Lisa Capoccia, MPH – Assistant Manager, SPRC Provider Initiatives.

Ms. Capoccia manages projects to increase the suicide prevention capacity of health and behavioral healthcare settings at local, state, and national levels. Most recently she led a national consensus development process to establish suicide care guidelines for emergency departments. Ms. Capoccia has nearly 20 years of experience implementing public and mental health programs and initiatives including developing coordinated systems of care for uninsured and underserved patients at the community level, providing technical assistance to American Indian and Alaska Native communities with SAMHSA grants, and working in community mental health systems. She received her undergraduate degree from the University of Massachusetts, Amherst, and her master’s degree from Boston University in Public Health.
Adam Chu, MPH – Prevention Specialist, SPRC Prevention Support Team.

Adam Chu is a Prevention Specialist at the Suicide Prevention Resource Center and works with state and campus Garrett Lee Smith Youth Suicide Prevention Grantees, and also with state suicide prevention coordinators and managers. In this position, he provides technical assistance and program support on topics including strategic planning, communications, infrastructure development, and sustainability. Mr. Chu co-facilitated a Community of Practice for Garrett Lee Smith Grantees focused on working with student veterans. Previously, he worked at the Metrowest Regional Center for Healthy Communities serving local communities west of Boston, Massachusetts. Mr. Chu obtained his B.S. from Tufts University and his M.P.H. from the Boston University School of Public Health.
Suicide Prevention in Emergency Departments: Engaging Patients and Providers in Care Transitions

Lisa Capoccia, MPH  
Assistant Manager, SPRC Provider Initiatives

Adam Chu, MPH  
Prevention Specialist

Suicide Prevention Resource Center, Education Development Center, Inc.
Disclosures

The views expressed in this presentation are those of the presenters and do not reflect the official policy of the Department of Defense or the U.S. Government.

- Presenters have no relevant financial relationships to disclose.
- Presenters do not intend to discuss off-label/investigative (unapproved) use of commercial products or devices.

The description of programs in this presentation is for descriptive purposes only and not intended to promote any individual program.
Learning Objectives

1. Describe the new resource Caring for Adults with Suicide Risk: A Consensus Guide for Emergency Departments, and consider how to incorporate them into your own work.

2. Demonstrate increased knowledge of how to form successful partnerships with EDs.

3. Discuss care transition improvements that can be made with enhanced engagement of the emergency medicine community using the guide.
Polling Question

What are your experiences with emergency department (ED) settings?

- I work/worked at an ED
- I partner with EDs
- I provide services to patients who visit EDs frequently
- I have limited experiences working with EDs
Presentation Overview

1. Background for Targeting Emergency Department (ED) Settings for Suicide Prevention
2. About the ED Guide
3. Forming Partnerships with EDs
4. Using the ED Guide to Promote Care Transitions
Suicide Prevention in Emergency Departments

**Population:**
Identify patients in high risk groups

**Individual:**
Treatment and referral of patients with confirmed suicide risk

**Health System:**
Prevent readmissions, lower costs
Rationale for Suicide Prevention in ED Settings

✓ U.S. EDs respond to over 800,000 visits for self-inflicted injuries annually (CDC, 2011).

✓ Of people with a recent suicide attempt (last 12 months), two thirds had visited an ED for any reason in the past year (Han, 2014).

✓ 43.8% of ED patients with suicidal ideation had a previous suicide attempt (Allen, 2013).
Rationale for Suicide Prevention in ED Settings

✓ People who die by suicide often come to the ED in relatively close proximity to their death.
  
  – 22% of people who died by suicide visited an ED in the 4 weeks prior to their death.

✓ Suicide is often not the presenting issue.
  
  – 60% of these ED visits were unrelated to suicide.

(Ahmedani, 2014)
Rationale for Suicide Prevention in ED Settings

✓ The risk of a suicide attempt or death is highest within the first 30 days after discharge from an ED or inpatient psych unit; Yet up to 70% of patients who leave the ED after a suicide attempt never attend their first outpatient appointment (Knesper, 2010).
Suicide Among Veteran Populations

✓ Males 30-64 years of age have the highest suicide rate among clients of the Veterans Service Administration (Blow et al., 2012).

✓ A majority of veterans who die by suicide are age 50 or older (Kemp & Bossarte, 2012).
Healthcare Contact Among Veterans in VHA Care with Substance Use Disorders

✓ Over half of male veterans in VHA care with substance use disorders who died by suicide were seen one month before their death, and one quarter were seen one week before their death.

✓ Of those seen one year before their death:
  – 56.6% seen in general medical setting
  – 32.8% seen in specialty mental health setting
  – 10.5% seen in substance abuse treatment

(Ilgen, 2012)
Healthcare Contact Among U.S. Service Members with Suicidal Behaviors

- Within a service member population, 45% of those who died by suicide and 73% of those treated for a suicide attempt had outpatient visits within 30 days of their death or attempt.

- Primary care was the most frequently visited clinical service prior to suicide and self-harm.

(Trofimovich, 2012)
Barriers to Mental Health Care Among Service Members and Veterans

- Behavioral health clinics hours may conflict with pre-deployment training cycle schedules and general difficulty getting time off work.

- A lack of military/uniformed mental health provider availability.

(Invisible Wounds of War, Tanielian, 2008)
Barriers to Successful Care Transitions for Service Members and Veterans

 ✓ Frequent changes in duty stations necessitate changes in health care providers and health insurance.

 ✓ Insufficient instructions that guide the transfer of patients across installation.

 ✓ Sharing of patient records across the systems.

 (*Invisible Wounds of War*, Tanielian, 2008)
Barriers to Successful Care Transitions for Service Members and Veterans

- Challenging experiences navigating a new health care system following a transition to post-military, civilian life.
- Lack of funds to pay out of pocket for community-provided treatment to avoid stigma.
- Culture and attitudes that inhibit access to mental health care.

*(Invisible Wounds of War, Tanielian, 2008)*
Prioritizing Emergency Departments in Suicide Prevention

- National Strategy for Suicide Prevention, Objective 9.6
- SAMHSA
- Action Alliance for Suicide Prevention
Prioritizing Emergency Departments in Suicide Prevention

- American Foundation for Suicide Prevention
- National Suicide Prevention Lifeline
- The Joint Commission, National Patient Safety Goal
Developing a Consensus Guide

- Develop a consensus-based suicide prevention guide for use in emergency departments
- For adult patients with suicide risk who may be appropriate to discharge
- Include decision support, interventions and discharge planning
- Build on past/current efforts
Consensus Development Process

- 62-member consensus panel
- Study design group
- Two studies: RAND & SSRE
- 70% participation
- Guidance on:
  - Decision support
  - Interventions
- Results informed the ED Guide development
## Participation

70% participation

- Consensus Panel Members Invited to Participate: 61
- Participated in at least one round of study: 50 (82%)
- Participated in round three: 43 (70%)

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (non-MH)</td>
<td>10 (29%)</td>
</tr>
<tr>
<td>Psychologists</td>
<td>9 (26%)</td>
</tr>
<tr>
<td>Clinical researcher</td>
<td>7 (21%)</td>
</tr>
<tr>
<td>Suicide prevention professional</td>
<td>7 (21%)</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>6 (18%)</td>
</tr>
<tr>
<td>Social workers</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Nurse (non-MH)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Federal agency representative</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Policy expert</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Suicide attempt survivor</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Suicide loss survivor</td>
<td>1(3%)</td>
</tr>
</tbody>
</table>

Percentages exceed 100% due to multiple affiliations by panelists.
1. Decision Support Tool (Secondary Screening)

2. Brief Suicide Prevention Interventions

3. Discharge Planning Checklist

www.sprc.org/ed-guide
## Using Primary, Secondary, and Risk Assessment Tools in the ED

<table>
<thead>
<tr>
<th>TYPE OF TOOL:</th>
<th>USED WITH:</th>
<th>TELLS YOU:</th>
<th>LOCATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Screening (Universal or</td>
<td>Every ED patient or patients with known risk factors</td>
<td>Whether suicide risk is present/absent</td>
<td>Appendix C</td>
</tr>
<tr>
<td>elective)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Screening (Decision Support</td>
<td>Patients with some suicide risk as identified through universal screening,</td>
<td>Whether discharge following ED-based interventions may be appropriate or</td>
<td>Section 2.2</td>
</tr>
<tr>
<td>Tool)</td>
<td>patient disclosure, or other indicators</td>
<td>further assessment by a mental health specialist is needed to make a</td>
<td></td>
</tr>
<tr>
<td>comprehensive</td>
<td></td>
<td>disposition determination</td>
<td></td>
</tr>
<tr>
<td>Suicide Risk Assessment</td>
<td>Patients with suicide risk who score positive (≥1) on the Decision Support</td>
<td>Information about a patient’s risk and protective factors, immediate</td>
<td>Appendix C</td>
</tr>
<tr>
<td></td>
<td>Tool</td>
<td>danger, and treatment needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*If resources permit, Suicide Risk Assessment may be used with any patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with suicide risk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Scoring:

0 = “No” on all 1-6.

Provide intervention prior to discharge.

≥ 1 = “Yes” on any 1-6.

Consult a mental health professional & suicide risk assessment.

<table>
<thead>
<tr>
<th></th>
<th>Scoring:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0 = “No” on all 1-6. Provide intervention prior to discharge.</td>
</tr>
<tr>
<td>2</td>
<td>≥ 1 = “Yes” on any 1-6. Consult a mental health professional &amp; suicide risk assessment.</td>
</tr>
</tbody>
</table>

#### TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION
Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (NOTE: Not part of scoring.)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>THOUGHTS OF CARRYING OUT A PLAN</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Recently, have you been thinking about how you might kill yourself? <strong>If yes, consider the immediate safety needs of the patient.</strong></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>SUICIDE INTENT</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Do you have any intention of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>PAST SUICIDE ATTEMPT</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Have you ever tried to kill yourself?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>SIGNIFICANT MENTAL HEALTH CONDITION</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>SUBSTANCE USE DISORDER</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>IRRITABILITY/AGITATION/AGGRESSION</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?</td>
<td></td>
</tr>
</tbody>
</table>
Decision Support Tool

- Obtaining information from collaterals
- Sharing patient health information
- Using a patient-centered approach
- About suicide risk assessment
### Brief Patient Interventions

Incorporate *crisis center/hotline information* into any intervention selected \(^3\):

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Patient Education (^1)</td>
<td></td>
</tr>
<tr>
<td>Safety Planning (^1, 2)</td>
<td></td>
</tr>
<tr>
<td>Lethal Means Counseling (^2)</td>
<td></td>
</tr>
<tr>
<td>Rapid Referral (^1)</td>
<td></td>
</tr>
<tr>
<td>Caring Contacts (^1)</td>
<td></td>
</tr>
</tbody>
</table>

Recommended by: (1) ED Consensus Panel, (2) Suicide Prevention Resource Center [Best Practices Registry](https://www.sprc.org/bestpractices), (3) The Joint Commission [guidance](https://www.jointcommission.org) on preventing suicide in emergency departments.

- Bundle interventions
- Use of crisis centers
- Tailor to patient needs & ED resources
Brief Patient Interventions – Descriptions

- Brief description
- “How”
- Resources
- Some sections: special note or sample scripts

3.3 Lethal Means Counseling

In the Lethal Means Counseling Intervention, the provider assesses whether a patient is at risk for suicide and uses access to firearms or other lethal means (e.g., prescription medications), and works with the patient and his or her friends, family, or outpatient provider to discuss ways to limit this access until the patient is no longer feeling suicidal.

Action Steps

- Tell the patient and his or her friends or family that suicidal risk can sometimes escalate rapidly, so it is important to consider the patient’s access to lethal means during these periods of increased risk.
- Ask the patient and his or her supports about the patient’s access to lethal means, particularly firearms. If the patient has access to firearms, ask about the location (e.g., closet, car, attic).
- Provide appropriate counseling to patients who report having access to lethal means. For a list of points to cover in the brief counseling sessions, view the Lethal Means Counseling Recommendations for Clinicians sheet available from Means Matter.
- Identify strategies for limiting access to lethal means, such as storing firearms at a friend’s house until the suicidal crisis has passed, and allowing a family member to keep medications under lock and key and dispense them as necessary in order to prevent self-poisoning.

Lethal Means Counseling Resources

- Recommendations for Clinicians — Lethal means counseling, Means Matter, Harvard School of Public Health
- Recommendations for Family — Information on lethal means, Means Matter, Harvard School of Public Health
- Counseling on Access to Lethal Means (CALM) — Online training course, Suicide Prevention Resource Center
- Firearms Safety and Injury Prevention — Policy, American College of Emergency Physicians (ACEP)

Guns at Home: How You Raise the Issue Can Make a Difference

Instead of:

“Do you have access to a gun?”

Consider:

“Let’s talk in terms your state has guns at home.” Research shows that a suicidal person is safer if they don’t have access to guns. What would gun owners in your situation do with...?”

Fatigue? Feeling better, or took them and ask someone to go to the doctor. If you have guns at home, I’m wondering if you’ve thought of a strategy like that.”

“You may substitute this sentence with ‘If I don’t know if you have guns at home, but if you do...”

—Catherine Barber, Means Matter
Discharge Planning Checklist

- Involve the patient as a partner
- Make follow-up appointments
- Review and discuss the Patient Care Plan (discharge plan)
- Discuss barriers
- Provide crisis center phone number
- Discuss limiting access to lethal means
- Provide written instructions and education materials
- Confirm that the patient understands the Patient Care Plan
- Share patient health information with referral providers
- Communicate your concern
Additional Topics Covered

- Providing patient-centered care
- Working with crisis centers
- Using telepsychiatry
- Addressing intoxication and SUDs
- Exploring legal issues
Appendices

✓ Guide Resources and URLs
✓ Suicide Risk Assessment: Information and Resources
✓ Sample Letter to Outpatient Mental Health
✓ Community Resource List Template
✓ Caring Contacts Sample Materials
✓ Key Elements of a Patient Care Plan
✓ Assessing Your Views toward Suicide
Quick Guide

- Two 8.5x11 sides folded
- Companion to the full guide
- Topics covered:
  - Diagram
  - Decision support tool
  - ED-based interventions
  - Discharge planning checklist

This guide assists Emergency Department (ED) providers with decisions about the care and discharge of patients with suicide risk with a focus on improving patient outcomes after discharge. It is a companion resource to the full guide, *Caring for Adult Patients with Suicide Risk: A Consensus-Based Guide for Emergency Departments*.

**Questions answered by Quick Guide:**

- Can this patient be discharged or is further evaluation needed?
- How can I intervene while this patient is in the ED?
- What will make this patient safer after leaving the ED?
Engaging the ED Sector

✓ Professional Organizations – State Chapters
✓ Serious Reportable Event Regulatory Agency/State Department of Health
✓ Academic Programs – Emergency Nursing, Emergency Medicine, Social Work, Emergency Psychiatry
✓ Local- or State-Level Suicide Prevention Coalition
✓ Emergency Medicine Conferences
Engaging the ED Sector

- Seek to Understand the ED’s Goals and Area(s) of Concern Related to Care of Patients with Suicide Risk
- Tie Suicide Prevention Strategies to ED Motivators (e.g., Decrease Problems Associated with Boarding, Reduce Re-Admissions)
- Bring Information About Resources (e.g., ED Guide, Information About Crisis Centers)
- Acknowledge ED Challenges (e.g., Time, Lack of Tools and Resources)
Care Transitions Improvements

- ED-Crisis Center Collaborations
- Tele-Psychiatry
- Rapid Referral
- Warm Handoff
- Motivational Interviewing to Address Modifiable Barriers
- Using Discharge Planning Checklists
- Engaging Family or Friends
Suicide Attempts and Suicide Deaths
Subsequent to Discharge from an Emergency Department or an Inpatient Psychiatry Unit

Continuity of Care for Suicide Prevention and Research

2011

This report was commissioned by the Suicide Prevention Resource Center (SPRC) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). David Esp, SPRC Director of Science and Policy, provided overall direction. Alan E. Berlin, Executive Director of the American Association of Suicidology (AAS), led the administration of the project. David J. Kuepfer, M.D., Department of Psychiatry, University of Michigan, is the author.

VA/DoD CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE
Department of Veterans Affairs
Department of Defense

Prepared by:
The Assessment and Management of Risk for Suicide Working Group

With support from:
The Office of Quality, Interagency violent Incidents, DC

Center Management Office: United States Army Reserve

Version 1.0 – June 2011

QUALIFYING STATEMENTS
The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based upon the best available evidence at the time of publication. They are intended to provide information and assist healthcare providers in caring for their patients. However, all healthcare providers are encouraged to keep informed about the latest information on suicide and demonstrate a commitment to ongoing professional development. They are intended to guide and supplement each provider’s clinical judgment, while also providing a framework for collaboration between VA, DoD, and community providers.


Knesper, D.J. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Suicide Prevention Resource Center.


Questions & Comments
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www.sprc.org
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You must register by 11:59 p.m. (PT) on September 11, 2015, to qualify for the receipt of CE credit.