Secondary Suicide Screening in Acute Care Settings

Screening for Suicide Risk Saves Lives!

- **Goal:**
  - Improve front-line clinician proficiency in conducting secondary screening and risk stratification of patients detected as being at non-negligible risk of suicide as part of primary screening.
- **Objectives:**
  - Learn the importance of suicide risk screening.
  - Learn how to use the ED-SAFE Patient Secondary Screening tool (ESS-6), including scoring and stratification.

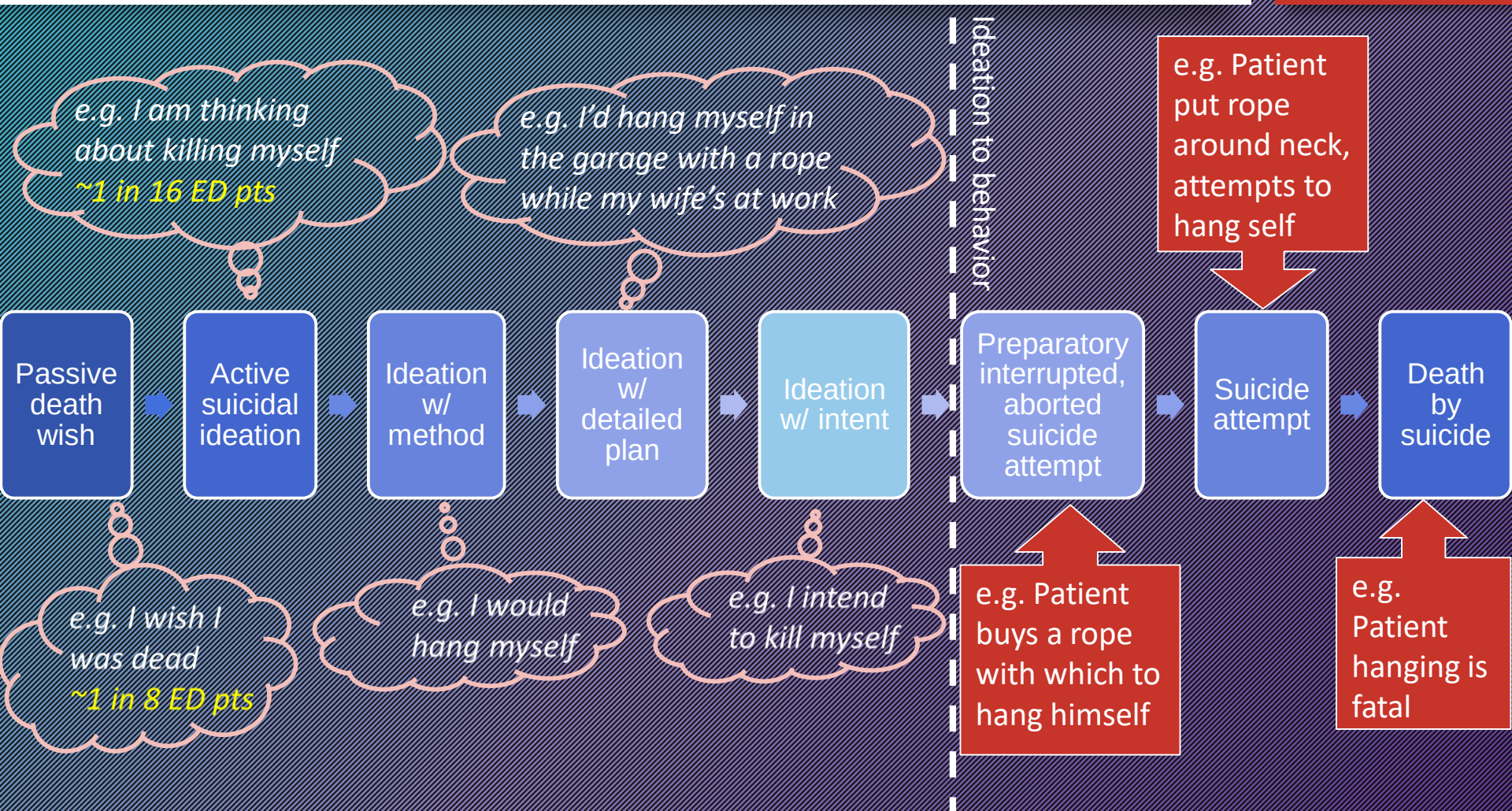
How Do We Prevent Suicide?

- What proportion of healthcare visits before a suicide death are not for mental health?

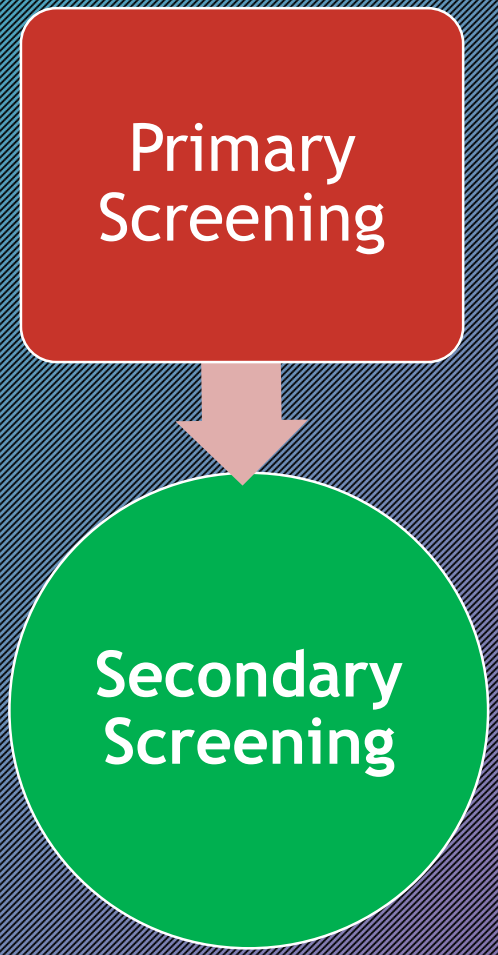
- We need to detect risk before the individual acts!

How? By screening all patients for suicide risk

Continuum of suicide risk

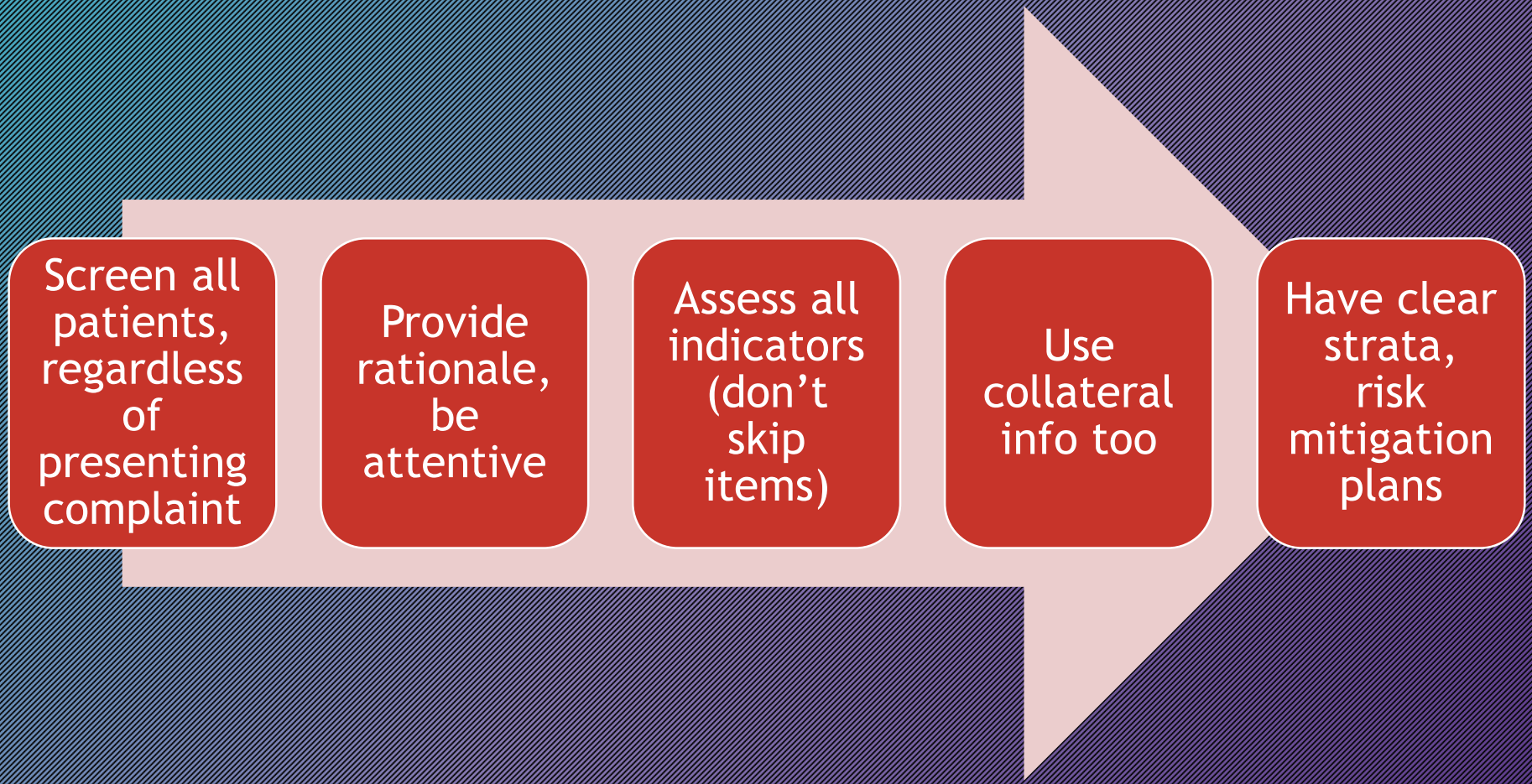


Universal Screening to Detect and Stratify



- Detects if non-negligible risk exists using specific criteria
- Stratifies risk to drive clinical action and risk mitigation

General Tips for Universal Primary and Secondary Screening



Primary Screener Recap: The Patient Safety Screener (PSS-3)

Introductory script: *"Because some topics are hard to bring up, we ask these same questions of everyone."*

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
   ☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

2. Over the past 2 weeks, have you had thoughts of killing yourself?
   ☐ **Yes** ☐ No ☐ Refused ☐ Patient unable to complete

3. Have you ever attempted to kill yourself?
   ☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

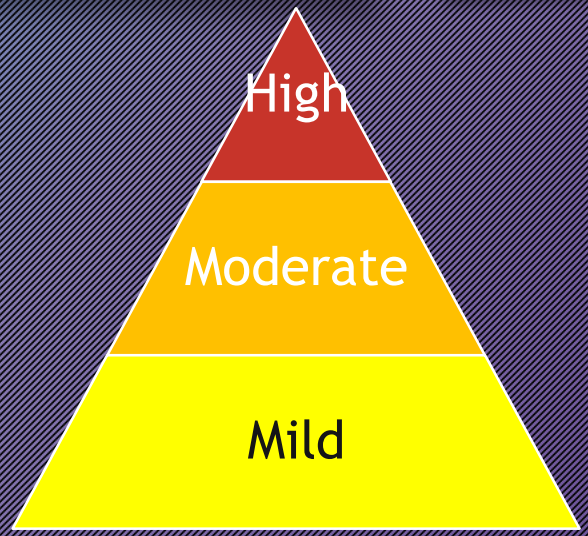
When did this last happen?

- ☐ **Within the past 24 hours (including today)**
- ☐ **Within the last month (but not today)**
- ☐ **Between 1 and 6 months ago**
- ☐ More than a six months ago
- ☐ Refused
- ☐ Patient unable to complete

Yes to Red = Positive Suicide Risk

Secondary Screener

- Purpose = initial risk stratification for clinical decision making and mitigation
- Indicators, not "items"
- Use all data:
  - Self report
  - Collateral (family, EMS/Police)
  - Chart review
  - Observation



ED-SAFE Patient Secondary Screener (ESS-6)

1. Positive on both safety screener (PSS-3) items – active ideation with a past attempt

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

2. Recent or current suicide plan

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

3. Recent or current intent to act on ideation

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

4. Lifetime psychiatric hospitalization

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

5. Pattern of excessive substance use

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

6. Current irritability, agitation, or aggression

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

- Six indicators
- Each "Yes" = 1

Secondary Screener: Indicator 1

Positive on both safety screener (PSS-3) items – active ideation with a past attempt

- Did the patient screen positive on both primary screening (PSS-3) items – active ideation with a past attempt in 6 months?
- Presenting with a current attempt = automatic Yes
- May need to review primary screening results

Secondary Screener: Indicator 2

- Recent or current suicide plan
- Has the individual begun a suicide plan?
- Presenting with current attempt = automatic Yes
- Suggested wording: Have you been thinking about how you might kill yourself?

Secondary Screener: Indicator 3

- Recent or current intent to act on ideation
- Has the individual recently had intent to act on his/her ideation?
- Presenting with current attempt = automatic Yes
- Consider specifying if intent is recent or current
- Suggested wording: Have you had some intention of acting on your thoughts?

Secondary Screener: Indicator 4

- Lifetime psychiatric hospitalization
- Has the patient ever had a psychiatric hospitalization?
- Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?
- Consider hospitalization for either mental health or substance abuse as a psychiatric hospitalization.

Secondary Screener: Indicator 5

- Pattern of excessive substance use

- Does the patient have a pattern of excessive substance use?
- If intoxication is present during visit = automatic Yes
- Suggested wording: Has drinking or drug abuse ever been a problem for you?
- Or administer CAGE or other standardized substance use screener or substance use problem

Secondary Screener: Indicator 6

- Current irritability, agitation, or aggression
- Is the patient irritable, agitated, or aggressive?
- Source: Primarily observations, collateral information, medical records review
- Suggested wording: Are you having thoughts of hurting other people?

Instructions for Use

- **Step 1** = Add the indicators (each "Yes"=1)

✓*Score = Sum*

(Range: 0 to 6)

- **Step 2** = Critical item review

Attempt?
Plan? Intent?

✓*Note critical items*

- **Step 3** = Check strata level for score and critical items

✓*Stratum = Highest level checked*

Stratification

Negligible	Mild	Moderate	High
No score (primary screener was negative)	▫ Score: 0 – 2	▫ Score: 3 – 4	▫ Score: 5 – 6
▫ No current attempt	▫ No current attempt	▫ No current attempt	▫ Current attempt
▫ Not applicable	▫ No intent or plan	▫ Intent or plan (not both)	▫ Intent and plan

Strata = Highest level checked

Consider other factors that may affect patient safety, such as altered mental status, intoxication, and legal hold status

Stratification Example 1

Mild	Moderate	High
▫ Score: 0 – 2	☑ Score: 3-4	▫ Score: 5 – 6
▫ No current attempt	☑ No current attempt	▫ Current attempt
▫ No intent or plan	▫ Intent or plan (not both)	☑ Intent and plan

- This patient is in the High risk group because he had suicidal intent and had begun a plan.
- Highest level for any of the criteria = stratum

Stratification Example 2

Mild	Moderate	High
☑ Score: 0 – 2	▫ Score: 3-4	▫ Score: 5 – 6
☑ No current attempt	▫ No current attempt	▫ Current attempt
☑ No intent or plan	▫ Intent or plan (not both)	▫ Intent and plan

- This patient is in the Moderate risk group because she obtained a low score and had no attempt, intent or plan, but was on involuntary behavioral health hold.
- Highest level for any of the criteria = stratum

Mitigation and Recommended Care

Mild	Moderate	High
✓ Constant observation not required	✓ Constant observation (1: several), make room safe recommended	✓ Constant observation (1:1), make room safe or ligature resistant room recommended
✓ Behavioral health evaluation voluntary	✓ Behavioral health evaluation recommended	✓ Behavioral health evaluation recommended
✓ Suicide Prevention and Mental Health discharge resources	✓ Suicide Prevention and Mental Health discharge resources	✓ Suicide Prevention and Mental Health discharge resources
✓ Safety plan recommended at discharge	✓ Safety plan recommended at discharge	✓ Safety plan recommended at discharge

Remember: How Screening is Done is as Important as the Questions Asked

- **Attentive, empathic, non-judging clinician**

- Better disclosure, honest report

Improved detection, lives saved!

Thank you!