



Welcome to SPRC's
Research to Practice Webinar on
Advancing Suicide Prevention Practice in the
Emergency Department Setting

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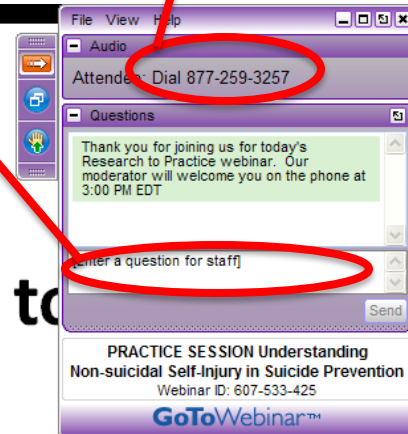
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Today's Speakers



**Glenn W. Currier,
MD, MPH**



**Patricia Alexander,
PhD**



**Denise Foster,
RN, MSN**



**Gary Parker,
PhD, MS, BSN**

Management of Suicidal Patients in Emergency Departments: Recent Innovations in Care

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VA Center of Excellence for Suicide Research

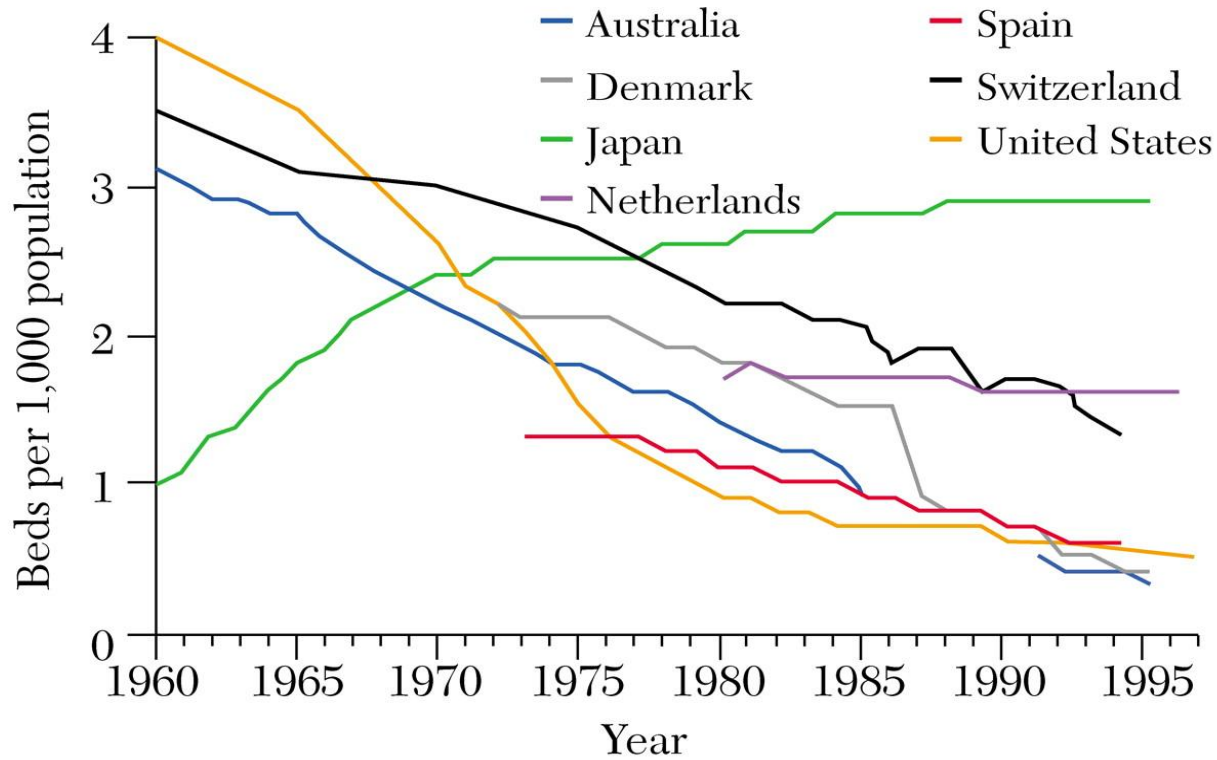
Canandaigua VAMC, Canandaigua, NY

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Disturbing Trends in Mental Health Care Delivery!

Figure 1

Psychiatric inpatient beds per 1,000 population in seven countries, 1960 to 1996¹

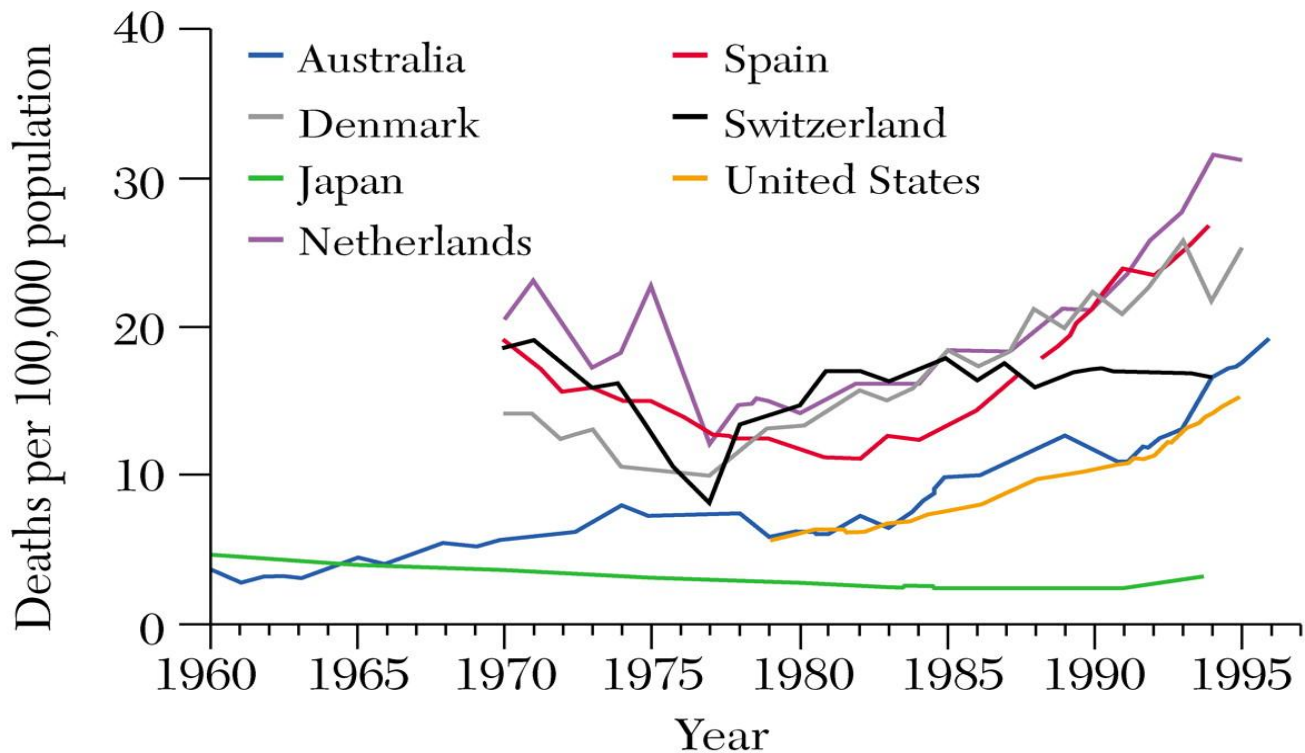


¹ Source: Author's calculations using OECD Health Data 98

How has decreased availability of specialty mental health services played out for patients?

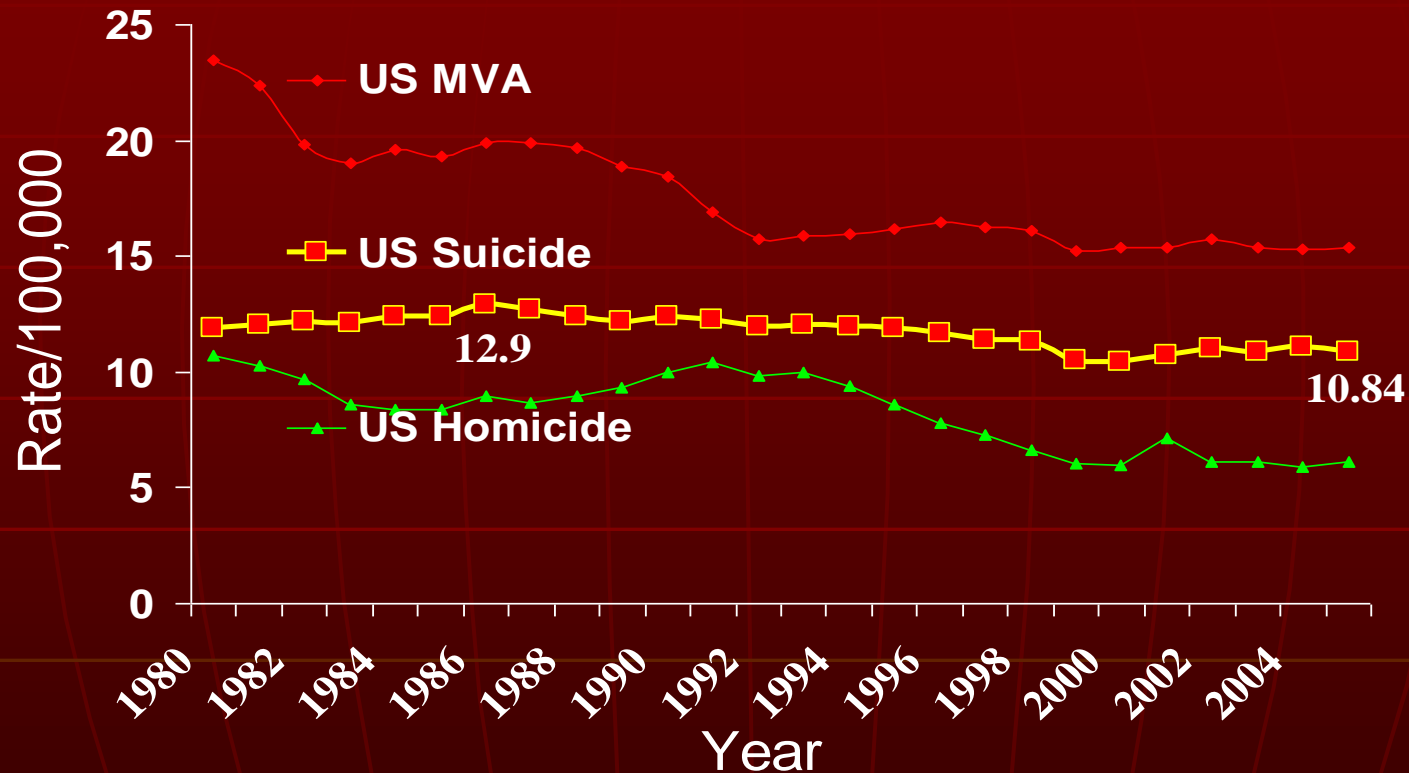
Figure 2

Deaths among persons with mental and substance use disorders per 100,000 population, 1960 to 1996¹



¹ Source: OECD Health Data 98

Suicide: Second or third leading cause of death among young people



Crude rates

http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

“Suicide Epidemic Among Veterans”

A CBS News Investigation Uncovers A Suicide Rate For Veterans Twice That Of Other Americans

NEW YORK, Nov. 13, 2007

“Veterans aged 20 through 24 ... had the highest suicide rate among all veterans, estimated between two and four times higher than civilians the same age. The suicide rate for non-veterans is 8.3 per 100,000, while the rate for veterans was ... between 22.9 and 31.9 per 100,000.”

Based on data from 45 states

How has decreased
availability of specialty
mental health services
played out for
Emergency Medical
Service Providers?

Emergency Department Treatment of Mental Disorders: A Growth Industry

- 100 million ED visits in 2002 [all causes]
- 20% increase in number of visits over prior decade
- 15% decrease in number of ED's over prior decade
- 6.3% of presentations were for MH
- 7% of these were for suicide attempts = 441K visits

Impact on Emergency Services

- Mood Disorders and Substance Abusers are highest service users, highest suicide risk
- Suicidal presentations 2nd most common
- Range of severity is extensive: “3 hots & a cot” to near-lethal attempts
- Most patients are not admitted to the inpatient psychiatric hospital
- Recidivism of discharged patients is common

Suicide Risk in Medical Emergency Care

- Suicidal ideation common in ED patients who present for medical disorders
- Study of 1590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans
- 4 of those 31 attempted suicide within 45 days of ED presentation

Classen & Larkin, 2005

ED GRIDLOCK

Although escalating patient acuity places a large strain on ED resources, the most important cause of ED overcrowding is insufficient inpatient capacity for ED patients who require hospital admission. Psych beds more scarce than general medical/surgical.

Richardson LD, Asplin BR, Lowe RA. Emergency department crowding as a health policy issue: past development, future directions. *Ann Emerg Med.* 2002;**40**:388–393. doi: 10.1067/mem.2002.128012. [[PubMed](#)]

American Hospital Association. Hospital Statistics. 1999.
<http://www.hospitalconnect.com/healthforum/hfstats/downloads.html>

What is the experience
of suicidal patients and
their families who
receive care in
Emergency
Departments?

ED Experience Can Run Counter to Mandate of **Primum Non Nocere**

- More than half of 465 consumers and almost a third of 300 family members felt directly **punished** or **stigmatized** by staff.
- Fewer than 40% of consumers felt that staff listened to them, described the nature of treatments to them, or took their injury seriously.
- Consumers and family members also reported negative experiences involving a perception of **unprofessional staff behavior**, feeling the suicide attempt was not taken seriously, and long wait times.

Emergency Departments as Locus of Care: Why Does Good ED Care Matter?

ED patients who survive suicide attempts are reluctant to engage in follow-up treatment:

- Up to half refuse outpatient treatment at outset
- Up to 60% of attempters do not attend up to 1 week of treatment after ED discharge

(Rudd et al, 1996)

(Jauregui et al, 1999; Piacentini et al, 1995)

Opportunities for improved care of suicidal patients in emergency departments:

- ✓ Improved screening and recognition
- ✓ Improved assessment/ risk stratification
- ✓ Improved provider knowledge and attitudes
- ✓ Improved range of definitive treatment options in ED itself
- ✓ Improved connection after ED discharge
- ✓ Improved aftercare & referral to specialty services

Project 1: A brief educational intervention regarding care of suicidal patients for ED Providers

- ✓Supported by Suicide Prevention Resource Center
- ✓Cooperative effort of the Emergency Research Network in the Empire State (ERNES)
- ✓Providers in four ERNES EDs completed surveys detailing recognition and care of suicidal patients before and after exposure to training materials.
- ✓Providers in one ED served as a comparator group, and completed the pre and post surveys but did not receive the educational materials.
- ✓Pre-post measures of staff attitudes toward suicide and suicide prevention, related practice patterns and perceived skills in suicide assessment.

Project 1:

The intervention consisted of:

- 1) A brightly colored, 11" X 17" poster mounted in the chart room or break room of each ED
- 2) Distribution of an accompanying clinical guide to all ED providers.

The study involved consisted of 3 phases including:

- 1) Completion and collection of baseline surveys (3 weeks)
- 2) Exposure to educational materials (4 weeks)
- 3) Completion and collection of follow-up surveys (3 weeks).

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 that 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.

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

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.**

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57392). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.



Emergency Nurses
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American Association of
Suicidology



American Association for
Emergency Psychiatry



American Foundation for
Suicide Prevention



Suicide Prevention
Resource Center

Suicide Risk: A Guide for ED Evaluation and Triage

Companion resource to the *Is Your Patient Suicidal?* poster.

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** or thoughts of suicide
- ❖ **Seeking lethal means** to kill oneself
- ❖ **Purposeless**—no reason for living
- ❖ **Anxiety or agitation**
- ❖ **Insomnia**
- ❖ **Substance abuse**—excessive or increased
- ❖ **Hopelessness**
- ❖ **Social withdrawal**—from friends/family/society
- ❖ **Anger**—uncontrolled rage/seeking revenge/partner violence
- ❖ **Recklessness**—risky acts/unthinking
- ❖ **Mood changes**—often dramatic

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.
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Ask if you see signs or suspect acute risk—regardless of chief complaint

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6. What are your reasons for wanting to die and your reasons for wanting to live?

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

These questions ease the patient into talking about a very difficult subject.

- Patients who respond “no” to the first question may be “faking good” to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
 - frequency, intensity, and duration of thoughts;
 - the existence of a plan and whether preparatory steps have been taken; and
 - intent (e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

Evaluation and rapid triage

High risk patients

- include those who have:
- Made a serious or nearly lethal suicide attempt
 - Persistent suicide ideation or intermittent ideation with intent and/or planning
 - Psychosis, including command hallucinations
 - Other signs of acute risk
 - Recent onset of major psychiatric syndromes, especially depression
 - Been recently discharged from a psychiatric inpatient unit
 - History of acts/threats of aggression or impulsivity

Recommended interventions:

- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete (*see below*)

Moderate risk patients

- include those who have:
- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
 - No other acute risk factors
 - A confirmed, current and active therapeutic alliance with a mental health professional

Interventions to consider:

- Guard against elopement until evaluation is complete (*see below*)
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend to monitor in ED if a locked door prevents elopement

Low risk patients

- include those who have:
- Some mild or passive suicide ideation, with no intent or plan
 - No history of suicide attempt
 - Available social support

Interventions to consider:

- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation

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

Document:

- Observations
- Mental status
- Level of risk
- Rationale for all judgments and decisions to hospitalize or discharge
- Interventions based on level of risk
- Informed consent and patient's compliance with recommended interventions
- Attempts to contact significant others and current and past caregivers

When patients elope

- Follow policies and procedures specific to retrieving all suicidal patients who have eloped
- Document the timeliness and reasonableness of actions taken
- The following actions may need to be modified to match each situation:
 1. For Involuntary Patients or Patients with High Suicidal Intent:
 - Follow your state's mental health statute dealing with involuntary returns
 - Immediately ask security and law enforcement personnel to return patient
 - Have a policy for authorizing physical restraint matching the risks posed
 - In addition, take steps outlined below (for voluntary patients)
 2. For Most Voluntary Patients with Low Suicidal Intent:
 - Attempt to contact the patient or significant others and request return
 - If an emergency exists, it may be necessary to breach patient confidentiality

**For additional resources
and materials, visit:**
Suicide Prevention Resource Center at
www.sprc.org



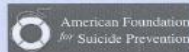
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Project 1: Results

Exposed subjects more readily endorsed:

- ✓ In subjects they're worried about, ED providers "always ask them about risk factors for suicide" (58% to 41%)
- ✓ Providers who were exposed to the poster "always ask directly if [patients they're concerned about] are having suicidal thoughts" (73% to 59%).
- ✓ (51.8%) of intervention site subjects reported they "suspected underlying or concealed suicidal ideation in a patient who presented without a mental health related chief complaint" in the past month, compared to less than one fifth (18.2%) of clinicians in the comparator site ($X^2=9.1$, $p<.003$).
- ✓ A higher proportion of intervention site subjects (74.1%) relative to comparator subjects agreed with the statement "The ED where I work has a very good protocol for managing suicidal patients when they are identified" (52.6%; $X^2=4.0$, $p<.04$).

Project 1: Conclusions

Significant improvements in self-reported practice patterns can be achieved through the simple intervention of hanging a wall poster and distributing a one-page clinical guide to ED clinicians.

Additional Resources: Is Your Patient Suicidal?

Poster:

http://www.sprc.org/library/ER_SuicideRiskPosterVert2.pdf

Suicide Risk: A Guide for ED Evaluation and Triage

<http://www.sprc.org/library/UsingIsYourPatientSuicidal.pdf>

***Project 2:
SAFE VET Demonstration Project
Designed to Enhance Care by:***

Improving the identification of suicidal veterans in VA and Community EDs;

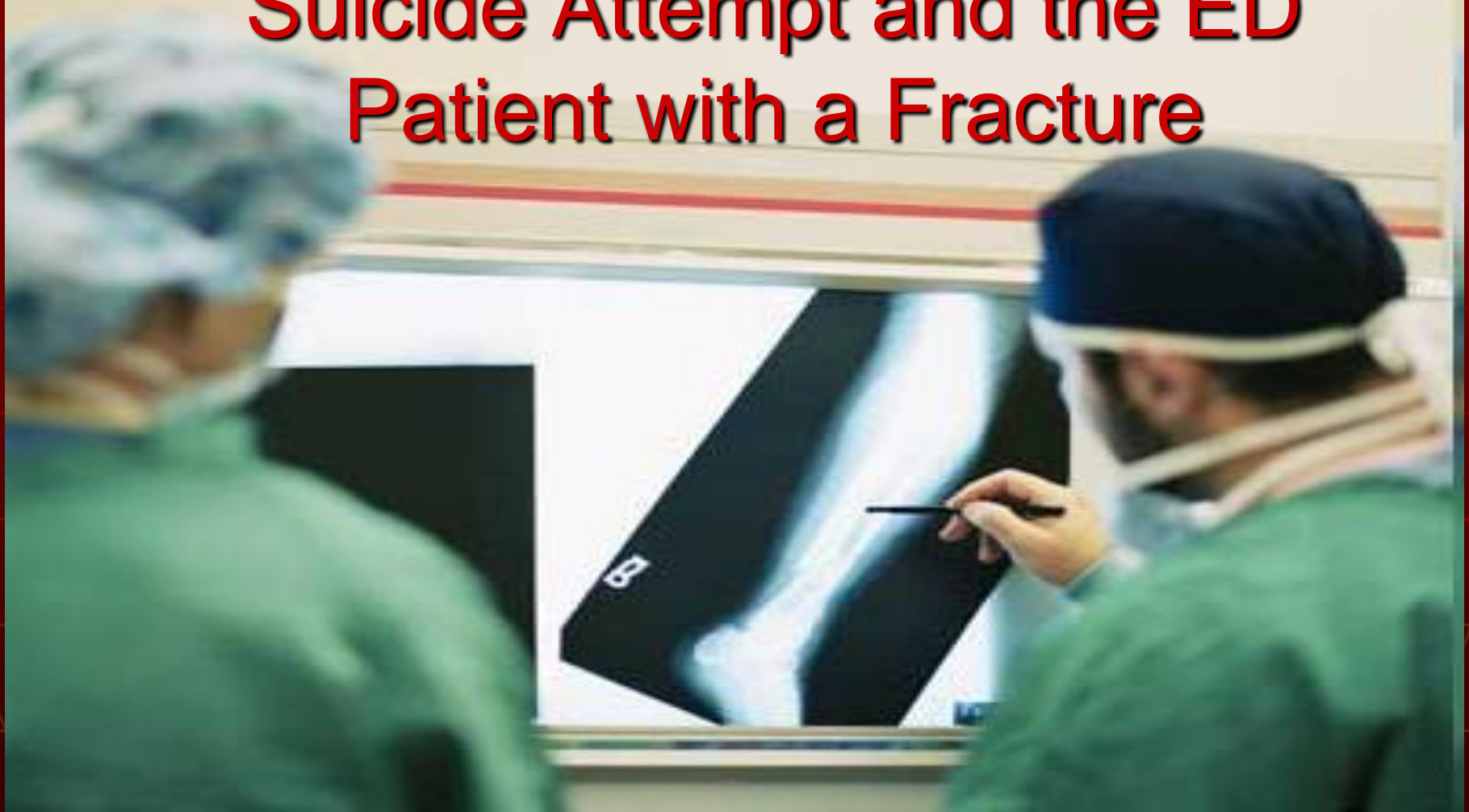
Linking suicidal veterans to appropriate VA services;

Providing a brief ED-based intervention to reduce suicide risk (safety planning) and enhance retention in outpatient treatment.

Ensuring that veterans receive appropriate follow-up care

SAFE VET now being carried out as standard clinical care at 5 VA ED sites across US. More recently added 4 control sites via external research funding.

Contrast the ED Patient with a Suicide Attempt and the ED Patient with a Fracture



ED Patient with apparent fracture

- **Diagnose**----exam and x ray
- **Treat**---Immobilize and Stabilize-
apply a cast- treat pain
- **Refer** for follow-up

Typical Approach to Suicidal Patients in the ED

- Assess imminent danger—conduct a risk assessment
- Triage---hospitalization vs. discharge to community
- If discharged, refer for treatment
- Is this approach acceptable with other problems presented in the ED?
- Where's the "Treat"?

Why don't we have the equivalent of a cast available for suicide risk?



Slide courtesy of Dr. Barbara Stanley

SAFE VET Demonstration Project incorporates aspects of two recent VA- wide initiatives

Stanley & Brown 2008 developed a brief behavioral intervention, Safety Planning Intervention, that incorporates elements of four evidence-based suicide risk reduction strategies: 1) means restriction, 2) teaching brief problem solving and coping skills (including distraction), 3) enhancing social support and identifying emergency contacts, and 4) motivational enhancement.

SAFE VET Demonstration Project incorporates aspects of two recent VA-wide initiatives

- New Position: Acute Services Coordinator
- ED-based but spans episode of care
- Works in conjunction with clinical staff
- Intervention includes operationalized risk assessment and safety planning
- Able to follow discharged patients until successfully linked to outpatient care
- Works in tandem with SPC
- Handles MODERATE risk patients in community

Intervention Steps 1 and 2:

1. Suicide Status Categorical Rating
 - ✓ Rating of current suicide status assigned to each individual
 - ✓ Concise and consistent manner of communicating current suicide status
2. Safety Planning
 - ✓ Several key components designed to help individuals cope with suicidal feelings and urges in order to avert a suicidal crisis
 - ✓ Hierarchically-arranged list of coping strategies identified for use during a suicidal crisis or when suicidal urges emerge over anticipated period between ED discharge and intake at VA

Step 3. Motivational Enhancement & Problem Solving

- ✓ Psychoeducation to address the importance of treatment and to correct any misconceptions regarding treatment
- ✓ Problem-solving to address any anticipated barriers to engaging in treatment
- ✓ Encouragement to attend outpatient therapy
- ✓ Motivational enhancement strategies to help:
 - ✓ Increase motivation to utilize the safety plan as developed
 - ✓ Attend ongoing treatment and next level of care

Follow-Up Protocol:

- Weekly contact for the first two weeks and biweekly contact for the next ten weeks
- Contact by phone, mail or email
- Content consists of:
 - Friendly support
 - Brief risk assessment
 - Safety plan review
 - Problem solving with respect to obstacles to treatment engagement



Safety Planning: A Stand Alone Intervention

Patricia Alexander, Ph. D.
Clinical Research Psychologist
Denver VA Medical Center



Typical Strategy for Crisis Intervention

- Assess suicidal risk (imminent danger).
- Refer for treatment or offer limited number of session to deal with crisis
- Crisis contact may be the only contact the suicidal individual has with the mental health system
- “ No suicide” contract signed

Problems with Typical Strategy

- Individuals may not have a way to manage their own crises
- May not engage in follow-up treatment
- Up to 60% of suicide attempters do not attend more than one week of treatment post-discharge from the ED
- Does not protect the patient or the clinician

(O'Brien et al., 1987; Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995)

Veteran's Administration's Program

Suicide Assessment and Follow Up Engagement: Veteran's Emergency Treatment (SAFE VET)

- Clinical Demonstration Project
- Rolled out: Fall of 2009
- Five VA sites: Denver, Manhattan, Buffalo, Portland, Philadelphia
- Patient's at Moderate Risk for suicide referred for Safety Plan from Urgent Care or ED setting
- Followed by phone until engaged in mental health treatment

Rationale for SAFE VET

- Highest risk period for further suicidal behavior: 3 months following an attempt
- Those at “moderate risk” are often overlooked
- Most people reporting suicidal ideation are discharged from ED, even if at relatively high risk.
- Up to 50 % of attempters and 90% of those with ideation refuse outpatient treatment or are no shows
- Up to 60 % of suicide attempters attend < 1 week of treatment post ED discharge

SAFE VET Safety Planning Goals

- Assist a patient in managing a suicidal crisis in the moment
- Facilitate recognition of available strengths and skills
- Facilitate application of those resources to his or her emotional life
- Provide regular support by phone or in person
- Facilitate engagement in mental health treatment

What Is A Safety Plan?

- NOT a “no suicide” contract
- A prioritized written list of coping strategies and resources for use during a crisis
- Provides increased sense of control
- Brief format in patient’s own words – all on one page
- Involves a collaborative relationship between patient and clinician

A Safety Plan is an Evidence-Based Suicide Risk Reduction Strategy

- Means restriction
- Teaching brief problem solving and coping skills (including distraction)
- Enhancing social support and
- Identifying emergency contacts
- Motivational enhancement
- “Stand Alone” intervention

VA Safety Plan

Step 1: Warning Signs

1. _____
2. _____
3. _____

Step 2: Internal coping strategies. Things I can do to take my mind off my problems without contacting another person

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction

1. _____ Phone: _____
2. _____ Phone: _____
3. Place _____ 4. Place _____

Step 4: People I can ask for help

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

VA Safety Plan

Step 5: Professionals or agencies I can contact during a crisis

1. Clinician Name _____ Phone: _____

Clinician pager or Emergency contact # _____
_____ Phone: _____

2. Clinician Name _____ Phone: _____

Clinician pager or Emergency contact # _____

3. Local Urgent Care Services

Address _____ Phone _____

4. VA Suicide Prevention Resources Coordinator

Name _____ Phone _____

5. VA National Crisis Line Phone: 1-800-273- TALK, Push "1" to reach a VA Mental Health Clinician

Step 6: Making the Environment Safe

1. _____

2. _____



Basics of Safety Planning

Six Steps

- 1. Recognize warning signs and triggers
- 2. Employ internal coping strategies without having to contact another person (distraction)
- 3. Identify People or Social Setting offering support or distraction
- 4. Identify People Whom I Can Ask For Help
- 5. Identify Professionals or Agencies I can contact During a Crisis
- 6. Making the Environment Safe

** In steps 2 thru 6, Address potential barriers or obstacles - “ How likely are you to use these strategies in a time of crisis?”; “what kinds of things would stand in your way of thinking of them or using them?”

Use a collaborative problems solving approach to address the difficulties



Step 1: Recognize the Warning Signs

- A Safety plan is only useful if the patient can recognize the warning signs.
- The clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis.
- Ask “How will you know when the safety plan should be used?”
- Ask, “What do you experience when you start to think about suicide or feel extremely distressed?”
- Or, “How will you know when you need to use your Safety Plan?”
- Write down the warning signs using the patients’ own words.
- Automatic Thoughts: “ I’m a failure”, “no one cares about me”, “ I’m worthless”
- Thinking process: “ I can’t stop the thoughts in my head”
- Mood: “I feel depressed”, “ I feel enraged”

Step 2: Using Internal Coping Strategies

- List activities patient can do without contacting another person
- Activities serve to distract a person from suicidal thoughts and can promote meaning in life
- Coping strategies can prevent suicidal thoughts from escalating
- It's useful for patients to cope with suicidal thoughts on their own, even briefly
- Examples:
 - Go for a walk.
 - Listen to inspirational music.
 - Take a hot shower.
 - Walk the dog.
 - Playing video games.

Step 3: People and Social Setting that Provide Distraction

- List people who can distract you from your feelings and help you feel better about yourself
- Don't have to tell them you're in a crisis
- Places you can go where you're not alone but don't have to interact with others if you don't want to
- Put the phone number on the safety plan

Step 4: Seeking Support

Contacting Family Members or Friends

- “Distractions” haven’t reduced the crisis – now it’s time to reach out for help
- Identify potential barriers to reaching out and problems solve around them
- Ask if safety plan can be shared with family members
- Put the phone numbers on the plan!

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
 - Clinicians
 - Local ED or urgent care services
 - VA Suicide Prevention Coordinator
 - VA National Crisis Line
[800-273-TALK \(8255\)](tel:800-273-8255), press “1” if Veteran
- May need to contact other providers especially if listed on the safety plan

Step 6 : Making the Environment Safe

- Ask patients what means of self-harm they have considered using during a suicidal crisis – help problem solve ways of making it more difficult to access those means
- Always ask whether the patient has access to a firearm
- Discuss medications and how they are stored and managed
- Consider Alcohol and Drugs as a conduit to lethal means

The Big Picture: It's Always About the Relationship

- Bring yourself and your personality into the collaboration
- Listen to and value your “Limbic Tunes”
- Immediately try to find some common ground
- Weave your questions about suicidal thoughts, plans and intentions into a conversation about the person's life
- The most useful information we can glean in our interactions does not come from a checklist – it comes from taking the time to find out who the person is and letting him or her know we're interested
- It doesn't take that much time to make a person feel valued and cared for

It's Always About the Relationship

- Be familiar enough with the Safety Planning steps that you don't have to go through it by rote
- Have a conversation with the patient as you develop the plan
- Recognize strengths and skills and help apply those to the safety plan
- Draw on the patient's history, as he or she is telling it, to support the positive side of the ambivalence

What You Need to Bring to the Relationship

- General “truisms” about suicidal people
 - Most do not want to end their lives, they want an end to their psychological pain and suffering
 - Most tell others that they are thinking about suicide as an option for coping with pain
 - Most have psychological problems, social problems and limiting coping skills – all things mental health professionals are usually well trained to tackle.

Source: Managing Suicidal Risk: A Collaborative Approach
(Jobs, 2006)



What You Need to Bring to the Relationship

- General understanding about suicide risk and crisis
- Degree of Comfort in talking about suicide
- Awareness of the intensity of your own feelings in dealing with suicidal patients
- Show No Fear – be the “alpha” in the room
- Awareness of the role Ambivalence is playing
- Most suicidal patients are searching for options –bring some

Bring Hope to the Relationship

“It is clear that the capacity to think about the future with a sense of hope is absolutely protective against suicide. It follows that a sense of hopefulness within our future thinking and key beliefs help us weather the rough spots help us weather the rough spots that we invariably encounter in life. Alternatively, the absence of hopefulness-particularly in the absolute sense of hopelessness- is an extremely pernicious risk factor for suicide... there is perhaps no single construct that has been more highly correlated with completed suicide than hopelessness”.

(Beck, 1986; Brown, Beck, Steer ,& Grisham, 2000)



Bring Hope to the Relationship

- Learn More about suicide.
- Familiarize yourself with Warning Signs, Risk and Protective Factors but don't limit yourself to checklists or algorithms or assessment measures alone
- Trust your “Limbic Tunes”
- Utilize your clinical training and experience to create options for a suicidal patient
- Talk about suicide openly and directly
- Understand and have compassion for the role suicidal thoughts are playing in the person's life.

patricia.alexander2@va.gov

<http://www.mirecc.va.gov/visn19/>



DEVELOPING A MODEL OF CARE TO REDUCE SUICIDE RISK AND IMPROVE CARE IN THE EMERGENCY DEPARTMENT

Denise Foster, MSN, RN, NE-BC

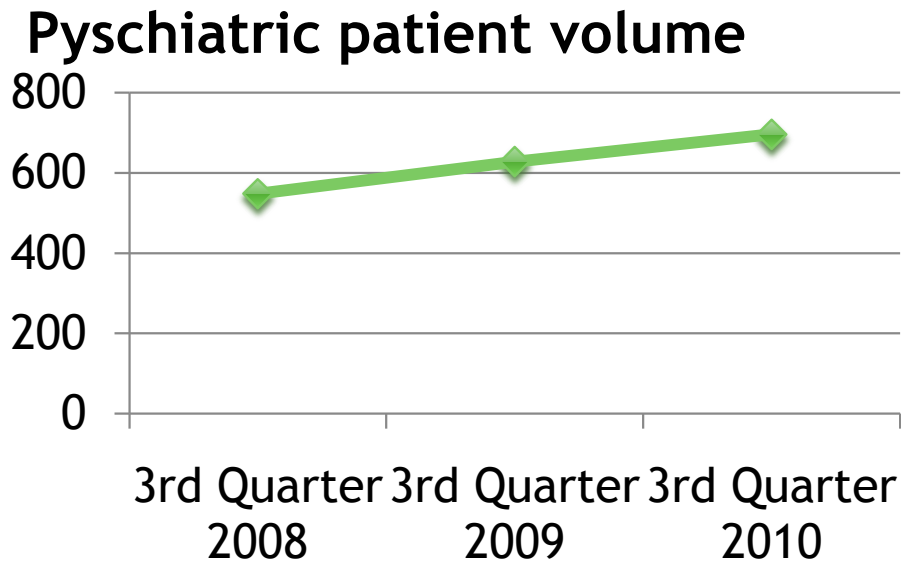


OBJECTIVES

- To develop a model of care for suicidal patients in the ED:
 - Describe essential priorities
 - Define the critical elements necessary for a successful model
 - List key stakeholders

OUR REALITY

- Increasing volumes of patients with psychiatric complaints



OUR REALITY

- ◉ Decreasing community resources
- ◉ Decreasing inpatient psych beds
- ◉ Increasing length of stay in the ED
- ◉ Increased demands on the ED



IDENTIFYING A NEED

Quality care

Staff satisfaction

Collegiality

Professional standards

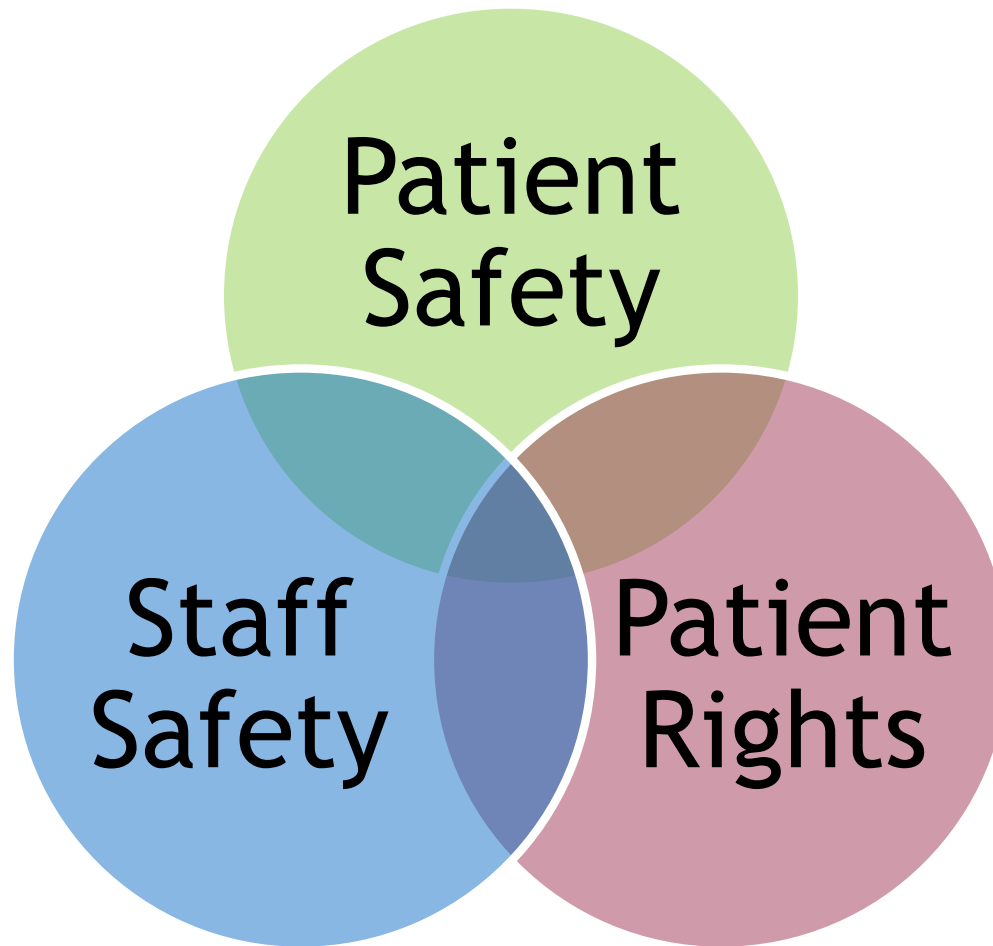
Regulatory

Patient satisfaction

Community reputation

Internal customers

PRIORITIES



CALLING THE HOTLINE: WHEN TO ASK FOR HELP

○ Internal support

- Inpatient psych
- Social work
- Public safety
- Nursing
- Physicians
- Executive

○ External

- Educational materials
- Professional organizations-ENA and APNA
- Consultant

SHARING THE NEED

Setting Goals

- Short term: improve documentation and decrease sitter use
- Long term: improve the quality of care and reduce restraint and seclusion

Threats and Opportunities

- What happens if we do nothing
- What happens if we do something

Assessing strengths and weaknesses

- Knowledge, comfort, environmental, resources

FIRST UNDERSTAND

- ⦿ Education with opportunity for feedback
- ⦿ What do you want to do most?
 - Take better care of our patients
- ⦿ How can we help you get there?
 - Allow us to focus on care
- ⦿ Risk assessment
- ⦿ Nursing care, assessments, medications, documentation.

MONITOR AND REEVALUATE



DOCUMENTATION

- ◉ Updated risk assessment to use the SAD Persons scale.
- ◉ Created a reference binder for documentation standards
- ◉ Chart audit tool revised

STAFFING MODEL

○ Old

- Mixture of patient types
- Medical needs were the focus
- Care often delegated to unlicensed staff
- No standardized plan of care
- Social workers acted as care coordinators

○ New

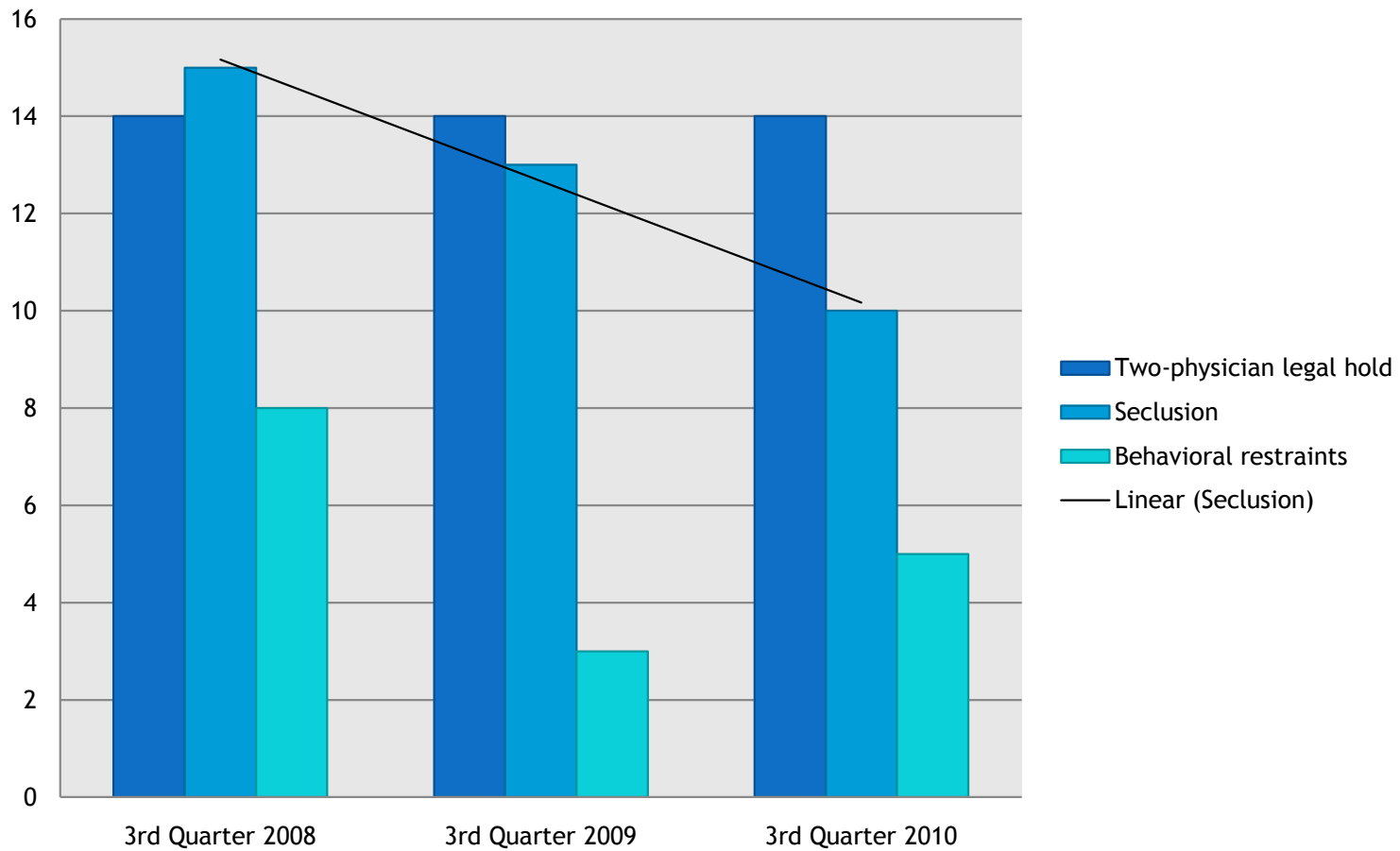
- Nurse assigned to high risk patients
- Focus on psychiatric needs
- Nurses provides majority of care
- Standardized order sets
- Nurse coordinates care

GOOD

	1st Quarter 2010 Mar-May	2nd Quarter 2010 Apr-Jun	3rd Quarter 2010 Jul-Sep	4th Quarter 2010 Oct-Dec
Documentation for Patients in restraint/seclusion Goal \geq 90% compliance	21	75	79	88

BETTER

Restraint-Seclusion Incidence



BEST

⦿ Anecdotally:

- Improved collaboration amongst caregivers and between departments
- Staff feel they are able to provide better care
- Improved patient satisfaction
- Physicians are instituting order sets early in stay

NEXT STEP

- ◉ Creating a healing physical environment
- ◉ Diversion activities
- ◉ Continued education for nursing and physicians
- ◉ Care pathways for suicidal patients



REFERENCES

- ◉ Emergency Nurses Association. (2009, March). Emergency care psychiatric clinical framework.
- ◉ Giordano, R. & Stickler, J. (2008). Improving suicide risk assessment in the emergency department. *Journal of Emergency Nursing*.
- ◉ Lukens, T., Wolf, S., Edlow, J., Shahabuddin, S., Allen, M, Currier, G. & Jagoda. (2005). Clinical Policy: Critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Annals of Emergency Medicine*,47(1), 79-99.
- ◉ Schumacher Group. (2010). Emergency challenges and trends. Survey of Hospital Emergency Department Administrators. Retrieved March 20, 2011 from http://schumachergroup.com/_uploads/news/pdfs/ED%20Challenges%20and%20Trends%2012.14.10.pdf



Suicide Prevention at Mercy Health Center

Gary Parker





Where We Work

Mercy Health Center



How it All Started

- The ER nurse's story
- Changed my life and work



Getting Started

- Collaboration
- Oklahoma Suicide Youth Coalition
- Research



What We Found

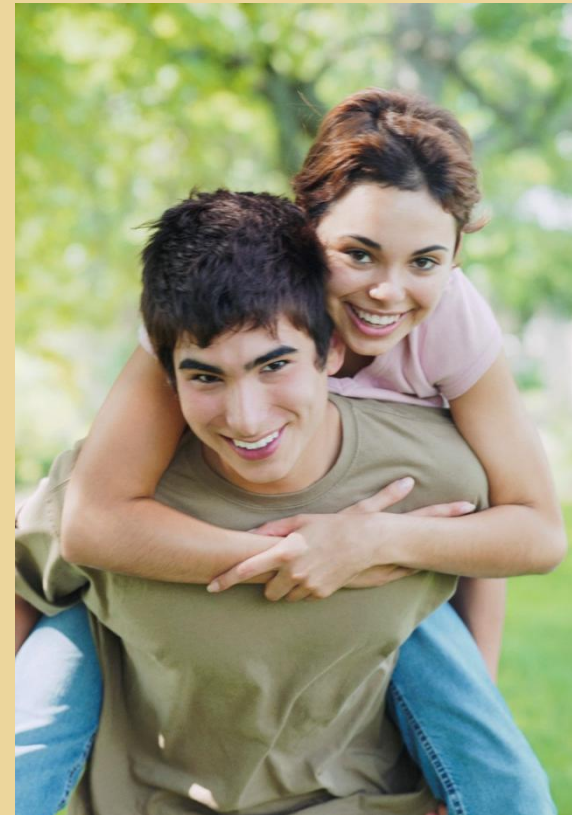
- At-risk adolescents are first seen in ER
- Providers often dismiss warning signs
- Findings served as foundation for our program



Our Approach is Multi-Faceted

Providing Education

- Developed educational program on signs and symptoms of suicide
 - Visited urban and rural facilities
 - Increased suicide awareness
 - Education provided every two weeks
 - Education provided across ministry
- Updated referral sheet





Multifaceted Approach

Screening

- Sought input from providers across ministry
- Found flaws with tools used
- Incorporated evidence-based tools
- Committee review of pediatric screening tools
- Partnered with Teen Screen
- High school screening

Multifaceted Approach

Changing Levels of care

- Mental-health screening of ED patients
- Admissions checklist:
 - Notify security
 - Notify nutrition services
 - Arrange sitter
 - Nurses perform safety checks
 - Notify Housekeeping



Future Directions

- Return for high school assessment
- Adding Tele – Psych
- CALL SAM
- Continuous improvements





Publications

- Parker, G., Fanning, L., Hawkins, J., Reyna, K., Round, T., Weigel, C. (2009). Adolescent suicide prevention: the Oklahoma community reaches out. *The Journal of Continuing Education in Nursing*, 40 (4), 177-180.

Manuscript in preparation:

“Mental Health Check-Ups: Screening Teens in the Community”





Questions?

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