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Best Practices for Monitoring of a Suicidal Patient: On Inpatient Services, in the ED, and in the Outpatient Setting

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Disclosures

UT Southwestern College of Medicine – Associate professor, all opinions expressed here are my own and do not represent official positions of UT Southwestern or the University of Texas System

Texas Society of Child and Adolescent Psychiatry – though currently serving as president of this organization, all opinions expressed here are my own and do not represent official positions of the Society

Janssen Pharmaceuticals – Study on the use of Seltorexant as an adjunct in treatment of depression

Study recruitment concluded 3/15/2024

Goals and objectives

- Identify important concepts related to suicidal patients and their presentation
- Apply these concepts to environmental and procedural aspects of their care in different treatment environments
- Recognize potential areas of conflict between safety and necessary care

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CRISIS HOTLINES CAN:

- Provide 24-hour access to staff trained in suicide assessment and intervention
- Thoroughly assess for risk of suicide, provide support, offer referrals, develop a safety plan, and dispatch emergency intervention, if necessary
- Connect directly with local mobile crisis teams
- Avert unnecessary ED visits and better ensure needed ED visits
- Intervene when a caller is not willing or able to ensure his or her own safety
- No matter the level of care, providing the crisis line number is another support in your clinical arsenal

General Concepts

- First, if we are going to be able to keep patients safe, we need to know what the risk is
- Once we know the risk, we need a plan in place to mitigate it
- We need to look at their environment and understand what needs to change to reduce access to lethal items
- We need to implement treatments targeted at suicidal thinking and behavior

- We need to be able to pull data and understand if we are making a difference

General Concepts

- Providers, regardless of training, are NOT able to predict suicidal thoughts, behaviors, or death in the future
  - Assessment is an ongoing process of
    - assessing risk in the moment and
    - attempting to find the lowest level of care that can safely treat the patient

- Suicidal thoughts are far more common than most believe, particularly in teens and minority populations, for instance:
  - 13% of high school girls had attempted suicide, while 30% had seriously considered it over the year
  - 20% of LGBTQ+ teens had attempted suicide, while 45% had seriously considered it over the year

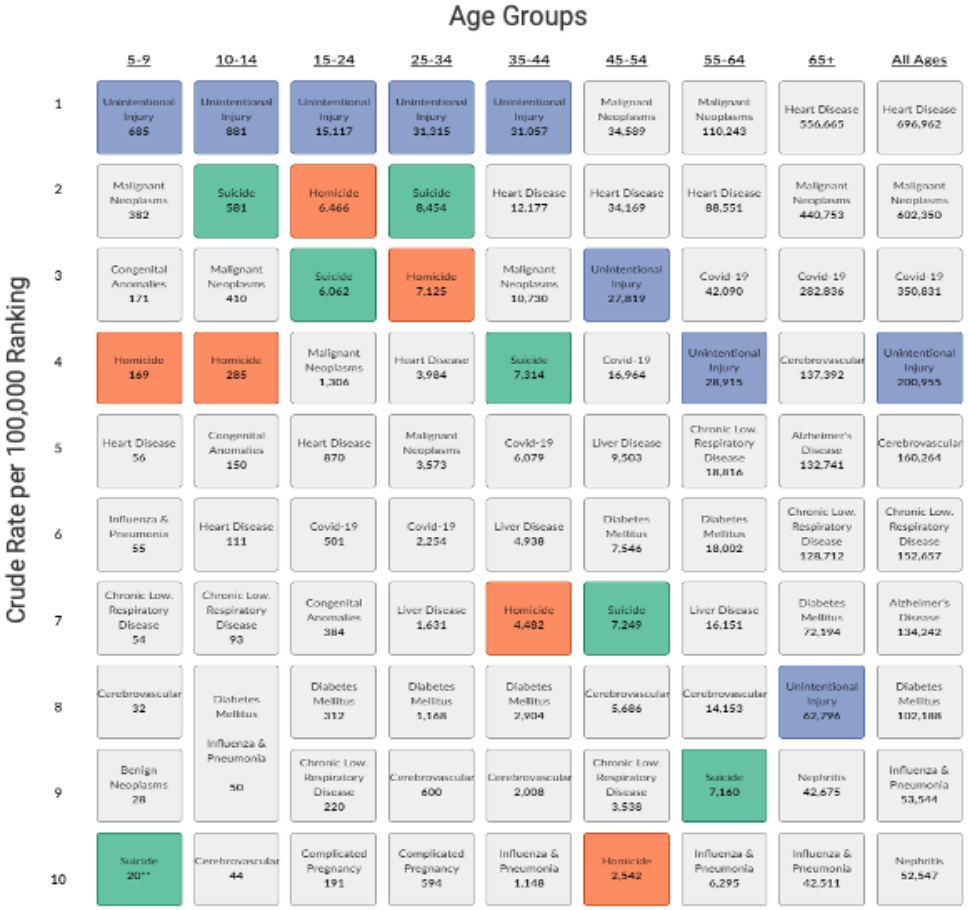
CDC, 2021

Some gains, some losses

- The good news:
  - Teen suicide rates decreased for the first time in 2023 since the pandemic began

- The bad news:
  - The overall rate, and particularly the rate of seniors continues to increase
  - It remains the 2nd leading cause of death for ages 10-44

Ten Leading Causes of Death by Age (U.S., 2020)



Source: CDC, 2021

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General Concepts

- The number of female patients presenting with suicidal ideation and/or attempt outnumbers males presenting with the same by a ratio of 3:1

BUT

- The number of male patients who die by suicide outnumbers females by a factor of almost 4:1 in 2022

Why? Who do we actually see?

Outpatient Setting

Outpatient Setting

- Set up the environment for success
  - The office and waiting area should be clean, clutter-free, and without high-risk items
    - (Be mindful of scissors and staples)
  - There should be consistent staff to monitor the waiting area, and if there is a known concern, it is important to have a staff with the identified patient
    - If a patient is identified at clinic to be at risk, do not leave them alone
- If a patient does decide to leave/elope, it is important to notify security in the building, or police outside of the building

Outpatient Setting

- Ensure that suicide is systematically and consistently assessed.
  - In spite of evidence to the contrary, there is still a sense of reluctance in some providers to bring up suicide as a possibility with at-risk patients
    - Some feel this creates medico-legal risk by "inserting the idea" into the patient's thinking
    - Others worry that this is uncomfortable and repeatedly addressing this impacts the patient relationship
  - Review of literature supports that assessing for suicidal thinking and activity does not increase risk for suicide and may help overcome the patient's hesitance to raise the topic themselves

    (Reynolds, Lindenboim, Comtois, & Linehan, 2006)

Strategy for Building Trust “LIVES”

- **Normalize the process by letting clients know that all clients are screened,**
- **Informing them about why they are being screened, and**
- **Ensuring they understand what will happen based on the results of the screening**

- **L**isten with empathy and without judgment.
- **I**nquire about needs and concerns, including emotional, physical, social, and practical.
- **V**alidate the person’s experiences, emphasizing belief in and understanding of their experience.
- **E**nhance safety and discuss strategies for safety.
- **S**upport the person by connecting them to services, information, and social support.

Screening Tools

- Brief Screens for Suicide
  - Ask Suicide-Screening Questions (ASQ)
  - Columbia-Suicide Severity Rating Scale (C-SSRS)
  - Patient Health Questionnaire-9 (PHQ-9)
  - Patient Safety Screener (PSS-3)

ASQ

1. In the past few weeks, have you wished you were dead? Yes or No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes or No
3. In the past week, have you been having thoughts about killing yourself? Yes or No
4. Have you ever tried to kill yourself? Yes or No

   If yes, how?

   When?

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? Yes/No

   If yes, please describe:

_____

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ASQ

- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen.
  - Ask question #5 to assess acuity:
- “Yes” to question #5 = acute positive screen (imminent risk identified)
  - Patient requires a STAT safety/full mental health evaluation.
  - Patient cannot leave until evaluated for safety.
  - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
- “No” to question #5 = non-acute positive screen (potential risk identified)
  - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an “against medical advice” (AMA) discharge.
  - Alert physician or clinician responsible for patient’s care.

C-SSRS

- This tool adds a greater complexity to the interview
- Requires some training to administer
  - Based on suggested probes for information
  - Puts more weight toward the professional's judgment
- A "confirmatory test" to work into the broader clinical assessment beyond the check boxes

C-SSRS

- Suicidal Ideation
  1. Wish to be Dead
  2. Non-Specific Active Suicidal Thoughts
  3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
  4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan
  5. Active Suicidal Ideation with Specific Plan and Intent

C-SSRS

- Suicidal Behavior
  1. Actual attempt
     a) Has subject engaged in Non-Suicidal Self-Injurious Behavior?
     b) Has subject engaged in Self-Injurious Behavior, intent unknown?
  2. Interrupted Attempt
  3. Aborted Attempt or Self-Interrupted Attempt
  4. Preparatory Acts or Behavior
  5. Suicide

How this is operationalized

- Clinician or clinical staff can perform an initial screen, informing the safety assessment by clinician
- This can be a single measure or staged, and any positive result should cue both safety precautions and a more comprehensive clinical assessment that further clarifies risk
  - We utilize the ASQ, and for anything other than a negative result, follow with a Columbia (C-SSRS)
  - Once the C-SSRS is complete, a clinician will delve further with clinical assessment to assess risk and then if possible, for ability to safety PLAN.

Screeners and Reality

- While helpful, screens are not sufficient to meet the standard of care, nor are they enough to protect from malpractice
- We are not going to pretend that we are excellent in any significant timeframe at predicting ongoing suicide risk, all are a moment in time, and rely on the patient to be either truthful or easily found out
  - Particularly at the point where the patient has dedicated themselves to moving forward with suicide, the clinical features may actually feel LESS alarming
    - They are not as anxious or perhaps less morbidly depressed appearing, and will commonly lie without revealing affect because we are adversarial in stance
      - We are no longer working together for life, we are a barrier to their efforts at death

I did mention a safety PLAN

- Safety contracts have long been debunked as clinically useful tools for showing safety from suicide if the patient agrees to a no-harm contract
- It can be useful to mention that they will NOT contract for safety, but this is redundant to the fact that they then also won't safety plan effectively if they are admitting they aren't even motivated to agree to be safe
- A safety plan includes active patient-driven efforts to establish
  - Environmental safety, alone coping, coping with others, identify safe individuals to support, and have contacts in place to stay safe

Home Safety Checklist

- Needed to address safety risks in the patient's home
- Creates a list of high-risk items to address prior to disposition of patient
  - Firearms – must be secured or removed from the home
    - This is determined by which is needed to keep the weapons away from the patient
  - Medications – must be secured in a locked container and administration supported by a family member
    - Includes vitamins/herbals/prescription/OTC/recreational
  - Sharps should be centralized and monitored by family
    - Need to ensure that items removed are used for their purpose and returned promptly

What do we look for to stratify risk?

- **Past suicidal behavior (>1 more predictive than 0 or 1)**
- **Current attempt and dangerousness/potential lethality**
- **Suicidal ideation**
- **Plan**
- **Preparatory actions**
- **Intent**
- **Non-suicidal Self-injury**
- **Protective factors**
- **Other significant assessment findings that would tend to decrease or increase risk**
    - Always be cautious using the “other” category to lower risk stratification, but easier to use it to increase risk
        - AKA “patient with personal hobby of collecting guns and swords”

What is next?
Stratify and Plan

Low Risk	Medium Risk	High Risk
• Continue treatment at the current level	•Escalate treatment plan to meet greater needs of patient •Safety planning, intermediate level of care, higher frequency of follow up	•Admit for inpatient care

Other environmental concerns

- The clinic location is where they spend only 1/730th of their month, and that is if they spend a whole hour with you
- The rest of their time is at home
  - At the most basic, if we have any history of self harm or suicidal behavior, home safety is the biggest key
  - We must assess for and plan for mitigating lethal means
    - Lock medications up (not hiding them)
    - Lock firearms up, and if they access this safe the firearms need to relocate to another place entirely
    - Consolidate sharps

Connecting with Higher Levels of Care -Communication is Key

- **Generate Documentation of clinicals and safety assessment/plan**
  - In connected systems, this clinical can be used directly to place patients for care
  - If not, this is still critical as there is a great deal of variance in report with multiple assessments
- **It is important to call for "warm handoff" of patient where possible**
  - so that providers at the receiving ER/Hospital will have critical elements of the story (if you know where they are going)
- **In both verbal contact and in written record, state your disposition/plan**
  - if there is need for more assessment then specify as well as possible (i.e. psychiatry to assess for autism/mania/psychosis, labs to evaluate ingestion, toxicology screen)
- **If you want INPATIENT, SAY SO!**

Connecting with Higher Levels of Care

- **If you are looking for an intermediate level of care**
  - Give parent specific referrals where possible
    - Give them a timeframe to call and know that you will follow up
  - Follow up
    - That they called
    - That the facility has availability in a reasonable timeframe (sometimes parents will just sign up for a 6-week wait list)
    - That they were accepted for the intended level of care
      - If there are concerns, don't be afraid to call the facility (after release to contact)
      - Make sure family signs a release for them to talk to you

Potential Conflicts

- The bulk of the heavy lifting in treatment for suicidal patients is in the outpatient setting
  - When we send them to inpatient psychiatric care, we are expecting some treatment thrust but it is to address safety in psychiatry and return them to outpatient care
  - It is not an intensive cure for mental illness
    - They get 24hrs/day of staff monitoring safety, but the patient is not getting 24hrs/day of therapy
    - Most therapeutic efforts are ***acute*** medication management and group therapy interventions
      - Acute medications are not done the same way as chronic medications, so it does tend to move treatment plans around quite a bit.
      - They aren't fixing their ADHD

Potential Conflicts

- Trauma is a major source of acutely worsening suicidal ideation
    - Triggers
    - Compounding trauma events
  - It doesn't treat acutely, and needs extensive outpatient therapy, so we will send them to inpatient but they won't acutely address that, so these may SLOW the therapy process
    - So even if it is the big, glaring elephant in the room, we can't just do a trauma narrative
- It is always easier to add a medicine than to remove one
  - Not removing unneeded medicines (and not disposing of the rest when you do) leaves more medicines in the home

Inpatient Setting

Inpatient Medical Setting

- A nationally representative sample of nonpsychiatric hospitals was surveyed on whether they carry out four best practices for helping patients at risk when they leave the hospital:
  (1) formal safety planning
  (2) warm handoffs to outpatient care
  (3) follow-up after discharge, and
  (4) lethal means safety planning.

- It found most hospitals apply one or two of these practices, but few apply all four at the same time as recommended.
- More than a quarter of hospitals were not using any of the interventions.

(Joint Commission and The Pew Charitable Trusts)

Inpatient Medical Setting

- Assessment
  - Important to occur as close to coming in the door as possible
    - In the ED
    - In the initial admission processes for direct admit
      - May inform room location
  - Initial assessment strategies are similar to those described in an outpatient setting
  - Daily reassessment if there are positive findings
- Stratify risk and adjust treatment plan accordingly

Stratify and Plan

Low Risk	Medium Risk	High Risk
• Continue medical treatment plan • No modified room • No additional staffing • No disposition change	•Involve MH team in treatment plan •Reduce high risk items •Q15 min PCTchecks/ documentation with Line of sight staffing •Q2 hr nursing safety checks •Daily reassessment of disposition	•Safer room if available •Low risk items and log belongings in/out •1:1 within arm's reach Q15 min documentation by PCT •Q2 hr nursing safety •Daily reassessment of safety/disposition •Admit for inpatient psychiatric care upon medical stabilization

Environmental Safety

- Reduce clutter, assess belonging location and needs
  - Lockers
  - Phones and communication devices (elopement risk?)
  - Medical implements
    - Sharps, tubes, lines have inherent risk
    - Patient self harm by manipulating/removing/damaging access or other medical device
  - Have family take home unnecessary items

Examples of Comfort Item Stratification

Red	Yellow	Green
• pens • DVD/media players • paintable ceramic figurines • bracelets/beads • Orby stress balls	• paint brushes • pencils/colored pencils • playing cards • X-box • Nintendo DS and Switch • soft cover books • hard cover book • Matchbox cars • sand art	• Crayons • Markers • individual color sheets • word puzzles • printer paper /construction paper /origami paper • sponges for painting • suction toys/suction basketball • stuffed animals • foam stress balls • plastic fidget toys • blankets and pillows

Inpatient Medical Setting

- **Medium or high risk should prompt an EMR flag**
  - Can be done in a variety of presentations
    - Epic at CMC produces an always visible left bar flag
  - Mental health consultation for med/high risk
    - Psychiatry for medication management
    - Psychology for short therapy interventions while in hospital
    - Support for disposition and safety planning activities
      - Placement for inpatient care
      - Facilitate connection w/ intermediate levels of care
      - Referrals for outpatient therapy/psychiatry

Inpatient Medical Setting

- **Hand off information is critical**
  - What has worked well this shift with the patient
    - Interaction style
    - Distractions from emotional state
    - Positive activities
  - What has not gone well
    - Triggers
    - Agitation
    - Refusing medical interventions
    - Refusing medications
    - Self-harm – including method, frequency, how discovered, situation/cues/triggers, how de-escalated
    - Additional/PRN medication and efficacy/side effects
  - Medical status and ongoing necessity for lines/tubes/sharps
  - Visitors – family, non-family, partner

Inpatient Medical Setting

- Formal Safety Planning
  - Assessment of ways to make the environment safer
    - Remove dangerous items from home, including firearms, sharps, meds, etc. remembering that hiding dangerous items is NOT sufficient
    - Availability of family/others to monitor
    - Recognize substance related risks in the environment
      - People
      - Places
      - Activites
    - Realize we can never make any location completely safe, only safer. There is always room to improve

Inpatient Medical Setting

- Formal Safety Planning
  - Warning Signs
    - Signs that either patient or those around them can identify that
      - Show worsening depression or irritability
      - Show worsening anxiety or impulsivity
      - Seem to come before suicidal thoughts or behavior
      - Show substance risk or consumption

Inpatient Medical Setting

- Formal Safety Planning
  - Individual coping
    - It is important to come up with a number of skills that the patient can use to
      - Distract from difficult or painful situations
      - Distract from suicidal thoughts themselves and allow them to pass
      - Improve mood or anxiety state
      - Build a future focus
      - Connect to supports
      - Build on their strengths

Inpatient Medical Setting

- Formal Safety Planning
  - Coping with others
    - Activities with patient-identified support people that
      - Distract from or reduce immediate mood or anxiety symptoms
      - Build the connection with others to want to re-engage
      - Move towards a future focus
      - Have a supported way to allow suicidal thoughts or impulses to pass

Inpatient Medical Setting

- Formal Safety Planning
  - Contact numbers
    - 911 (if something happened)
    - 988 (for emergency support of suicidal thoughts/behavior)
    - Emergency contacts for providers
    - Contact numbers for support people

Inpatient Medical Setting

- Disposition
  - Know the landscape
    - The patient or family often needs to make contact with the receiving provider before an appointment is able to be made
    - Conversely, some providers have them to show up in person and wait to be seen
    - Does the recommendation include therapy services? Psychiatry services? Partial hospitalization? Intensive outpatient care?
    - Once we have an appointment for a provider, how can we connect and have the warm hand off of a patient?
      - Who does it? Physician? Therapist? Social Work?

Inpatient Medical Setting

- Set the appointment
  - Provide the information on the hospital discharge paperwork
  - Provide the safety planning information
  - Provide the information in the language of the patient and family
- Have a method of follow up
  - If there is a connected provider, there should be a feedback loop to understand that they did get to the follow up and make sure information exchange has happened
  - If there is a provider outside the system, there needs to be a follow up phone call to ensure that patient has connected with that provider as planned, and if not to create a backup plan

Potential Conflicts with Care

- Safety planning in a hospital requires removing ligatures
  - Which can include IV lines, NG tubes, etc.
    - Critical parts of their medical care
- It also involves limiting potentially dangerous ways to harm themselves
  - If they are getting PLEX for their MS, there is tubing everywhere, and they have a gigantic line going into their neck with plenty of ends to grab
- In psychiatry, we also try to limit any type of device from which one could hang themselves

Potential Conflicts with Care

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Conflicts with Care

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ED Setting

ED Setting

- The ED setting takes the intensity of intake, the intensity of disposition, and the intensity of the presenting complaint and concentrates it into
  - Shorter
  - Higher acuity
  - High resource
  - High risk
  - High impact!
- It can be looked at as taking the needs of all of the other options and squeezing them into the most efficient package possible

ED Setting

- Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that even EDs without dedicated MBH services conduct medical screening examinations and provide stabilizing care for patients presenting with MBH symptoms

ED Setting

- Again, once through the door it is important to prioritize a screen for suicide as a routine part of the ED's initial contact with the patient
  - In Triage (with the advantage of deciding the room), or
  - In room and with initial nursing assessments
    - Sometimes this means moving patients and families when new information is uncovered
- ASQ is very useful due to brevity, though follow up with a C-SSRS is helpful
  - Note that if there ever has been an attempt, an ASQ will always be positive. Increasing stratification based on a years-old event may not be helpful.

ED Setting

- The Assessment
  - What resources are accessible?
    - Psychiatric ER / Psychiatrist for ED
    - Dedicated ED assessment team
    - Activating a mental health provider from another area
    - LMHA mobile crisis team
    - Virtual resources

ED Setting

- Until this assessment resource is available, what do we do with the presenting complaint/initial positive screen?
  - Visible and/or safer room options
  - Controlled access
  - 1:1 staffing with Q15 documentation by PCT/Q2h safety check by nursing
  - Remove cords from the room (chargers, etc) as well as other items that could be considered a ligature risk

ED Setting

- Upon assessment, again stratify into risk tier
- If cleared for outpatient care by assessor, may discharge home with follow up plan per assessment and follow up call in 1 week
- If a higher stratified risk, maintain observation and precautions until level of care recommended is obtained
    - Typically this remaining level of care is an acute inpatient psychiatry placement, in which case these precautions will persist until they are on an ambulance and depart to the facility
- Work to ensure that disposition is attainable by the patient
    - Only 31.2% of pediatric patients had an outpatient MBH visit within 7 days after an ED MBH-related visit, and
    - Only 55.8% had a visit within30 days
    - Consider alternative options (bridge clinics)

Areas of Conflict

- Boarding patients
  - They need to move elsewhere and are stuck
  - Benefit from additional hospital supports
    - Daily Schedule
    - Social work for addressing concerns or barriers to care
      - No coverage to qualification for Medicaid
      - Address childcare if adult/parent needs for peds
      - Work/school concerns
    - Consider if psychiatry could improve placement chances by management of agitation or other behavioral concerns
    - Ongoing efforts for placement benefit from efficient, automated processes (ex. Transferall)
      - Being stuck for too long could mean losing the placement acuity

Areas of Conflict

- Patients with suicide concerns again run into conflicts with ED rooms
  - Fixtures designed for rapid access aren't also designed for ligature free situations
  - The department by the front door isn't always the most insulated from elopement
  - The ED can fall victim to other emergencies pulling away people, equipment, and time from a suicidal crisis
    - And we are accidentally complicit, because running to an emergency we can immediately, physically act on is a more comfortable place for the ED providers and staff

Conclusions

- Time to assessment is critical at any level of care
- Once assessed, stratify risk and plan based on that level of risk
- Make sure the environment is planned for the level of risk
  - Sometimes this conflicts with medical care, and we have to work through finding the safest process
  - Utilize observation to maintain safety needs and allow for rapid recognition of worsening or change
- Have a follow up plan that fits the patient's needs, clinically and logistically
  - The best follow up is the follow up with a patient that shows up!

One more thing…

- Be very aware that assessing risk is not perfect, and there will be completed suicides in spite of our best efforts and using best practice standards.
  - When this happens, it is critical to have supports in place for staff that work in this capacity, as they already will have intense doubts about ability and competence following such an event. It never feels like a statistic when it's a person you assessed.
  - When we do look at process it is important to actually look at process, how it functioned, and how well we followed it.
    - Where possible, find an improvement to a process that helps the humans in the process get to the desired markers more consistently.
    - The humans involved are already punishing themselves and need support from the system, not blame.

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