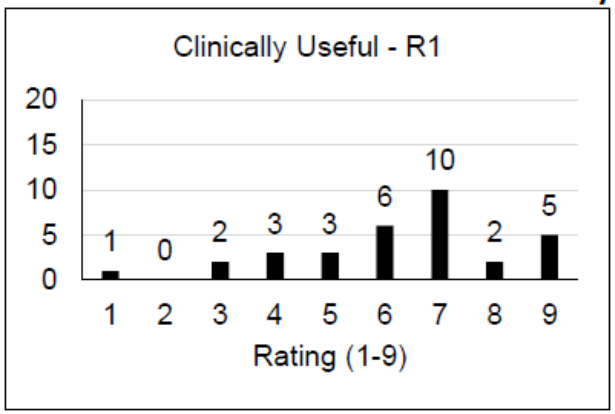
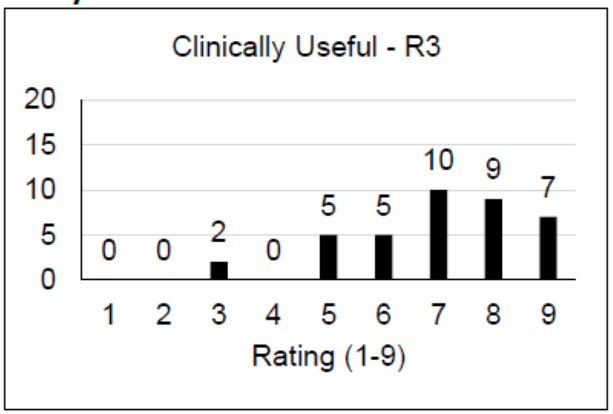
Brief patient education: Clinical usefulness

Brief Patient Education – Intervention #1

How clinically useful is providing brief patient education? The most common rating in Round One was **7** and the most common rating in Round Three was **7**. Overall, **68.4%** of respondents fell within the same band as the most common rating (i.e. 7-9). This indicates that there is ***consensus*** that Brief Patient Education is **Very Clinically Useful**.





During Round One, participants were asked to provide additional comments to clarify their rating. These comments may be helpful for interpreting the ratings for this item.

R1 Rating	R1 Comment
3	Brief education is likely to be adopted only by those who are readily dissuaded.

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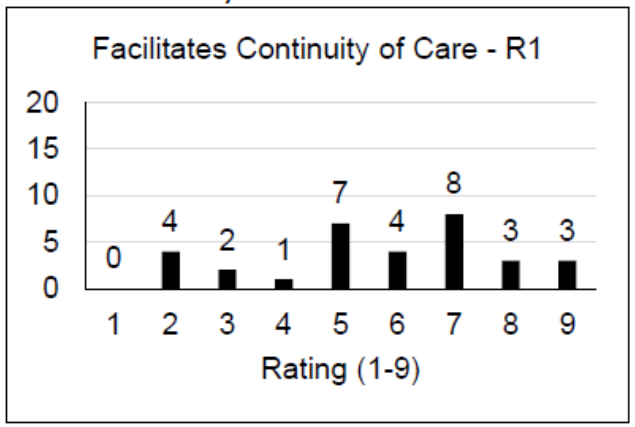
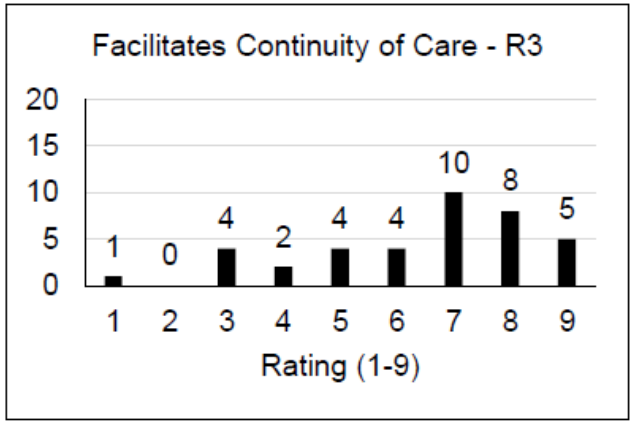
Brief patient education: Facilitates continuity of care

To what degree does providing brief patient education facilitate continuity of care? The most common rating in Round One was **7** and the most common rating in Round Three was **7**. Overall, **60.5%** of respondents fell within the same band as the most common rating (i.e. 7-9). This indicates that there was a ***lack of consensus*** on the extent to which Brief Patient Education facilitates continuity of care.





During Round One, participants were asked to provide additional comments to clarify their rating. These comments may be helpful for interpreting the ratings for this item.

R1 Rating	R1 Comment
2	It is a 2, unless the education expressly transmits benefits of available f/u resources.
2	In our area, either you can reach / leave a message / make an appointment for the outpatient provider or you can't. Educating the family does not create outpatient appointment openings.

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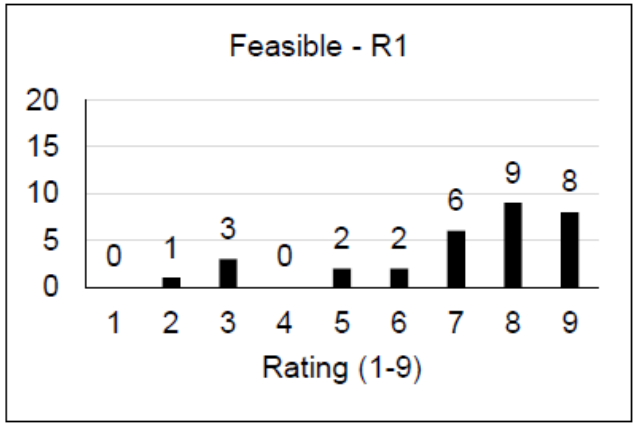
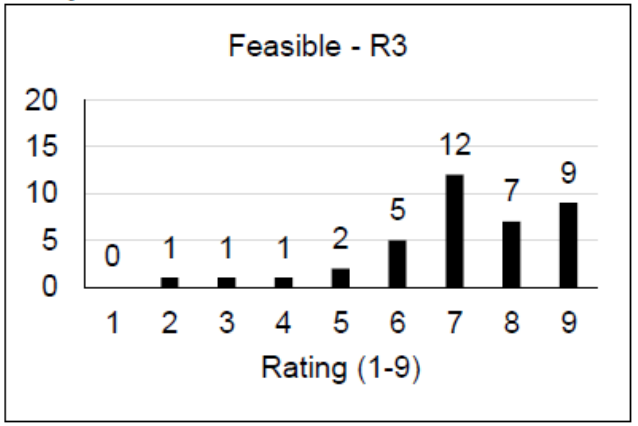
Brief patient education: Feasibility

How feasible is it to provide brief patient education in the ED? The most common rating in Round One was **8** and the most common rating in Round Three was **7**. Overall, **73.7%** of respondents fell within the same band as the most common rating (i.e. 7-9). This indicates that there is ***consensus*** that Brief Patient Education is **Very Feasible**.





During Round One, participants were asked to provide additional comments to clarify their rating. These comments may be helpful for interpreting the ratings for this item.

R1 Rating	R1 Comment
2	It may be feasible by someone, but not by MD/MD extenders/nurses.
3	Most ED's even in very busy and chronically short staffed.
3	Takes time, space, and personnel.

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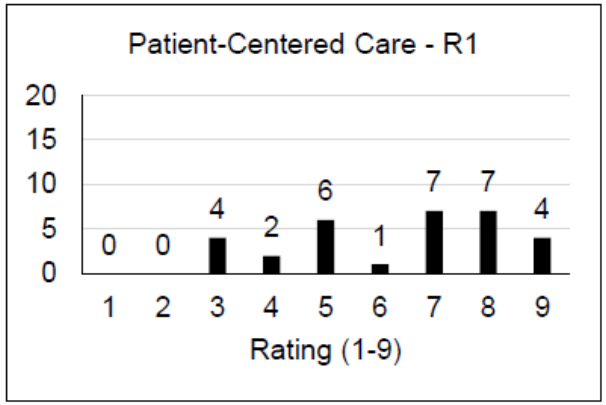
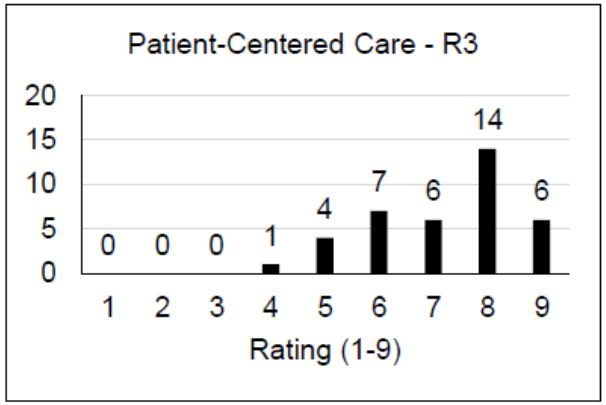
Brief patient education: Patient-centered

To what extent does providing brief patient education address principles of patient-centered care? The most common ratings in Round One were **7 and 8** and the most common rating in Round Three was **8**. Overall, **68.4%** of respondents fell within the same band as the most common rating (i.e. 7-9). This indicates that there is ***consensus*** that Brief Patient Education is **Very Patient Centered**.





During Round One, participants were asked to provide additional comments to clarify their rating. These comments may be helpful for interpreting the ratings for this item.

R1 Rating	R1 Comment
3	It's not actually engaging them in the decision making process. A 1-way street of information. Yet, patients can decide what to use and how often, so they have choice after receiving the information.
3	These are cookie cutter documents, usually. Not focused on the patient as an individual.

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Summary Findings: Areas of Consensus

Table 1: Areas of Expert Consensus

	Clinically Useful	Facilitates Continuity of Care	Feasible	Patient-Centered
Brief patient education	X		X	X
Patient-administered safety planning				X
Clinician-administered safety planning	X	X		
Lethal means counseling	X			
Crisis center helpline information			X	
Brief motivational interviewing	X			X
Telepsychiatry				
Rapid follow-up/referral	X	X		X
Subsequent contact or caring contacts	X	X		X

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Ranking Prioritization Criteria

1. **Clinically Useful**
2. **Feasible**
3. **Facilitates Continuity of Care**
4. **Patient-Centered**

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Summary Findings: By Rank Order

Table 2: Findings by Rank Order

	Clinically Useful	Facilitates Continuity of Care	Feasible	Patient-Centered	RANK SCORE (0-10)
Brief patient education	4	0	3	1	**8**
Patient-administered safety planning	0	0	0	1	**1**
Clinician-administered safety planning	4	2	0	0	**6**
Lethal means counseling	4	0	0	0	**4**
Crisis center helpline information	0	0	3	0	**3**
Brief motivational interviewing	4	0	0	1	**5**
Telepsychiatry	0	0	0	0	**0**
Rapid follow-up/referral	4	2	0	1	**7**
Subsequent contact or caring contacts	4	2	0	1	**7**

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Additional topics examined

- ✓ Patient-Centered Care
- ✓ Documentation
- ✓ Technology Use in EDs
- ✓ Sub-Populations

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Selected Comments: Criteria Rank Ordering

"Some patients will not follow-up or seek subsequent care. Therefore, clinical usefulness is primary – something that works right then and there. After that it's important to facilitate continuity of care since that is the objective – to engage patients in the next level of care."

"The issue will not be solved in a single visit; Arranging continuity of care is the single most important intervention we can provide."

"We work in EDs in a very isolated, rural setting with few providers and few resources. It doesn't matter if it's an evidence based miracle, if the provider isn't able to provide (deliver) the intervention then it's useless."

"What is clinically helpful should take precedence. If something is clinically helpful the environment should figure out how to make it feasible. Many practices that save lives wouldn't be in place if feasibility was the determining criterion."

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Selected Comments: Providing Patient-Centered Care

"Better and more complete explanation to patients about decisions involving involuntary commitment. Attempt to engage patient in decision-making even when they don't initially agree."

" Clear statements/explanations of why staff are doing what they are doing to the patient, e.g., we search everyone for weapons, or anytime we're told someone might be suicidal we keep staff near them."

"Determine patient preference for the type of intervention they wish to receive. Help them develop strategies they can use to manage suicidal feelings on their own. Do all interventions in a collaborative manner."

"Make trained peer advocates and plain-language guides to rights available to all as soon as possible, certainly before detention/commitment."

Next steps

- ✓ Product development
  - Develop drafts
  - External reviews
    - *ED provider/reviewers*
    - *National stakeholder orgs*
  - Webpage development
- ✓ Consensus Study Methodology Report
- ✓ Ongoing dissemination planning

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ED Setting Developments

- ✓ Sub-populations (e.g., older adults, adolescents, chronically suicidal)
- ✓ Balancing practices to promote patient safety and patient dignity
- ✓ Technology – tele-psychiatry, mobile apps, EHRs
- ✓ Peer specialist models
- ✓ Red flags for screening
- ✓ AFSP project

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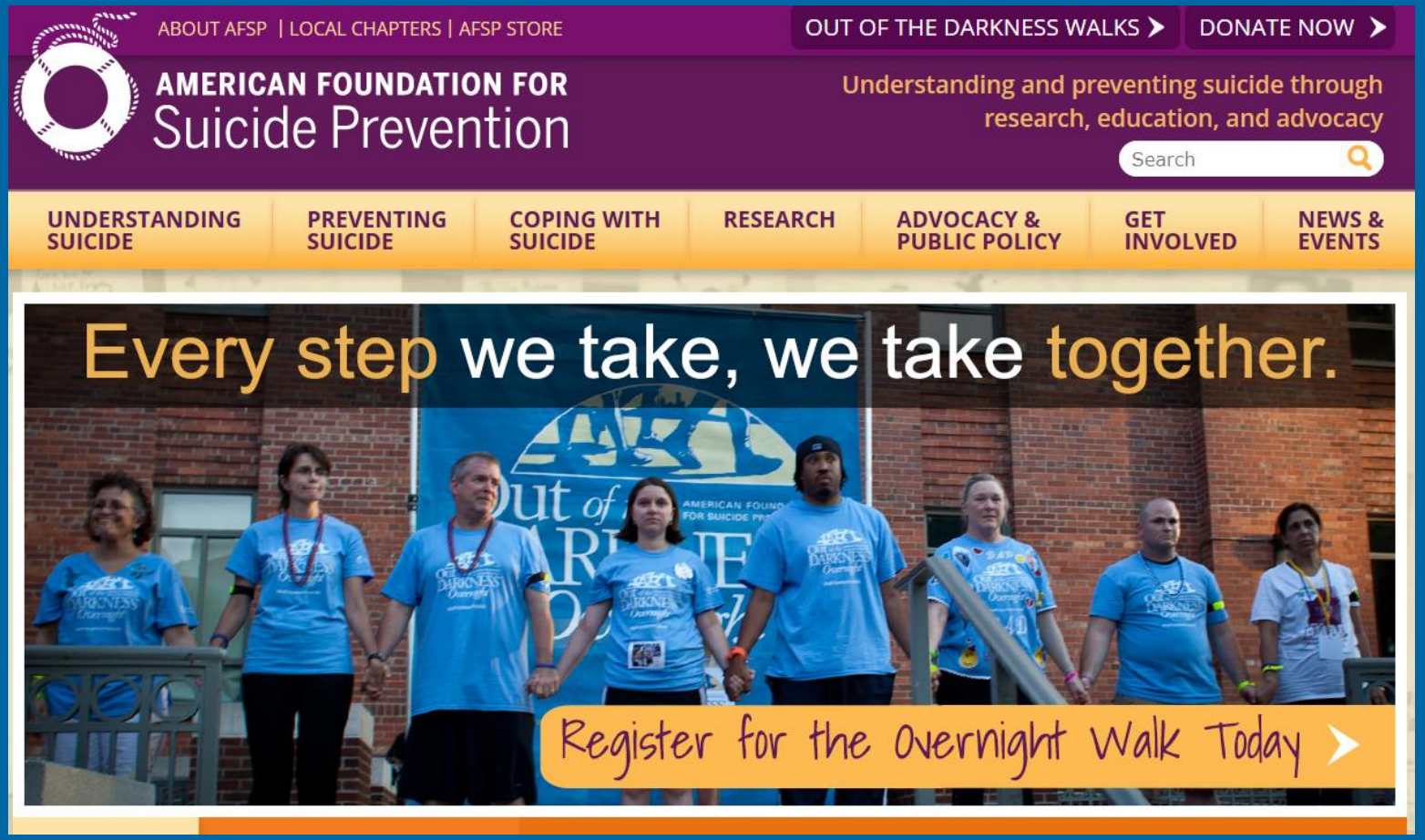
AFSP ED Project Update: Jill Harkavy-Friedman



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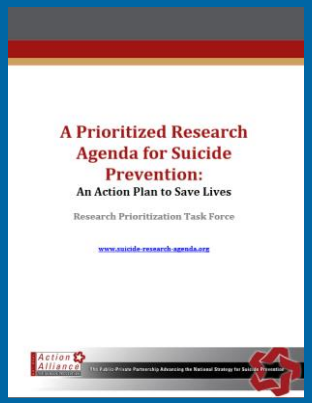
Prioritized Research Agenda for Suicide Prevention



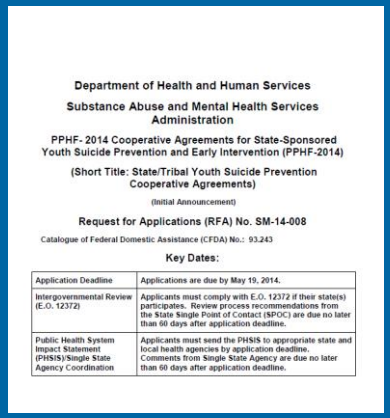
"…effective intervention in EDs could reduce annual suicide deaths by 20%"
-- Trofimovich, 2012

Attempt Survivor Task Force of the Action Alliance

Forthcoming:

"The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience"

SAMHSA State & Tribal Youth Suicide Prevention Grant RFA



Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

PPHF- 2014 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (PPHF-2014)

(Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements)

(Initial Announcement)

Request for Applications (RFA) No. SM-14-008

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Key Dates:

Application Deadline	Applications are due by May 19, 2014.
Intergovernmental Review (E.O. 12372)	Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.

- Improve continuity of care and follow-up of youth identified at risk for suicide discharged from emergency department and inpatient psychiatric units.
- Link specifically with emergency departments and inpatient psychiatric units to ensure continuity of care and follow-up of youth identified at risk for suicide.

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