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 ED Project: RAND ExpertLens Results

Consensus Panel Review and Discussion Welcome!

Wednesday November 13, 2013

For audio please call **1-866-343-8793**

Be sure to mute the volume on your computer to avoid feedback.

The meeting will begin at 2:00pm

Technical Orientation Slide

- ✓ Technical problems joining the webinar? Please call 617-618-2984 or Adobe Connect 1-800-422-3623.
- ✓ Questions or comments? Type into the chat box on the left hand side of your screen and we will attempt to assist you.
- ✓ You can also make the presentation screen larger at any time by clicking on the “Full Screen” button in the upper right hand corner of the slide presentation. If you click on “Full Screen” again it will return to normal view.
- ✓ This webinar will be recorded.

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SPRC ED Project:
RAND ExpertLens Results
Consensus Panel Review and Discussion

Wednesday November 13, 2013

Welcome

Project Staff:

Zoe Baptista, Med
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Researcher

Social Science Research & Evaluation, Inc.

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SPRC Director of Prevention and Practice

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EDC Research Associate

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Webinar outline

- ✓ Project recap
- ✓ Review results of RAND ExpertLens study
- ✓ Q & A
- ✓ Discussion

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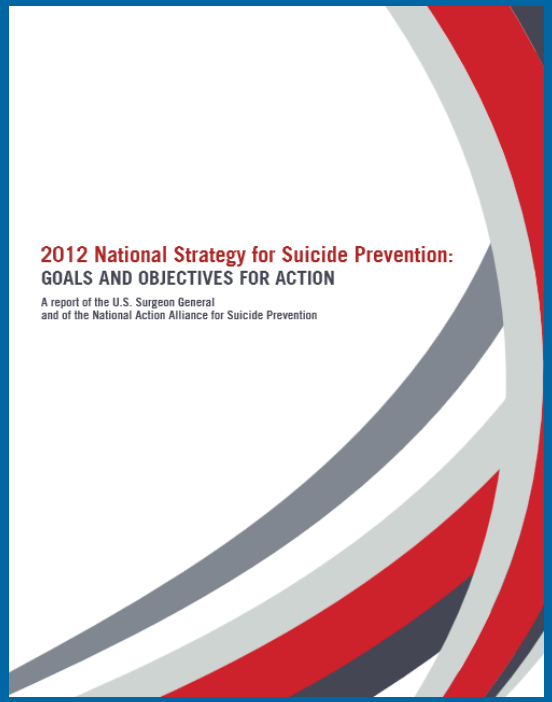
2012 NSSP



Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

EDs are key settings for providing services to persons with high suicide risk, particularly those who have attempted suicide. In 2009, 374,486 people were treated in EDs for self-inflicted injuries.[1]

Standardized protocols should be developed for use within EDs that allow for differentiated responses based on risk profiles and assessed clinical needs (e.g., intoxicated and suicidal, chronically suicidal,

http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

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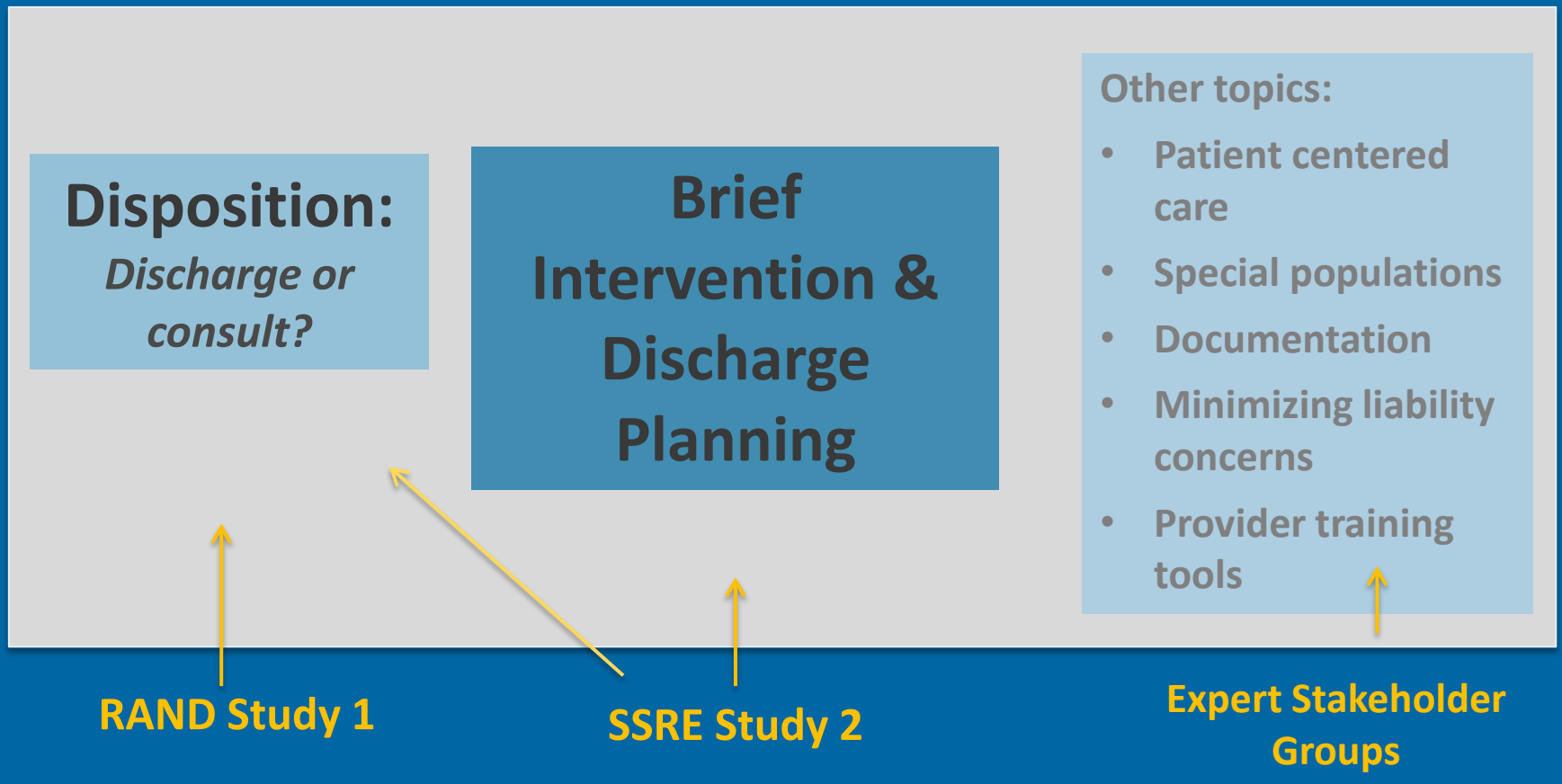
Project recap – end product



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Project recap – current focus

Disposition:
Discharge or consult?

RAND Study 1

Other topics:

- Patient centered care
- Special populations
- Documentation
- Minimizing liability concerns
- Provider training tools

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- ✓ Secondary screening
- ✓ Not risk assessment
- ✓ Not “discharge or admit”
- ✓ For patients with some known suicide risk (SI = Yes)
- ✓ Rule out the need for further assessment
- ✓ All “no’s” = consider discharge without consult
- ✓ Any “yes” = consider MH consult

Disposition:
Discharge or consult?

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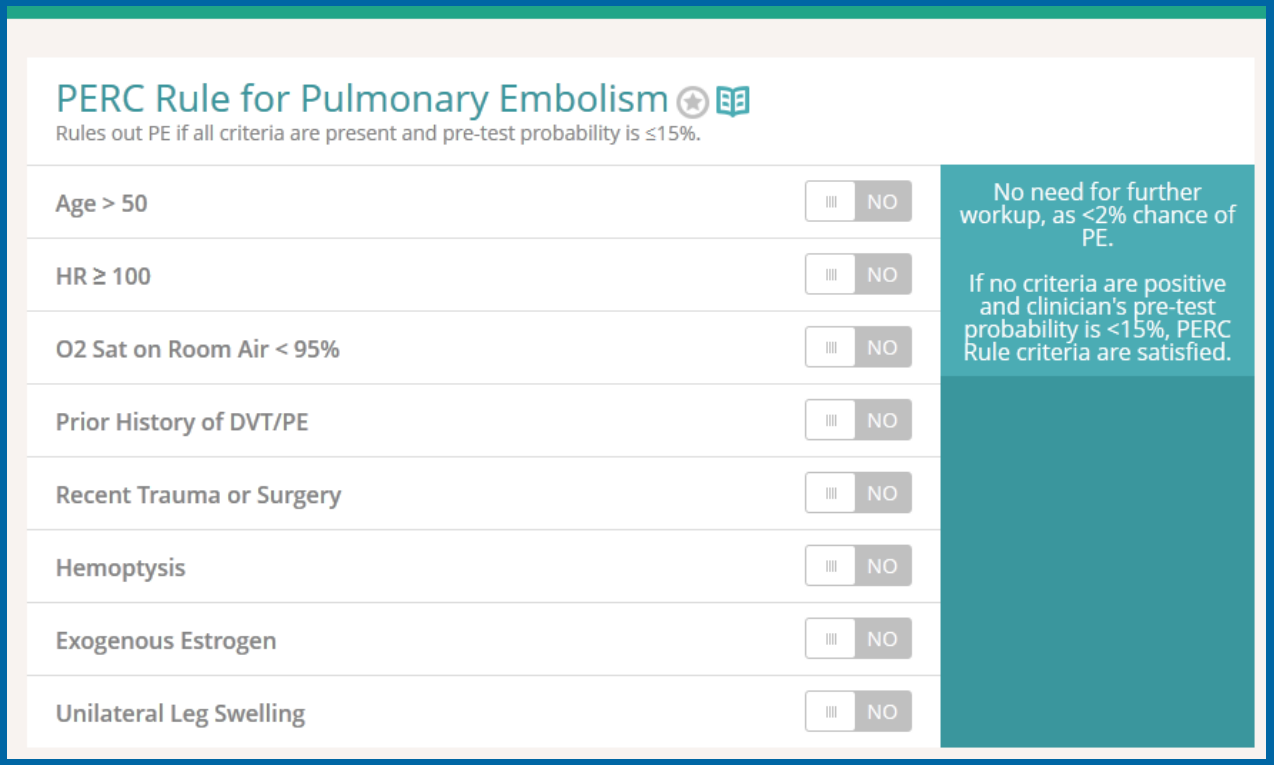
Example:



http://beta.mdcalc.com/perc-rule-for-pulmonary-embolism/

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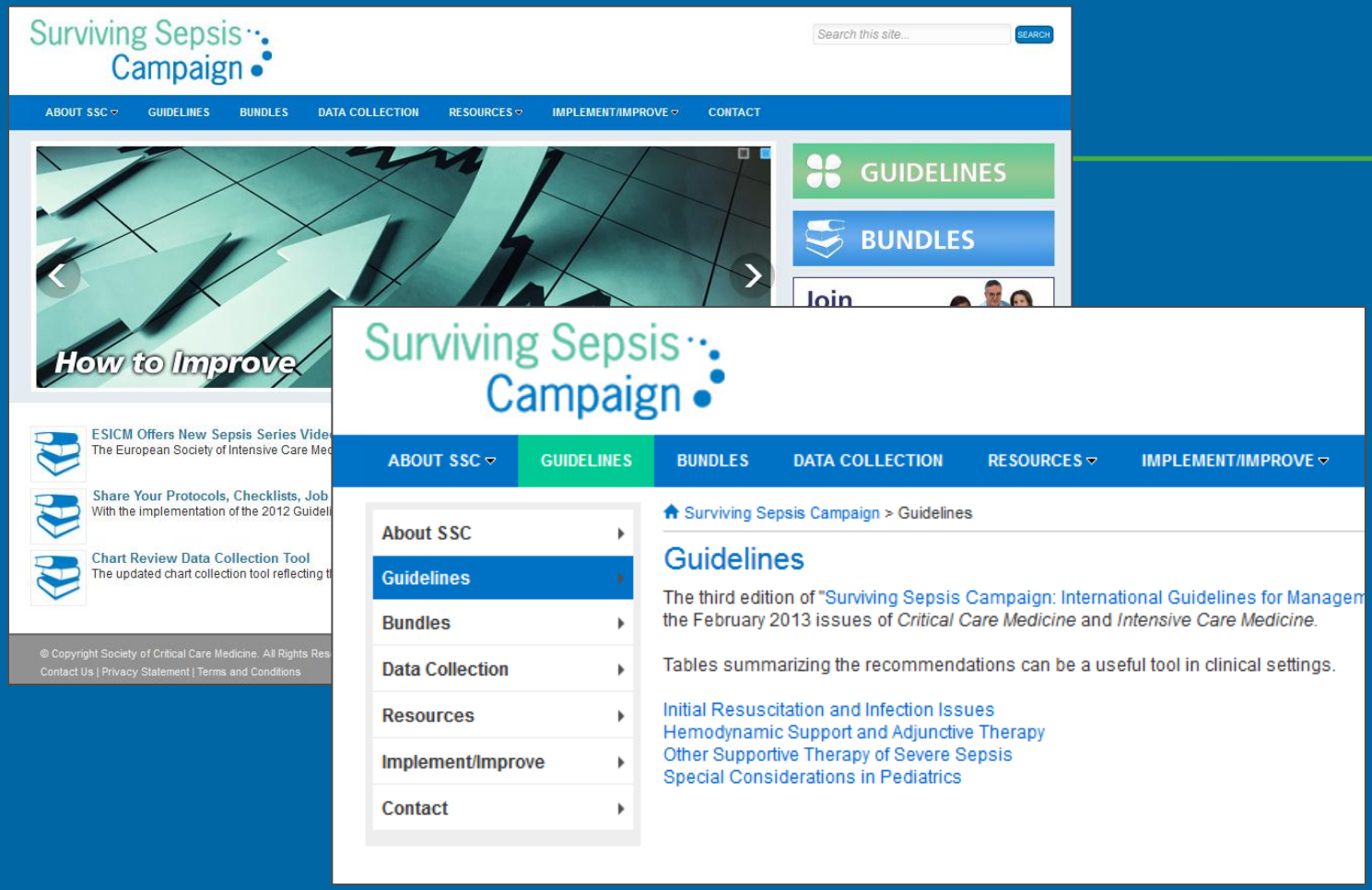

http://www.survivingsepsis.org/Pages/default.aspx

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Scott Formica, MA
Social Science Research and Evaluation, Inc.

- ✓ Methodology
- ✓ Item ratings & subgroup analysis
- ✓ Optimal assessment tool length
- ✓ Rating criteria importance
- ✓ Post completion questions

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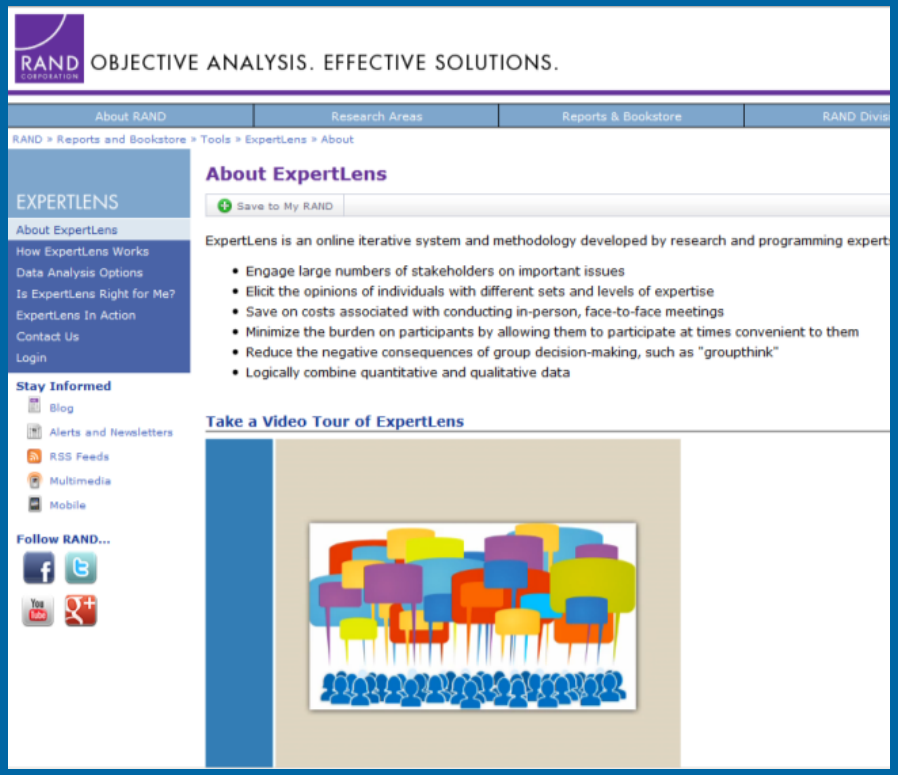
RAND ExpertLens



- ✓ Remote
- ✓ Three rounds
- ✓ Feedback loop & discussion
- ✓ Anonymous
- ✓ Approx. 6 weeks: 7/16/13 – 8/30/13

http://www.rand.org/pubs/tools/expertlens.html

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Participation rates

Participation

Summary | All Participants

Question Answer Rates

Percentage of users that answered questions

	Percentage of Questions Answered			Question Counts
	> 0%	> 50%	> 90%	
Round One Of the Users Invited	72.58% (45 / 62)	66.13% (41 / 62)	58.06% (36 / 62)	Questions: 82
Round Three Of the Users Invited	72.58% (45 / 62)	67.74% (42 / 62)	48.39% (30 / 62)	Questions: 102
Round Three Of Round One Participants	100.00% (45 / 45)	93.33% (42 / 45)	66.67% (30 / 45)	

Discussion Rates

Percentage of users that accessed the discussion

	Logged In	Posted	Post Counts
Round Two Of the Users Invited	67.74% (42 / 62)	50.00% (31 / 62)	Threads: 42 (16 by Moderators) Comments: 205 (57 by Moderators)
Round Two Of Round One Participants	93.33% (42 / 45)	68.89% (31 / 45)	

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Participant affiliation

Affiliation (n=43)	Primary	Secondary
Attorney	1	-
Federal Agency Representative	2	-
Nurse – Non-MH	2	1
Physician – Non-MH	7	1
Policy Expert	1	5
Psychiatric Nurse	1	-
Psychiatrist	10	1
Psychologist	4	3
Clinical Researcher	1	7
Social Worker	1	2
Suicide Attempt Survivor	1	1
Suicide Prevention Professional	4	4
Family Member	-	2
Patient Advocate	1	3
Suicide Loss Survivor	-	1
Missing	7	12

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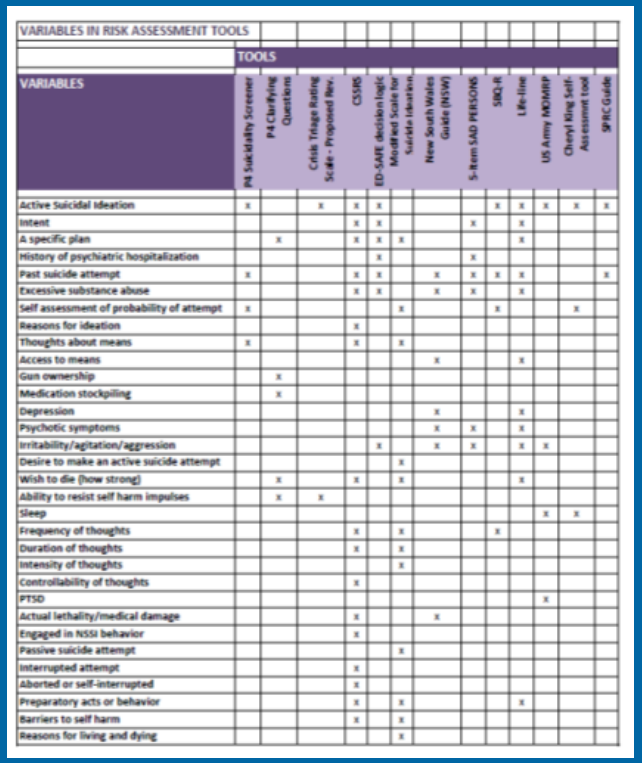
Item selection for study

- ✓ 13 tools
- ✓ 47 items
- ✓ Narrowed down to 13 items
- ✓ Example questions selected from tools used in analysis



VARIABLES IN RISK ASSESSMENT TOOLS												
	TOOLS											
VARIABLES	P4 Suicidality Screener	P4 Clarifying Questions	Crisis Triage Rating Scale - Proposed Rev.	CSSRS	ED-SAFE decision logic	Modified Scale for Suicide Ideation	New South Wales Guide (NSW)	S-Rees SAD PERSONS	SIRQ-R	Life-line	US Army MRMIP	Cheryl King Self-Assessment tool	SPRC Guide
Active Suicidal Ideation	x		x	x	x				x	x	x	x	x
Intent				x	x			x		x			
A specific plan		x		x	x	x				x			
History of psychiatric hospitalization					x			x					
Past suicide attempt	x			x	x		x	x	x	x			x
Excessive substance abuse				x	x		x	x		x			
Self assessment of probability of attempt	x					x			x			x	
Reasons for ideation				x									
Thoughts about means	x			x		x							
Access to means							x			x			
Gun ownership		x											
Medication stockpiling		x											
Depression							x			x			
Psychotic symptoms							x	x		x			
Irritability/agitation/aggression					x		x	x		x	x		
Desire to make an active suicide attempt						x							
Wish to die (how strong)		x		x		x				x			
Ability to resist self harm impulses		x	x										
Sleep												x	x
Frequency of thoughts				x		x			x				
Duration of thoughts				x		x							
Intensity of thoughts						x							
Controllability of thoughts				x									
PTSD											x		
Actual lethality/medical damage				x			x						
Engaged in NSSI behavior				x									
Passive suicide attempt						x							
Interrupted attempt				x									
Aborted or self-interrupted				x									
Preparatory acts or behavior				x		x				x			
Barriers to self harm				x		x							
Reasons for living and dying						x							

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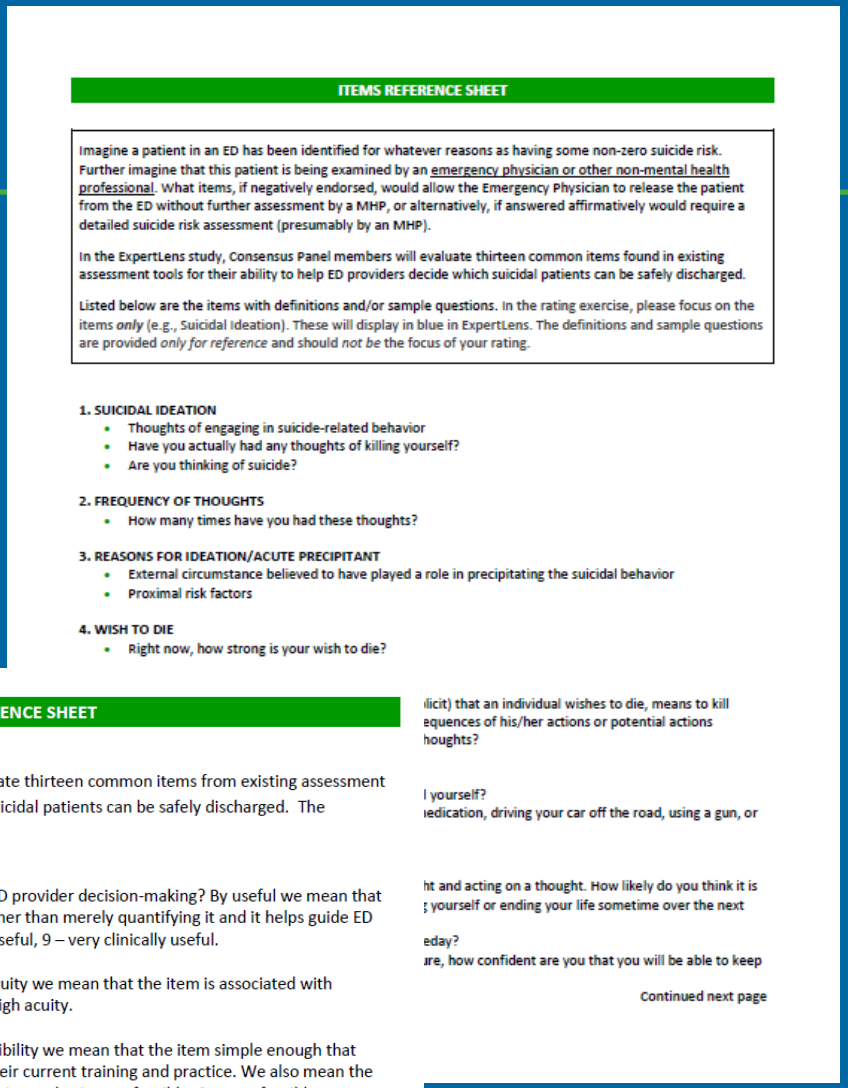
Handouts

- ✓ Criteria definitions
- ✓ Items with sample questions



ITEMS REFERENCE SHEET

Imagine a patient in an ED has been identified for whatever reasons as having some non-zero suicide risk. Further imagine that this patient is being examined by an emergency physician or other non-mental health professional. What items, if negatively endorsed, would allow the Emergency Physician to release the patient from the ED without further assessment by a MHP, or alternatively, if answered affirmatively would require a detailed suicide risk assessment (presumably by an MHP).

In the ExpertLens study, Consensus Panel members will evaluate thirteen common items found in existing assessment tools for their ability to help ED providers decide which suicidal patients can be safely discharged.

Listed below are the items with definitions and/or sample questions. In the rating exercise, please focus on the items ***only*** (e.g., Suicidal Ideation). These will display in blue in ExpertLens. The definitions and sample questions are provided *only for reference* and should *not be* the focus of your rating.

1. SUICIDAL IDEATION
- Thoughts of engaging in suicide-related behavior
- Have you actually had any thoughts of killing yourself?
- Are you thinking of suicide?

2. FREQUENCY OF THOUGHTS
- How many times have you had these thoughts?

3. REASONS FOR IDEATION/ACUTE PRECIPITANT
- External circumstance believed to have played a role in precipitating the suicidal behavior
- Proximal risk factors

4. WISH TO DIE
- Right now, how strong is your wish to die?

CRITERIA REFERENCE SHEET

In the ExpertLens study, Consensus Panel members evaluate thirteen common items from existing assessment tools for their ability to help ED providers decide which suicidal patients can be safely discharged. The evaluation criteria and their definitions are listed below.

1. Clinical Usefulness: How useful is this item in guiding ED provider decision-making? By useful we mean that the item suggests ways to understand and modify risk rather than merely quantifying it and it helps guide ED provider decision-making. Rating scale: 1 – not clinically useful, 9 – very clinically useful.

2. Acuity: What is the degree of acuity of this item? By acuity we mean that the item is associated with imminent or chronic risk. Rating scale: 1 – no acuity, 9 – high acuity.

3. Feasibility: What is the feasibility of this item? By feasibility we mean that the item simple enough that most ED practitioners can ask and interpret it based on their current training and practice. We also mean the item is low-burden and does not disrupt the workflow. Rating scale: 1 – not feasible, 9 – very feasible.

4. Objectivity: What is the objectivity of this item? By objectivity we mean the item has elements that can be observed or gathered from interaction or examination and thereby provide a different type of data than the patient's report. It can also be uniformly and consistently interpreted. Rating scale: 1 – not objective, 9 – very objective.

5. Applicability: How applicable is this item? By applicable we mean the item has relevance to the majority of ED patients who are suicidal rather than only a small subset. Rating scale: 1 – not applicable, 9 – very applicable.

ılicit) that an individual wishes to die, means to kill
equences of his/her actions or potential actions
houghts?

l yourself?
ıedication, driving your car off the road, using a gun, or

ht and acting on a thought. How likely do you think it is
; yourself or ending your life sometime over the next

eday?
ıre, how confident are you that you will be able to keep

Continued next page

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Imagine a patient in an ED has been identified for whatever reasons as having some non-zero suicide risk. Further imagine that this patient is being examined by an emergency physician or other non-mental health professional.

What questions, if answered in the negative, would allow the Emergency Physician to release the patient from the ED without further assessment by a MHP, or alternatively, if answered affirmatively would require a detailed suicide risk assessment (presumably by an MHP).

Item ratings

KEY:	1-3 (low)	4-6 (inconcl.)	7-9 (high)		
	CLINICAL USEFULNESS	ACUITY	FEASIBILITY	OBJECTIVITY	APPLICA-BILITY
Suicidal Ideation *	90%		83%	73%	90%
Frequency of Thoughts			67%	73%	
Reasons for Ideation/Acute Precipitant					76%
Wish to Die	88%	93%	88%		91%
Intent	98%	98%	85%		95%
Thoughts of Carrying Out a Plan	97%	92%	87%	77%	97%
Self-Assessment of Probability of				78%	
Preparatory Behaviors	90%	95%	76%		85%
Gun Ownership	76%		85%		70%
History of Psychiatric Hospitalization			73%		
Past Suicide Attempt, including aborted and interrupted attempt	90%	78%	80%		87%
Substance Use Problem				72%	
Irritability/Agitation/Aggression	71%	76%	71%	68%	68%

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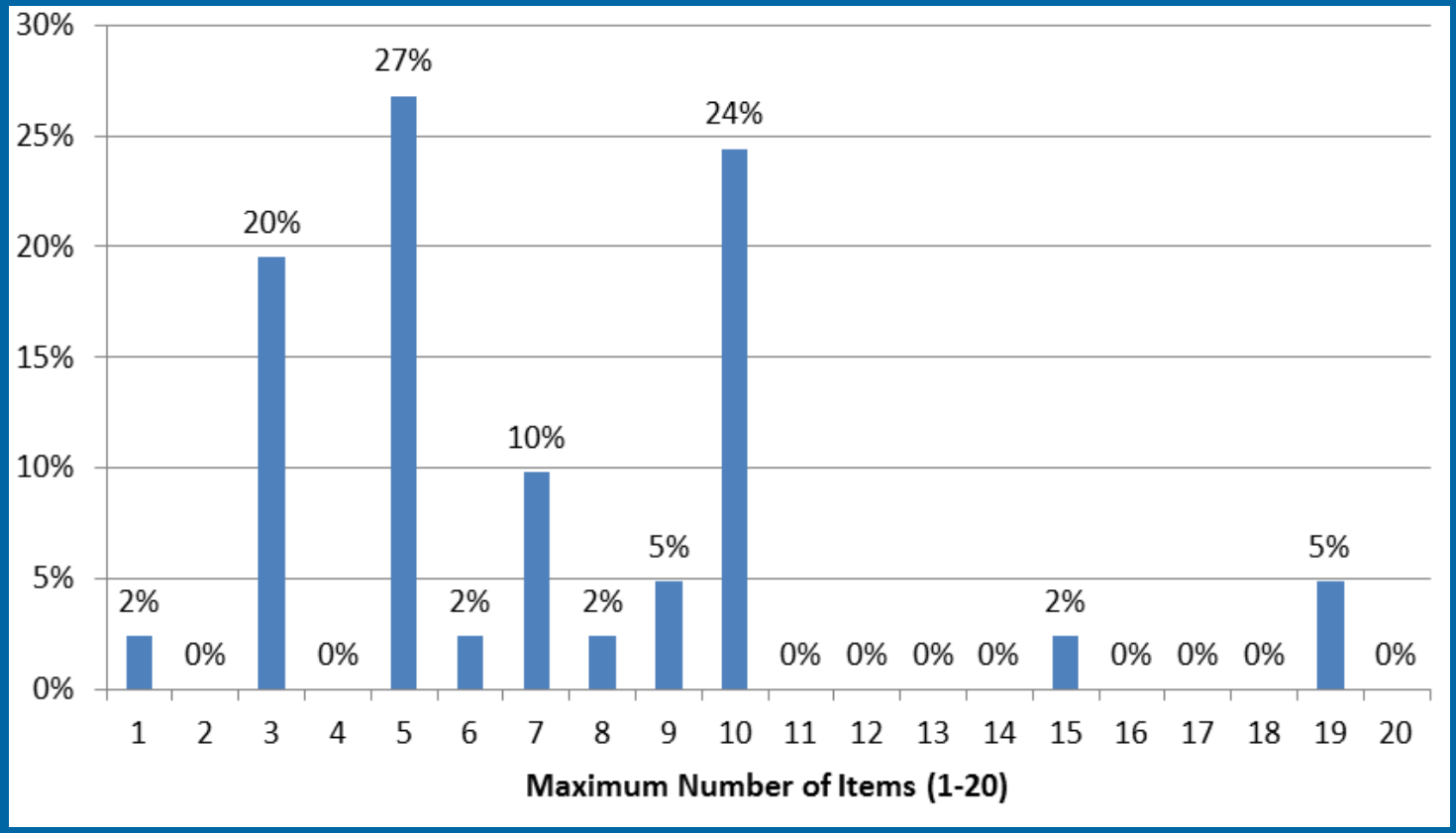
Optimal Assessment Tool Length for ED Setting



N = 41; mean = 7.15; median = 6; mode = 5)

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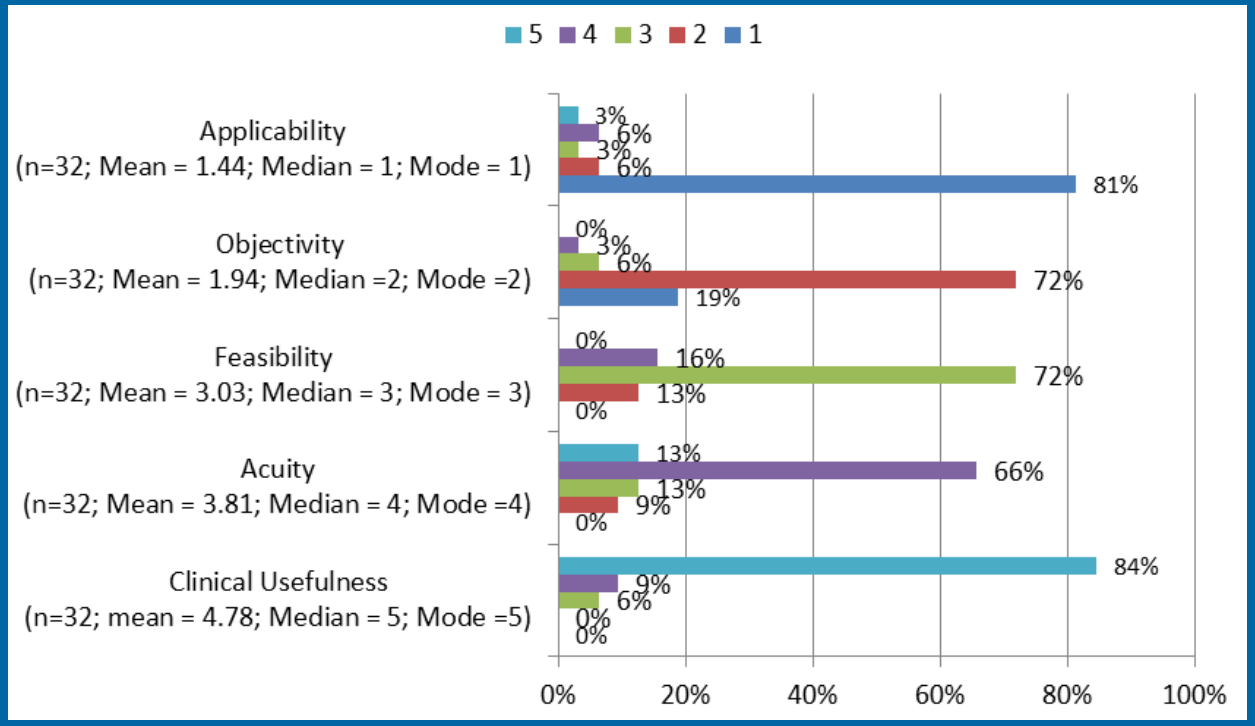
Determining the Importance of Rating Criteria



1. Clinical usefulness
2. Acuity
3. Feasibility
4. Objectivity
5. Applicability

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RAND ExpertLens Post Completion Questions

1 = Strongly disagree; 4 = Neutral; 7 = Strongly agree	Mean (1-7)
A small number of people dominated the discussions	4.17
The discussions gave me a better understanding of the issues	5.12
This study was too long	3.70
I had trouble following the discussions	3.47
I was reluctant to share some of my views during the discussions	2.61
The ExpertLens system was easy to use	5.29
Participants debated each other's viewpoints during the discussions	4.88
Participation in this study was frustrating	3.56
The discussions brought out views I hadn't considered	4.62
Participation in this study took a lot of effort	3.74
The discussions brought out divergent views	5.20
Participants sometimes misinterpreted each other's comments during the discussion	4.23
Participation in this study was interesting	5.35
The discussion round caused me to revise my original answers	4.10
I was comfortable expressing my views in the discussion round	5.46
The right set of questions was asked in this study	3.88
I would like to use ExpertLens in the future	4.43
My expertise/experience is relevant to the topic of this study	6.33
The introductory webinar provided necessary background about the study	5.45
The presentations during the introductory webinar helped increase my understanding of the issue	5.07
The introductory webinar clearly described the project goals, timeline, and participant roles	5.46
The introductory webinar was a good use of my time	5.14

Qualitative results outline

- ✓ Risk assessment goals in ED settings
- ✓ Comments by item (summary)
- ✓ Optimal tool length comments
- ✓ Missing items and comments
- ✓ Round two online discussion

What are the goals of risk assessment in ED settings?

- ✓ In General – Comments emphasized more maintaining safety and less decreasing symptoms.
- ✓ "Determine if risk is sufficiently high to be evaluated by a mental health professional."
- ✓ "The primary goal is to assess for imminent risk – i.e., if the ED personnel do not take some action is there a high likelihood that this individual will take action to harm themselves in the next 24-48 hours?"
- ✓ "To identify the environment in which the patient's non-zero risk can be addressed."

Comments by item (summary)

- ✓ Add timeframes to items
- ✓ Some items are more useful for later-stage treatment or discharge planning
- ✓ Each question adds burden
- ✓ Provider training is needed for some items
- ✓ Suggestions made for wording changes
- ✓ Greater congruence in item-specific comments than in Round Two Discussion

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Comments by item (summary)

- ✓ Some comments assumed full risk assessment would take place
- ✓ Some comments assumed negative SI
- ✓ Tension between predicting imminent risk versus negative prediction
- ✓ Comments illustrated **a great degree of thought and consideration**

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Optimal tool length comments (selection)

"A maximum of five brief validated items that would be feasible to use to screen for suicide risk and if positive would trigger either the need for further consultation or if negative would provide a rationale for very safe discharge with close follow-up and close observation by others."

"More than eight will probably not be adopted."

"The nature may be fast-paced but risk of death is important and needs to be addressed the same as heart attach or stroke."

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Missing items (selection)

- ✓ Available support resources/network, and/or is there someone who will be with the patient after discharge? "What supports keep you safe or are in place for you if you are discharged at this time?“
- ✓ Access to outpatient care: currently receiving mental health treatment, e.g., "Do you have a solid relationship with an outpatient mental health professional? Do you intend to see this person within the next 3 days?"
- ✓ Acute or chronic medical conditions associated with unmanageable pain
- ✓ Reasons for living

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Round Two Online Discussion

- ✓ Anonymous, vibrant, respectful discussion
- ✓ 29 participants (excl. moderators)
- ✓ Detailed commentary on each item
- ✓ Difficult cases (e.g., intoxicated patient denies SI when sober)
- ✓ Distinguishing between voluntary and involuntary patients
- ✓ Questions about the scope of screening (e.g., universal, secondary, full risk assessment)
- ✓ Gaps in data
- ✓ Patient willingness to answer honestly

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Round Two Online Discussion, cont.

- ✓ Liability concerns and discharge patients with positive SI
- ✓ Threshold for tolerating false negatives – is 0% failure our goal?
- ✓ The wording of each question matters
- ✓ Different ED settings with different levels of mental health consult access
- ✓ Stigmatizing language
- ✓ Documentation practices
- ✓ Contingent suicidality – patients with needs the ED can try to meet
- ✓ Provider training needs, skills to ask secondary screen questions

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Questions and discussion

- Clarifying questions about the results
- What surprised you about the results?
- Which results affirmed your view?
- Did you reconsider any views during the study? If so, which?
- Topics raised in the study:
  - Liability concerns
  - Patient centered care
  - Patient willingness to honestly report
  - Tolerating false negatives
  - Secondary screening

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Save the Date

SPRC Emergency Department (ED) Consensus Panel Webinar

Tuesday December 10, from 2:00 – 3:30 PM Eastern Time

(1:00 – 2:30pm CST; 12:00 – 1:30pm MST; 11:00 – 12:30pm PST)

Speakers:

- **Cara Anna**, Journalist, Editor, American Association of Suicidology (AAS) Attempt Survivor Blog and Founder, TalkingAboutSuicide.com
- **Susan Stefan, Esq.**, Visiting Professor, University of Miami School of Law
- **Barbara Stanley, PhD**, Professor of Clinical Psychology, Department of Psychiatry, Columbia University College of Physicians & Surgeons

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The Weekly Spark

November 8, 2013

Read this newsletter on the web

Announcements

ICF International Seeks Evaluation Scientist/Manager
Search for job numbers 1200002548 (NY) and 1200002526 (Atlanta)

For more information

International Survivors of Suicide Day

Every year, survivors of suicide loss gather together in locations around the world to build community, promote healing, and connect with others. This year, International Survivors of Suicide Day is being observed on November 23, 2013.

For more information

Director's Corner

90 Percent

by Jerry Reed

In September I attended the International Association for Suicide Prevention 2013 World Congress in Oslo, Norway. Several of the speakers addressed an issue that I've been thinking about a lot lately: the often quoted statistic that more than 90 percent of suicides are associated with mental illness or a substance use disorder. Read more

Research

Suicide Screening in Emergency Departments

A pilot project on suicide screening found that a substantial proportion of people treated for medical issues in emergency departments (EDs) screened positive for risk factors for suicide. More than three percent of the patients who reported suicidal ideation within the past two weeks had attempted suicide at some point in their lives. The authors cite this finding as "perhaps the strongest argument to date for screening in EDs" since a combination of ideation with a prior attempt is a critical indicator of suicide risk which would have not been discovered if the patients had not been screened. Read more

Thank you!

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