Working with Emergency Departments: New Tools and Grantee Models
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
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
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

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

Results at 18 Month F/U

<table>
<thead>
<tr>
<th></th>
<th>Died of Any Cause</th>
<th>Died by Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care</td>
<td>2.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>1.0</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Percent of Patients
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 the 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.

---

**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.
Screen:

- Universally or selectively
- Paper/pencil, computer, or by clinician
# Emergency Department

## Evaluation and rapid triage

<table>
<thead>
<tr>
<th>High risk patients</th>
<th>Recommended interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include those who have:</td>
<td>Rapid evaluation by a qualified mental health professional</td>
</tr>
<tr>
<td>• Made a serious or nearly lethal suicide attempt</td>
<td>• One-to-one constant staff observation and/or security</td>
</tr>
<tr>
<td>• Persistent suicide ideation or intermittent ideation with intent and/or planning</td>
<td>• Locked door preventing elopement from assessment area</td>
</tr>
<tr>
<td>• Psychosis, including command hallucinations</td>
<td>• Inpatient admission</td>
</tr>
<tr>
<td>• Other signs of acute risk</td>
<td>• Administer psychotropic medications and/or apply physical restraints as clinically indicated</td>
</tr>
<tr>
<td>• Recent onset of major psychiatric syndromes, especially depression</td>
<td>• Other measures to guard against elopement until evaluation is complete (see below)</td>
</tr>
<tr>
<td>• Been recently discharged from a psychiatric inpatient unit</td>
<td></td>
</tr>
<tr>
<td>• History of acts/threats of aggression or impulsivity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderate risk patients</th>
<th>Interventions to consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include those who have:</td>
<td>Guard against elopement until evaluation is complete (see below)</td>
</tr>
<tr>
<td>• Suicide ideation with some level of suicide intent, but who have taken no action on the plan</td>
<td>Psychiatric/psychological evaluation soon/when sober</td>
</tr>
<tr>
<td>• No other acute risk factors</td>
<td>Use family/friend to monitor in ED if a locked door prevents elopement</td>
</tr>
<tr>
<td>• A confirmed, current and active therapeutic alliance with a mental health professional</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low risk patients</th>
<th>Interventions to consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include those who have:</td>
<td>Allow accompanying family/friend to monitor while waiting</td>
</tr>
<tr>
<td>• Some mild or passive suicide ideation, with no intent or plan</td>
<td>May wait in ED for non-urgent psychiatric/psychological evaluation</td>
</tr>
<tr>
<td>• No history of suicide attempt</td>
<td></td>
</tr>
<tr>
<td>• Available social support</td>
<td></td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Program Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Type</td>
</tr>
<tr>
<td>Treatment</td>
</tr>
<tr>
<td>Target Age</td>
</tr>
<tr>
<td>6-19</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Female &amp; Male</td>
</tr>
</tbody>
</table>
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