SPRC • Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

SPRC Research to Practice Webinar Q&A with the Panelists
Emergency Departments:
A Key Setting for Suicide Prevention

On June 16, 2015, SPRC hosted a "Research to Practice" webinar entitled, "Emergency Departments: A Key Setting for Suicide Prevention." The panelists generously agreed to respond to selected questions from people who attended the webinar and people who submitted questions on the SPRC Training Institute website. We hope that you find this information helpful in your suicide prevention efforts.

Research to Practice Panelists

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1. **Q: What is occult suicidal ideation?**
   A: Suicide risk that is present but undetected in an emergency department (ED) patient who may be presenting for a medical emergency

2. **Q: What are examples of evidence-based options for brief ED treatment?**
   A: Brief patient education, safety planning, lethal means counseling, rapid referral, and caring contacts. The new ED Guide provides detailed information on these on page eight of the guide: www.sprc.org/ed-guide.

3. **Q: How are ED-provider and primary care provider communications important in the care of suicidal patients? What is the expectation?**
   A: For a patient who has come to the ED with suicide risk, outpatient care providers, family, and friends can provide critical information. Providers should ask for the patient's consent to make such contacts, but HIPAA allows these contacts without consent if the clinician believes the patient is a danger to self or others. For a patient being discharged from the ED, communication to outpatient providers can enhance patient safety and quality of care by facilitating a smooth transition in care. Primary care providers should alert EDs when referring a patient for emergency care and provide relevant clinical information. EDs should transmit information about the patient's ED visit to his or her primary care provider.

4. **Q: Are there examples of ED-crisis center follow-up programs? Are they successful?**
   A: Yes. SAMHSA has funded ED-crisis center follow-up grants and according to an internal report of the National Suicide Prevention Lifeline, several of these grant sites demonstrated positive outcomes (e.g., decreased re-hospitalizations, decreased suicidal ideation, increased safety plan development, increased linkage with outpatient services). An article in Psychiatric Services also demonstrates the return on investment for ED-crisis center follow-up. For more information on return on investment, see: Richardson, J.S., Mark, T.L., McKeon, R. (2014). The Return on Investment for Post-Discharge Follow-Up Calls for Suicidal Ideation or Deliberate Self-Harm. Psychiatric Services. doi: 10.1176/appi.ps.201300196.

5. **Q: Can this information be applied to pediatric patients?**
   A: The new ED Guide was not designed for pediatric patients. However, some of the content is applicable to adolescent patients (e.g., ED-based brief interventions). Younger children are an exception. Through the NIMH-funded study, Emergency Department Screen for Teens at Risk for Suicide (ED-STARS), a brief and personalized screen for adolescents with suicide risk in EDs will be developed. For more information visit the following study descriptions: http://www.nimh.nih.gov/news/science-news/2014/personalized-screen-to-id-suicidal-teens-in-14-ers.shtml and http://projectreporter.nih.gov/project_info_description.cfm?aid=8755416&icde=21651658&ddparam=&ddvalue=&ddsub=&cr=3&csb=default&cs=ASC.

6. **Q: Do you recommend waiting to assess for suicide risk in intoxicated patients? I am frustrated when some physicians initiate involuntary admission while a patient is altered (ETOH).**

   A: The ED Guide recommends waiting to conduct secondary screening or risk assessment until the patient is determined to be clinically sober. Patients who are intoxicated may recant suicide when they are sober. Therefore, the recommendation is to wait unit a non-altered assessment can be performed. See the section: *Suicide Risk Associated with Intoxication and Substance Use Disorders* of the ED Guide, page 22: www.sprc.org/ed-guide.

7. **Q: What are your recommendations for how to make follow-up mental health appointments after hours?**

   A: There are a number of means to make follow up appointments for patients after hours. A handoff process to the next shift to arrange for such appointments would be valuable. The use of electronic scheduling, if available, is one means to obtain an appointment after hours. Some referral sources have walk in clinic hours or open appointments for those recently discharged from acute care settings. It is important to know what resources are available in the community for patient referrals and means to access scheduling for patients after hours. A Community Resource List Template is available in the Appendices of the ED Guide, page 45: www.sprc.org/ed-guide.

8. **Q: Do ED clinicians ask about insomnia when screening for suicide risk? What is the reason it is not on the Decision Support Tool?**

   A: Insomnia was offered as a potential item and did not score well enough to be included. This occurred for several reasons. First, while incredibly sensitive, it is not specific to suicide thoughts and behaviors and hence not very valuable for negative prediction. Second, a major focus of the tool was capability and other items were more useful in that domain. Finally, patients with irritability and agitation may be at higher risk for insomnia so it may have been viewed as redundant given the importance of limiting the number of items for feasibility.

   There is a gap in data which addresses the frequency of various questions used by EDs in a population screened for suicide. ED clinicians likely do not ask about insomnia except in the context of depression screening, and it is not clear how often they do that.

9. **Q: Were suicide attempt survivors included in putting together the guide?**

   A: Yes. For a list of members of the Consensus Panel, visit http://www.sprc.org/sites/sprc.org/files/consensuspanelroster.pdf. Individuals with lived experience also reviewed drafts of the ED Guide, including people who were not members of the Consensus Panel.

10. **Q: What are the legal ramifications if the patient has access to a gun at home but we deem their risk to be low?**

A: Low is not zero. Efforts should be directed at managing whatever the risk level of the patient. Some patients with low imminent risk will have moderate long term risk and means restriction interventions may be appropriate. The guide addresses minimizing legal risk and documentation is critical. See page 26 of the guide, Reducing Liability Concerns: www.sprc.org/ed-guide.

11. **Q: Are Case Managers utilized in any of these screenings or follow up?**

A: ED nurses typically perform screening. Some EDs staff case managers or patient navigators for follow-up.

12. **Q: Who should ask screening questions? The triage nurse or primary nurse?**

A: The purpose of triage is to identify the presenting problem and assign it a priority. In one national study, ED-SAFE, primary nurses were asked to do the screening because experience with domestic violence screening suggests that screening at triage is less reliable. The triage nurse does not usually provide care. If something is identified at triage, it still requires effort by other members of the team which may then be duplicative. The primary nurse is responsible for any discharge plan that involves suicide risk. Therefore, the primary nurse is generally favored for these reasons.

13. **Q: I find that just about all the patients with suicide ideation I see in the ED will score 1 or greater, therefore not very useful.**

A: The Decision Support Tool will be most useful in EDs that conduct universal screening. It may also be useful with patients who present for non-psychiatric reasons and whose risk factors or warning signs (e.g., substance abuse, recent loss) are identified by the primary nurse or physician mid-way through the ED visit.

14. **Q. What do you think about the SAFE-T for risk assessment? Do clinicians need training to use it? How long does it take to conduct?**

A: The SAFE-T is a strong approach for risk assessment. It is more of a guideline than a structured assessment, but it contains the major domains that one should consider when assessing risk. Most clinicians who are mental health professionals probably need minimal training, while others without mental health training may need more training. The length of a risk assessment varies based on the individual patient; there is no objective data on this. For more information visit Appendix C: Primary Screening and Suicide Risk Assessment of the ED Guide, www.sprc.org/ed-guide, p. 38. The Zero Suicide Toolkit (www.zerosuicide.com) also provides information on the SAFE-T, the Columbia Suicide Severity Rating Scale, and other risk assessment resources.

15. **Q: What is your advice for working with an ER nurse manager who is resistant to suicide prevention assessments and interventions (i.e., convincing him or her to adopt these protocols)?**

A: First, it will be important to identify the reason(s) for his or her resistance. The reason(s) could include a lack of knowledge and tools for how to respond to a patient's suicide risk, a lack of understanding about suicide and the belief that a suicidal emergency is secondary to a medical emergency, and/or a lack of support from the hospital leadership. Refer to Appendix I: Examining Your Views About Suicide in the ED Guide, www.sprc.org/ed-guide, p. 49, before talking with the nurse about his or her sources of resistance and discussing ways to overcome barriers. You might consider offering to pilot the new interventions outlined in the ED Guide first before implementing them fully. This can be less threatening and the experiences often are less onerous than the initial expectations. Most resistance revolves around concerns about time and workload, so figuring out how to balance this realistic concern against the need for strong suicide prevention protocols is essential. It is always helpful to have staff consider how well their current policies and practices are working with regard to suicide care or how prepared staff feel to handle those at risk for suicide. A slightly longer visit to do a brief intervention or a stronger link to an outpatient provider may result in reduced readmissions to the ED for patients with suicide ideation and this might be a catalyst for change.