



# Suicide Prevention in Emergency Departments

Richard McKeon Ph.D.

Chief, Suicide Prevention Branch



# Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



# Why are ED's critical to U.S. suicide prevention efforts?

- Many people at high risk are seen in Emergency Departments and many suicide deaths and attempts occur after discharge.
- Post discharge follow up and care transitions are often problematic.
- There is strong evidence that intervention at this time can be life saving.

# TOUGH REALITIES



2005-20011: 51%↑ in emergency department visits for drug related suicide attempts among people 12 and older

South Caroline National Violent Death Reporting System-19% of suicides seen in ED within 60 days

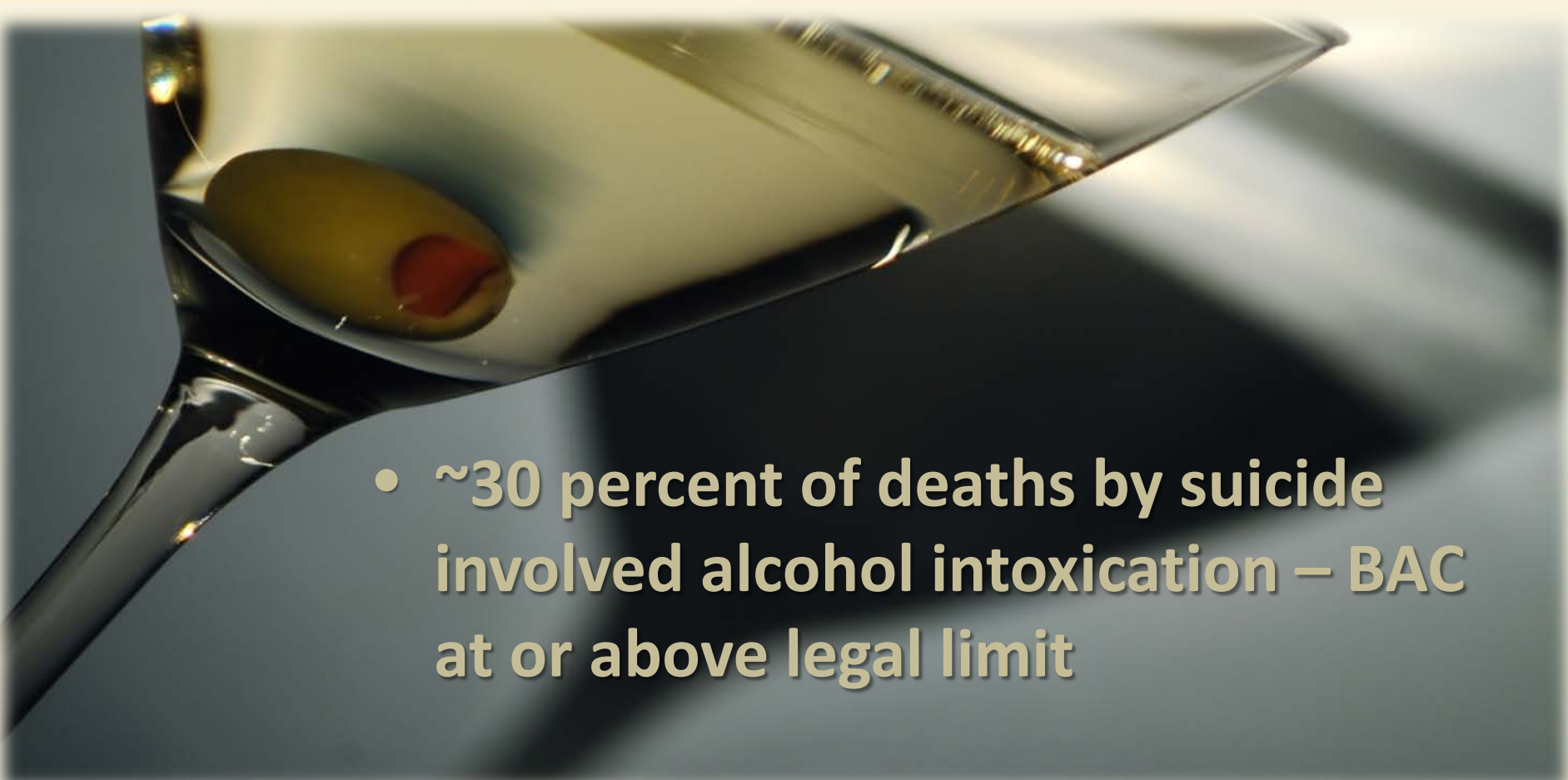
Every year > 650,000 persons receive treatment in emergency rooms following suicide attempts





# TOUGH REALITIES

5

- 
- ~30 percent of deaths by suicide involved alcohol intoxication – BAC at or above legal limit

# MISSED OPPORTUNITIES = LIVES LOST



- The numbers of people being seen in EDs for a suicide attempt has been increasing, while the proportion hospitalized has been decreasing (Larkin, 2008)
- Only 48% of adult Medicaid recipients seen in EDs for a suicide attempt received a mental health evaluation and only 52% received outpatient follow up within 30 days



# MISSED OPPORTUNITIES = LIVES LOST



- For youth age 10-19 who receive Medicaid and were seen in the ED for a suicide attempt, almost 73% were discharged BUT only 39% received a mental health evaluation, and 43% received outpatient treatment within 30 days
- Best predictor of outpatient follow up was recent outpatient mental health treatment

# Mortality Following Serious Suicide Attempt

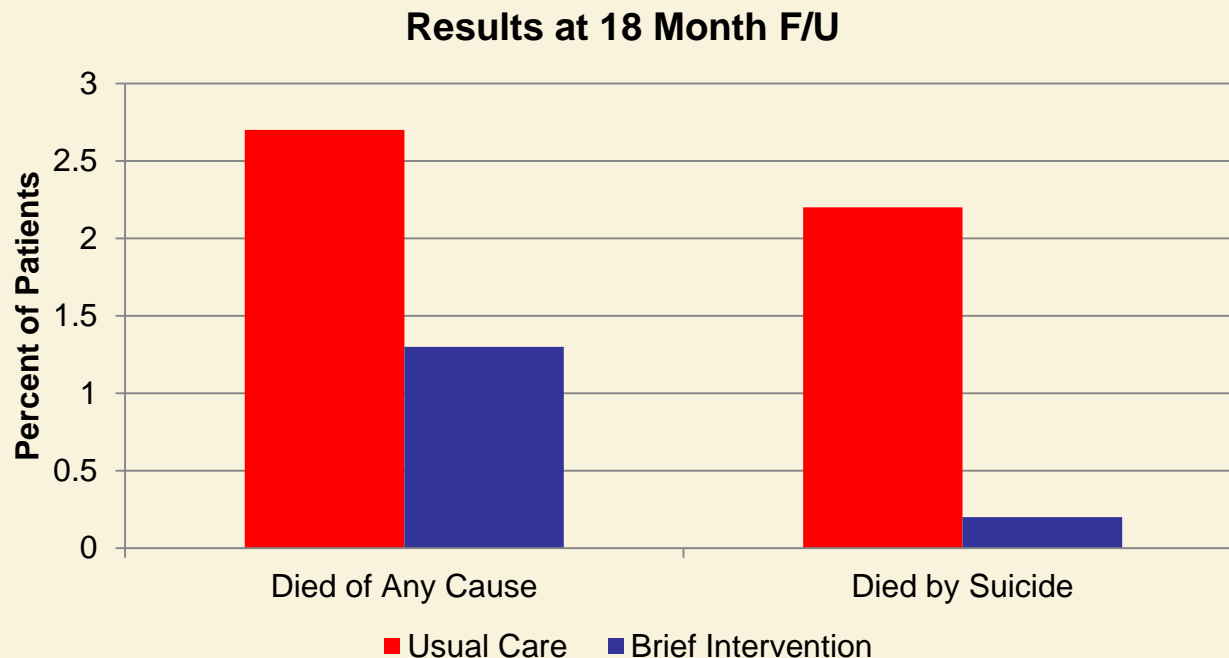
## *Beautrais –New Zealand*

- Most deaths in the 5-year follow-up period (62.5% of suicides; 59% of all deaths) occurred within 18 months of the index attempt.
- However, deaths (from suicide and all causes) continued throughout the entire 5-year period.
- There was a significant change of method in suicide attempt of those who died in the 5-year follow-up period: 75% changed from the method used at the index attempt (usually O/D) to a more lethal method (CO, hanging) that resulted in their death.




# EMERGENCY DEPARTMENT F/U

- 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



- *Motto 1976:*
  - 389 pts. refusing outpt. assigned to “no contact” (up to 24 letters over 5 years)
  - **Contact group sig. fewer suicides than no-contact group (particularly first 2 yrs)**
- *Carter et al, 2005:*
  - Postcards to 378 attempters, varying monthly intervals, 12 mos. after d/c
  - **Approx 50% reduction in attempts**

# major international efforts have reduced suicides



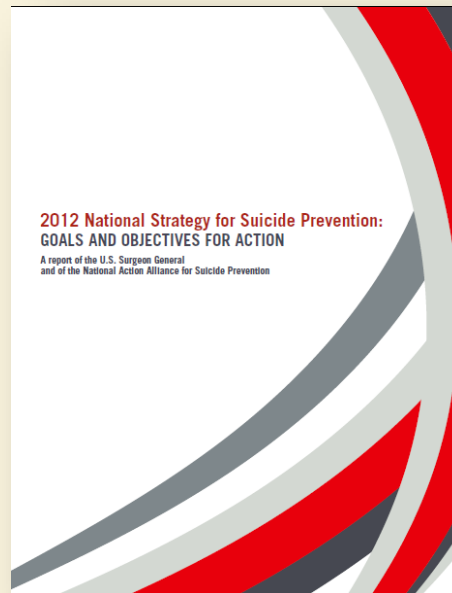
- Taiwan-nationwide effort to intervene with those who have attempted suicide, 50,000+
- 63.5% reduction in suicide attempts among those who accepted the program. Those who refused but then persuaded 22% reduction.
- English National Strategy- 24 hours crisis care strongly associated with reduction in suicides.

# What if we targeted these groups for suicide prevention programs?

	Estimated Number in Population (Number in Thousands)	Past year Suicidal Ideation (Number in Thousands)	Past Year Suicide Attempt (Number in Thousands)	Pat year SMI and suicidal ideation (Number in Thousands)	Past year SMI and Suicide attempt (Number in Thousands)
Full time Employed (18+)	118,225	3,678	351	1,213	149
<b>Treated in ER for any reason in past year (18+)</b>	<b>57,977</b>	<b>3,839</b>	<b>686</b>	<b>1,686</b>	<b>403</b>
Military Veterans (18+)	24,356	804	74	276	44
<i>Adults (18 +) on Medicaid/CHIP</i>	<i>18,629</i>	<i>1,383</i>	<i>270</i>	<i>644</i>	<i>164</i>
Full time College Students (18+)	14,612	785	108	312	64
<b>Adults (18+) on Probation or Parole</b>	<b>5,581</b>	<b>585</b>	<b>161</b>	<b>285</b>	<b>106</b>
<b>Adults in Substance Use Treatment</b>	<b>2,292</b>	<b>395</b>	<b>106</b>	<b>238</b>	<b>80</b>

Everyone





# ***National Strategy for Suicide Prevention***



# Objective 8.4

**Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.**

- There is substantial evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide. Death by suicide in the period after discharge from inpatient psychiatric units is more frequent than at any other time during treatment.<sup>92</sup>

# NSSP Objective 8.8

- **NSSP Objective 8.8-Develop collaborations between Emergency Departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow up after discharge.**

# NSSP Objective 9.6

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.

# Key Issues for EDs and Suicide Prevention

- Screening and Risk Assessment
- Suicide ideation or attempt as presenting problem
- Mental health or substance abuse as presenting problem (mood disorders, psychosis, substance abuse etc)
- Occult suicidality

# Key Issues in EDs and Suicide Prevention

- ED based interventions
- Psychoeducation
- Safety Planning
- Reducing Access to Lethal Means
- Improving Dispositions



# Key Issues EDs and Suicide Prevention

- Disposition and Follow Up
- Improving empirical justification for risk levels
- Physicians reluctant to discharge to community with limited supports.
- Linkage to crisis centers
- GCAL model
- EDs as part of a comprehensive crisis system

# SAMHSA efforts focused on suicide prevention in ED's

- SPRC ED Consensus Project
- Crisis Center Follow Up grants-linking Lifeline centers with Emergency Departments
- SPRC/AAS Continuity of Care Paper and Summary Guide
- Component of SAMHSA suicide prevention grants
- SPRC tools and products

# Crisis Center Role in Follow-Up

## National Suicide Prevention Lifeline

- ❑ 160 crisis centers nationwide/1-800-273-TALK

## Crisis Centers Uniquely Positioned

- ❑ 24-hr access to staff trained in suicide assessment (RA, support, referrals, safety plan, and emergency rescue)
- ❑ Connect directly to local crisis teams
- ❑ Facilitate linkage/maintain linkage
- ❑ Provide telephonic support in rural areas
- ❑ Avert unnecessary ED visits/Reduce ED burden

## Lifeline/SAMHSA Investment in Follow-Up

- ❑ SAMHSA Follow-Up Grants
  - Since 2008 – 44 follow-up grants to 41 centers

❑ Ongoing Follow-Up Evaluation

# Lifeline Network Resources

- ❑ Follow-Up Guidance for Crisis Centers
  - Approaches to follow-up, templates – safety planning, consent forms, sample crisis center MOUs with local EDs
- ❑ Crisis Center-Emergency Department Toolkit
  - Case studies, partnership planning exercises, letter templates, fact sheets, meeting tools, and sample materials
- ❑ Lifeline/ED Collaboration Paper
  - Background research, barriers to implementation, sample proposals, and consent forms
- ❑ Safety Planning Training
  - ❑ Video, templates, MY3 App
- ❑ General Follow-Up Training Module (NYSOMH)

# Reports From Lifeline Centers: ED Follow-Up

## Mental Health Services, Cleveland (2010-11)

- ❑ 46/49 patients consented/All contacted
- ❑ 100% reported lower risk
- ❑ 72% followed safety plan
- ❑ 50% contacted referrals
- ❑ No reported attempts or readmissions

## The Effort, Sacramento (2010-11)

- ❑ 74/75 patients consented/All contacted
- ❑ 100% reported lower distress
- ❑ 100% followed safety plan
- ❑ 76% contacted referrals
- ❑ No reported attempts or readmissions



# Reports From Lifeline Centers: Inpt. Follow-Up

## LifeNet, NYC (2010-11)

- ❑ 183 referred
- ❑ 55% contacted
- ❑ 100% of those contacted followed safety plan
- ❑ 100% of those contacted linked to referrals
- ❑ No reported attempts or readmissions

## Contra Costa, CA

- ❑ 59 attempt survivors after hospital d/c
- ❑ 100% reported f/u calls were “helpful” or “somewhat helpful”
- ❑ 98% reported calls made them feel more safe and connected
- ❑ No person attempted suicide over 8 months



# States with Systems Support

## TEXAS

- ☐ State funded EDs must partner with the state funded safety net centers for each county or region
- ☐ Safety net centers must operate a 24-hour hotline, provide follow-up, mobile crisis and residential treatment
- ☐ At least 85% of patients must be contacted within 7 days of discharge

## WISCONSIN

- ☐ Requires local law enforcement gain clearance from crisis center before involuntary detentions
- ☐ Crisis centers required to follow-up with patients discharged from ED

## MAINE

- ☐ Requires continuity of care among behavioral health agencies
- ☐ Provides a state-wide crisis hotline
- ☐ Crisis centers provide services and partner with EDs, inpatient units, mobile crisis teams & jail facilities

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# Caring for Patients with Suicide Risk: A Consensus-Based Guide for Emergency Departments

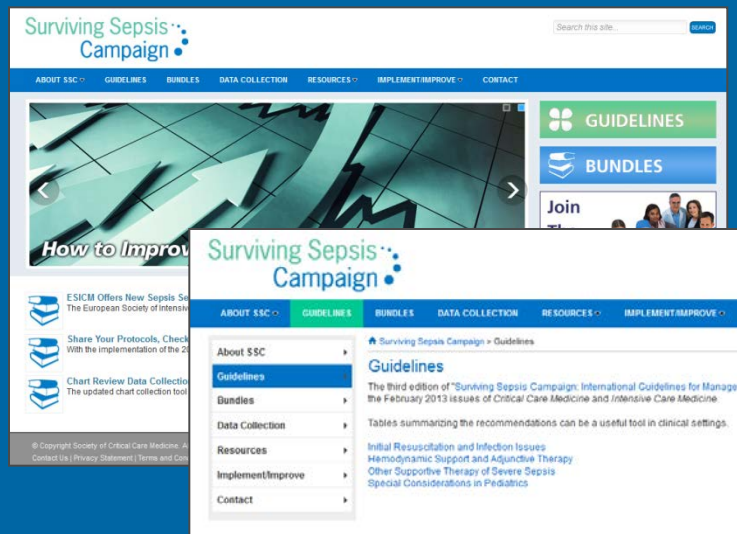
# Project Goal

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Develop a consensus-based guide for use in emergency departments

- ✓ For patients with known suicide risk who may be appropriate to discharge
- ✓ Include decision support for disposition
- ✓ Include interventions and discharge planning
- ✓ Build on past/current efforts
- ✓ Involve emergency medicine community

# Vision



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

### PERC Rule for Pulmonary Embolism

Rules out PE if all criteria are present and pre-test probability is  $\leq 15\%$ .

Age > 50	<input type="checkbox"/> NO	<p>No need for further workup, as &lt;2% chance of PE.</p> <p>If no criteria are positive and clinician's pre-test probability is &lt;15%, PERC Rule criteria are satisfied.</p>
HR $\geq 100$	<input type="checkbox"/> NO	
O2 Sat on Room Air < 95%	<input type="checkbox"/> NO	
Prior History of DVT/PE	<input type="checkbox"/> NO	
Recent Trauma or Surgery	<input type="checkbox"/> NO	
Hemoptysis	<input type="checkbox"/> NO	
Exogenous Estrogen	<input type="checkbox"/> NO	
Unilateral Leg Swelling	<input type="checkbox"/> NO	

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



# Consensus Panel Process & Timeline

Formed  
62-member  
Consensus  
Panel

Held remote  
Consensus  
Panel  
studies

Analyzed  
results ;  
Collected  
panel  
feedback

Write draft  
guide &  
methodology  
report

Reviews /  
pilot test  
draft

Develop  
supplemental  
materials ;  
Recruit  
dissemination  
partners /  
endorsements

Launch  
guide

*Review research literature & empirical evidence*



# Consensus Study: Decision Support Tool draft

- Seven items
- MH consult or discharge
- For use with patients with decision making capacity

ITEM <i>With sample question</i>	Required for discharge without further assessment
<b>1. SUICIDAL IDEATION</b> <i>Have you had recent thoughts of killing yourself?</i> <i>(or is there other evidence of suicidal ideation, e.g., collateral report)</i> <i>[This is a forced item but providers will still assess.]</i>	YES (or other evidence of suicide risk, e.g., collateral report)
<b>2. THOUGHTS OF CARRYING OUT A PLAN</b> <i>Have you recently been thinking about how you might kill yourself?</i> <i>[If YES, assess the immediate supervision needs of the patient.]</i>	NO
<b>3. INTENT</b> <i>Do you have any intention of killing yourself?</i>	NO
<b>4. PAST SUICIDE ATTEMPT</b> <i>Have you ever attempted to kill yourself?</i>	NO
<b>5. SIGNIFICANT EMOTIONAL PROBLEM OR PSYCHIATRIC ILLNESS</b> <i>Have you had any treatment for emotional problems, or do you have a mental health condition like depression or anxiety that affects your ability to do things in your life?</i>	NO
<b>6. SUBSTANCE USE PROBLEM (NOT CURRENT INTOXICATION)</b> <i>In the past year have you had 5 (men) or 4 (women) drinks in a day?(1)</i> <i>In the past year have you used drugs or prescription medication for non-medical reasons?(2)</i> <a href="http://www.ncbi.nlm.nih.gov/pubmed/22511015">http://www.ncbi.nlm.nih.gov/pubmed/22511015</a> (1) Smith PC, Schmidt SM, Allesworth-Davies D, et al. Primary care validation of a single-question alcohol screening test. <i>J Gen Intern Med</i> 2009;24:783e6. (2) Smith PC, Schmidt SM, Allesworth-Davies D, et al. A single-question screening test for drug use in primary care. <i>Arch Intern Med</i> 2010;170:1155e60.	NO
<b>7. IRRITABILITY/AGITATION/AGGRESSION</b> <i>Recently have you felt so anxious, agitated, or keyed up that you felt like you could just jump out of your skin or are you having conflicts or getting into fights with people?</i>	NO
SCORE	ALL NO on lines 2 through 7 = Discharge may be considered
	ANY YES on lines 2 through 7 = Further assessment recommended


*For patients being discharged without further assessment, providers should ask about access to lethal means and protective factors during brief intervention and/or discharge planning discussions. For all other patients, questions about lethal means and protective factors should be included in the full assessment/mental health consultation.*




# Consensus Study: Brief Suicide Prevention Interventions

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Interventions /  
Strategies  
for ED Settings

- 
1. Brief patient education
  2. Patient-administered safety planning
  3. Clinician-administered safety planning
  4. Lethal means counseling
  5. Crisis center helpline information
  6. Brief motivational interviewing
  7. Telepsychiatry
  8. Rapid follow-up/referral
  9. Subsequent contact or caring contacts

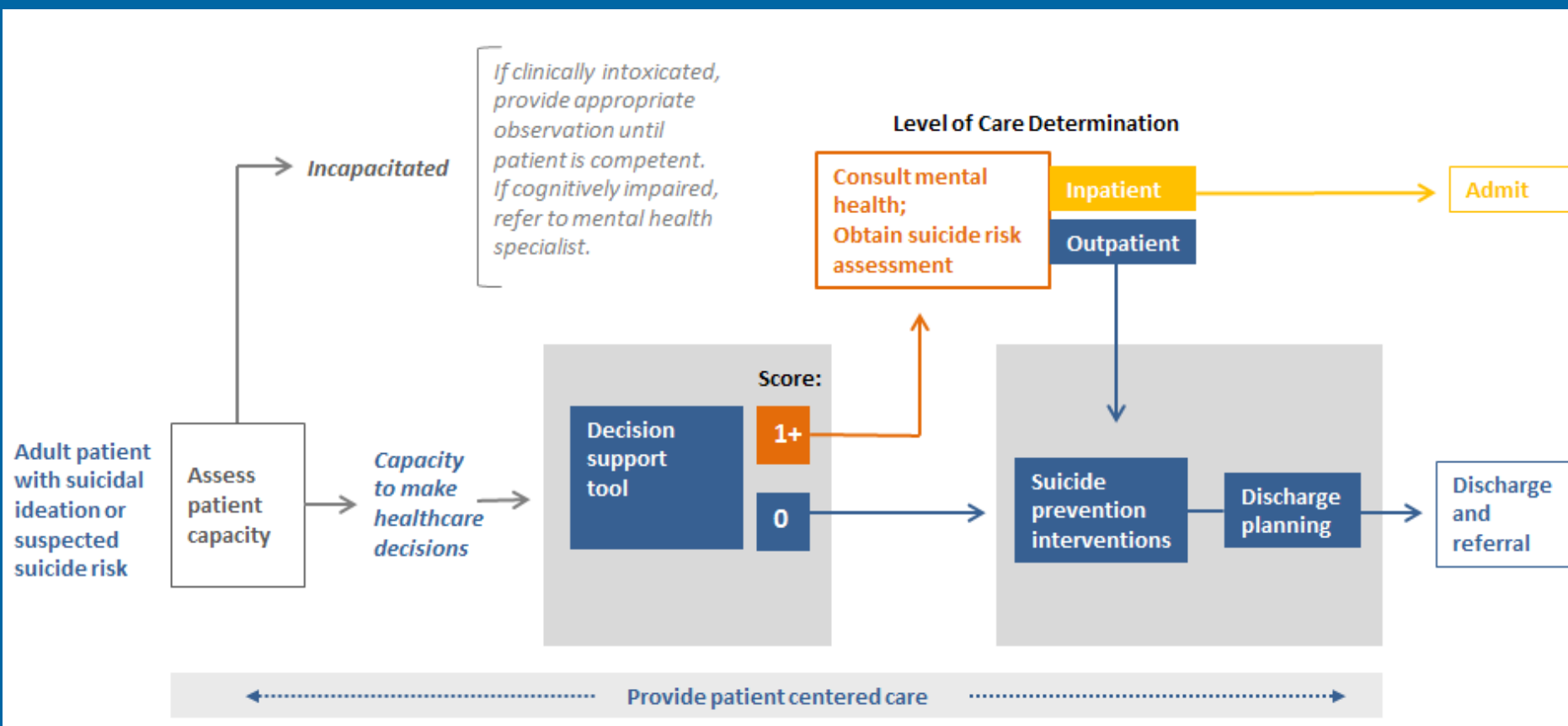
Rating  
Criteria

- 
1. Clinically Useful
  2. Facilitates Continuity of Care
  3. Feasible
  4. Patient-Centered

# Summary Findings: By Rank Order

	CLINICALLY USEFUL	FACILITATES CONTINUITY OF CARE	FEASIBLE	PATIENT- CENTERED	RANK SCORE (0-10)
Brief patient education	4	0	3	1	8
Rapd follow-up / referral	4	2	0	1	7
Subsequent contat or caring contacts	4	2	0	1	7
Clinician-administered safety planning	4	2	0	0	6
Brief motivational interviewing	4	0	0	1	5
Lethal means counseling	4	0	0	0	4
Crisis center helpline information	0	0	3	0	3
Patient-administered safety planning	0	0	0	1	1
Telepsychiatry	0	0	0	0	0

# Draft process diagram



# Dissemination strategies

Target audience	Approach	Strategy
<b>ED care providers (e.g., MDs, RNs,, MH providers)</b>	Engage national organizations (e.g., ACEP, ENA, AAEM, AHA, etc.) in marketing ED guide to membership	Market to national org members via conference presentations, newsletters, websites; EP Monthly
<b>State suicide prevention programs and mental/public health agencies</b>	Work through SPRC's state and grantee contacts so they can disseminate guide to state EM organizations	SPRC communication vehicles: website, Weekly Spark e-newsletter, listservs, SPRC TA, Research to Practice webinars
<b>Local communities</b>	States disseminate to community coalitions who can connect with the local EM community	
<b>Community crisis centers</b>	Partner with NSPL to engage crisis centers in disseminating to local EM organizations	NSPL/SPRC ED/Crisis Center Toolkit

# EMERGENCY DEPARTMENT

- 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 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?

*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 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.**

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## RESOURCES

- Download this card and additional resources at [www.sprc.org](http://www.sprc.org) or at [www.stopasuicide.org](http://www.stopasuicide.org)
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide [www.sprc.org/library/jcsafetygoals.pdf](http://www.sprc.org/library/jcsafetygoals.pdf)
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors [www.psych.org/psych\\_pract/treatg/pg/SuicidalBehavior\\_05-15-06.pdf](http://www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf)

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**National Suicide Prevention Lifeline**  
**1.800.273.TALK (8255)**

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[www.sprc.org](http://www.sprc.org)



[www.mentalhealthscreening.org](http://www.mentalhealthscreening.org)

# SAFE-T

## Suicide Assessment Five-step Evaluation and Triage

**1**

### IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

**2**

### IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

**3**

### CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans behavior and intent

**4**

### DETERMINE RISK LEVEL/INTERVENTION

Determine risk. Choose appropriate intervention to address and reduce risk

**5**

### DOCUMENT

Assessment of risk, rationale, intervention and follow-up

**National Suicide Prevention Lifeline**  
**1.800.273.TALK (8255)**



*Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.*

## 1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ **Access to firearms**

## 2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

## 3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self-injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

\* **Homicide Inquiry:** when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.

## 4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk level** is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

## 5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan

# Other Major Federal and Private Initiatives

- NIMH ED SAFE (also adolescent ED risk assessment)
- VA Safe Vet-VA/DOD Practice Guidelines
- CMS Community Care Transition grants-reducing readmissions
- Excellence in Mental Health Act/Section 223
- ENA Clinical Practice Guideline: Suicide Risk Assessment



Contact information:  
Richard McKeon, Ph.D., M.P.H.  
Branch Chief, Suicide Prevention, SAMHSA  
240-276-1873  
[Richard.mckeon@samhsa.hhs.gov](mailto:Richard.mckeon@samhsa.hhs.gov)

