Suicide Prevention and Risk Mitigation in Psychiatric and Acute Care Settings

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Objectives

1. Participant will outline key components of a thorough suicide risk assessment.
2. Participant will review effective interventions for acute care suicide prevention.
3. Participant will identify essential components of effective documentation of a robust suicide risk assessment and mitigation plan.

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Epidemiology of Suicide

- Suicide is the 10th leading cause of death in US
  - 43,000 deaths by suicide in 2014
  - 24% increase since 1999 with steepest increase in last 10 years
  - Highest rates among males occur in those over 75 years of age
  - Highest rates among females in those 45-64 years of age
  - Most frequent methods in 2014 . . . .
    - Firearms for males and poisoning for females
      - Over half of suicides are by firearms
      - Firearm suicides outnumber firearm homicides 2:1
- Suicides occur in all settings, *including hospitals*
  - At least 1500 per year

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Clinical Experience:

Clinical Observations

- Patients who attempted suicide in hospitals did *not disclose their suicidal intentions to staff*
- Most had denied current suicidal ideation and/or "contracted for safety" prior to the event
- Staff “trusting their gut” and doing an additional check on the patient often was the key factor that prevented completion of suicide

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Clinical Experience:

Clinical Observations

- Most exhibited one or more of these clinical symptoms and signs prior to the event:
  - Intense psychological anguish or distress
  - Intense self-loathing
  - Delusions of guilt
  - Agitation or perturbation
  - Hopelessness
  - Feeling that death would bring relief

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Clinical Experience :
Environment of Care

- Doors, door knobs, and even fixtures close to the floor could be used for hanging.
- Self-strangulation *did not require hanging.*
- *Practically anything* could be used for purposes of self-harm.

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Clinical Experience:

Keys to Prevention

- Safe physical environment and risk mitigation plan
- Clinical milieu that inspires hope and relieves psychological distress
- Suicide risk assessment practices that identify patients needing special precautions
- Vigilant patient monitoring and limiting access to secluded areas without supervision

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Standards, Quality and Accreditation

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Joint Commission Core Measures Program:

Hospital Based Inpatient Psychiatric Services Quality Measure #1

Violence Risk to Self

- Screen for violence to self over the 6-month period preceding psychiatric hospitalization
- Document within 3 days of admission

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Joint Commission National Patient Safety Goal:

Hospital and Behavioral Health Standards

Identify individuals at risk for suicide (NPSG.15.01.01)

- Rationale:
  - Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

- Elements of Performance
  - Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
  - Address the immediate safety needs and most appropriate setting for treatment of the individual served.
  - When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.

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CMS Quality Measure

- **Clinical Depression Screening and Follow-Up**:
  - Screen for depression using an age appropriate standardized depression screening tool on the date of the encounter
  - If the screen is positive, document a follow-up plan on the date of the screen
  - Do this at least once per year

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CMS Quality Measure

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or hav				
5. Poor appetite or ov				
6. Feeling bad about y have let yourself or				
7. Trouble concentrati newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

"Thoughts that you would be better off dead or hurting yourself in some way"

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Reporting to Agencies

Suicide in a 24-hour treatment setting and within 72 hours following discharge:

- The Joint Commission
  - A reviewable “Sentinel Event”
  - Reporting not mandatory but encouraged
- Maryland Office of Healthcare Quality (OHCQ):
  - “Level 1” event
  - Reporting mandatory

A credible root cause analysis required by both

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Suicide Risk Assessment

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Ask Suicide-Screening Questions (ASQ)

National Institute of Mental Health

- In the past few weeks, have you wished you were dead?
- In the past few weeks, have you felt that your family would be better off if you were dead?
- In the past week, have you been having thoughts about killing yourself?
- Have you ever tried to kill yourself?
  - If yes, how?
  - If yes, when?
- Are you having thoughts of killing yourself right now?

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Suicide Assessment Five-Step Evaluation and Triage: SAFE-T
(APA, SAMHSA)

1. Identify risk factors
2. Identify protective factors
3. Conduct suicide inquiry
4. Determine risk level/intervention
5. Document

This is an approach, not a form or a scale.

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Assessing a patient's suicidality or intent to harm others is complex and cannot possibly be addressed by merely asking the patient a "yes" or "no" question.

John R. Lion, M.D.

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The estimation of suicide risk, at the culmination of suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior.

American Psychiatric Association 2003

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Markers of Imminent Risk

- Serious suicide attempt immediately prior to admission
- Statements of intention to harm self while in hospital
- Plan for self-harm that is actionable in hospital
- Recent severely distressing loss, disappointment or threat
- History of suicide among friends or family
- Active substance abuse problem

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Markers of Imminent Risk

Clinical findings suggesting imminent suicide risk even in absence of expressed suicidal ideation or intent . . .

- Extreme psychological anguish or distress
- Intense self-hatred
- Hopelessness
- Agitation or "perturbation"
- Psychosis, especially delusional guilt
- A wish for death

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Protective Factors

- Dependent children living in the home
- A strong sense of responsibility to family or pets
- The following sources of support:
  - Friends, relatives, co-workers
  - Belonging to a faith-based community
  - Positive therapeutic relationship with a professional
- A sense of hope and future-orientation
- Ability to articulate reasons for living

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Comprehensive Suicide Risk Assessments

- Upon admission and frequently for patients identified as being at risk
- When moving inpatients from a close level of observation to a less restrictive level
- When a significant stressor occurs (i.e. patient receives distressing news)
- Prior to discharge
- Whenever there is a concern about the patient's safety or clinical presentation

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Inpatient Assessment Tool

1. Recent suicide attempt (seriously attempted suicide immediately prior to admission)	5. Self-hatred (shows signs of extremely poor self-esteem & feeling of worthlessness & guil…	10. Family/Peer suicidal history (hx of suicide attempts or successful suicide by family member or friend)	Presence of dependents? [is pregnant or has children at home]
Describe recent suicide attempts	Describe self-hatred	Describe family/peer suicide history	or pets]
2. Imminent suicide attempt (current desire to kill self in program)	6. Hopelessness (does not believe that he/she will ever feel better)	11. Substance abuse (recent history of substance abuse or dependence)	Sources of support? [has the following sources of support]
Describe imminent suicide risks	Describe hopelessness	Describe substance abuse history	
3. Actionable plan (has a specific plan that can be acted upon in the program)	7. Agitation (visibly restless & tense)	12. Recent severe stressors (experienced a devastating loss, disappointment or threat)	Hope/Future oriented?
Patient's actionable plan	8. Psychosis (has delusions, especially delusional guilt, or hallucinations)	Describe recent severe stressors	
4. Psychological pain or anguish (shows signs of extreme psychological anguish or distress	Describe psychosis		

Describe psychosis

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Thorough Risk Assessment

"Safety contracts" have NOT been proven to prevent suicide.

Reliance on safety contracts may lead to a false sense of security/safety and reduce staff vigilance.

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SHEPPARD PRATT HEALTH SYSTEM

POST-DISCHARGE SUICIDE PREVENTION

LEAN QUALITY IMPROVEMENT PROJECT

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Project Goal

Reduce the rate of suicide completions and attempts within 30 days of discharge by improving processes during and immediately following inpatient care.

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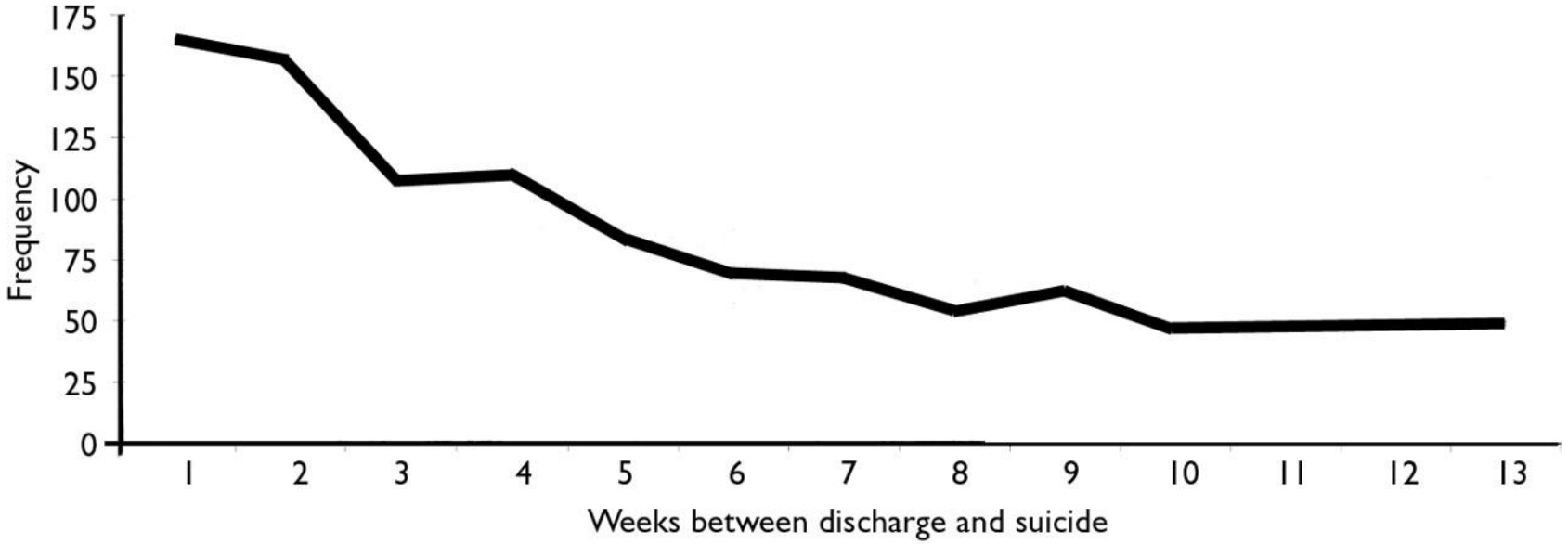
Why the need?



Highest Risk of suicide is within the first 2 weeks of a stay within a Psychiatric Hospital

[http://bjp.rcpsych.org/content/188/2/129]

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Project Barriers

- Lack of comprehensive baseline data (Open system vs. HMO)
- Volume of patients inadequate to demonstrate statistically meaningful change
- No evidence-based method for predicting individual risk

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“Perfect Depression Care”

C. Edward Coffey, M.D., Henry Ford Health System

- Marked decrease in suicide rate across large HMO system
- Multiple simultaneous interventions
    - Means reduction
    - Safety assessment
    - Improved access to care and active outreach

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Means Reduction

Getting Serious About Reducing Suicide
More "How" and Less "Why"

Jeffrey W. Swanson, PhD[1]; Richard J. Bonnie, LLB[2]; Paul S. Appelbaum, MD[3]

JAMA The Journal of the American Medical Association
December 1, 2015

For suicide in the United States, the most important modifiable risk factor is access to firearms

- Firearms used in 51% of completed suicides
- Case-fatality rate for intentional self-injury with firearm 84%

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Means Reduction

Admission Psychosocial Assessment

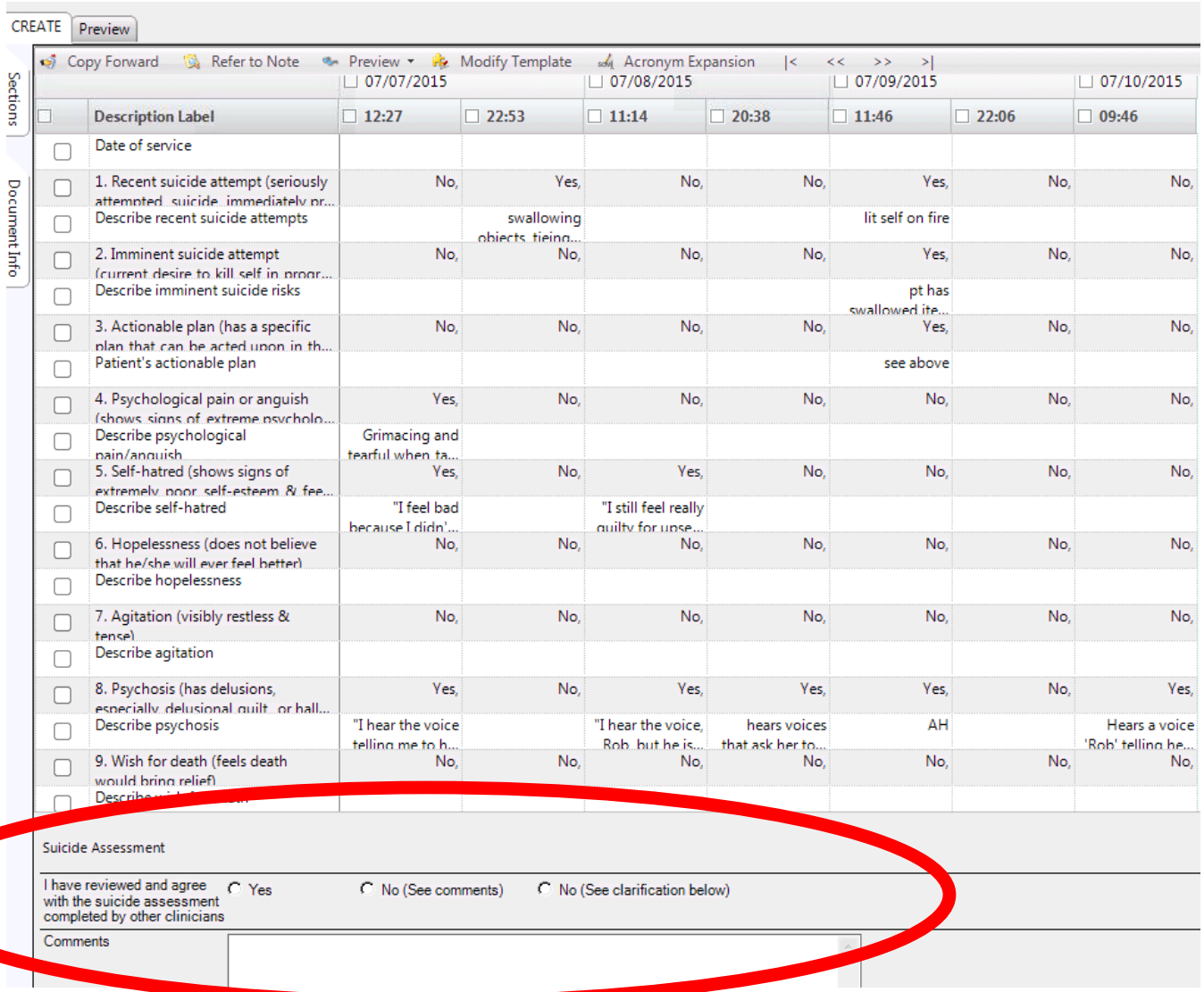
- **Explain:** Prior to her 5/2015 admission, patient attempted t
  Patient has history of lighting herself on fire more than
- **Access to Firearms/Weapons:** No
- **Other Risk Behavior:** Yes
- **Time Frame:** Current, Past 6 Months, Lifetime

Psychiatric Discharge Note

Means Reduction

Access To Dangerous Items	☐ Dangerous items were present in home and have been removed	☐ No dangerous items were present in home	☐ Other, see below
Specify			

Safety Assessment: Inpatient



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Date of service							
1. Recent suicide attempt (seriously attempted, suicide, immediately pr...	No,	Yes,	No,	No,	Yes,	No,	No,
Describe recent suicide attempts		swallowing objects, tieing...			lit self on fire		
2. Imminent suicide attempt (current desire to kill self in progr...	No,	No,	No,	No,	Yes,	No,	No,
Describe imminent suicide risks					pt has swallowed ite...		
3. Actionable plan (has a specific plan that can be acted upon in th...	No,	No,	No,	No,	Yes,	No,	No,
Patient's actionable plan					see above		
4. Psychological pain or anguish (shows signs of extreme psycholo...	Yes,	No,	No,	No,	No,	No,	No,
Describe psychological pain/anguish	Grimacing and tearful when ta...						
5. Self-hatred (shows signs of extremely poor self-esteem & fee...	Yes,	No,	Yes,	No,	No,	No,	No,
Describe self-hatred	"I feel bad because I didn'...		"I still feel really guilty for upse...				
6. Hopelessness (does not believe that he/she will ever feel better)	No,	No,	No,	No,	No,	No,	No,
Describe hopelessness							
7. Agitation (visibly restless & tense)	No,	No,	No,	No,	No,	No,	No,
Describe agitation							
8. Psychosis (has delusions, especially delusional guilt, or hall...	Yes,	No,	Yes,	Yes,	Yes,	No,	Yes,
Describe psychosis	"I hear the voice telling me to h...		"I hear the voice, Rob, but he is...	hears voices that ask her to...	AH		Hears a voice 'Rob' telling he...
9. Wish for death (feels death would bring relief)	No,	No,	No,	No,	No,	No,	No,
Describe							

Suicide Assessment

I have reviewed and agree with the suicide assessment completed by other clinicians: ○ Yes ○ No (See comments) ○ No (See clarification below)

Comments

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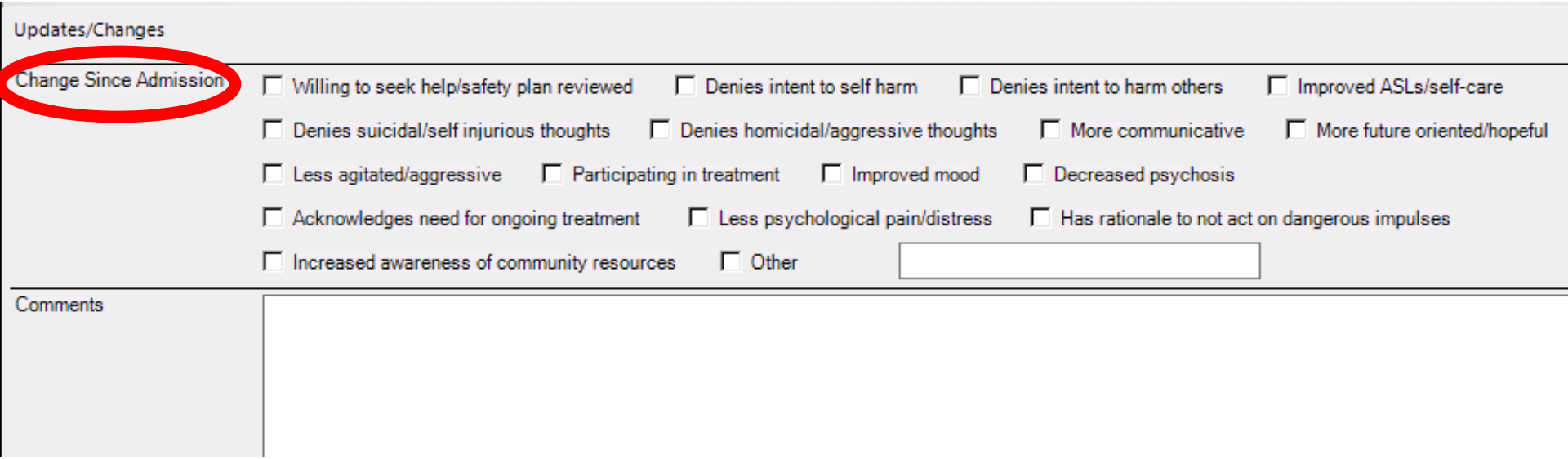
Safety Assessment: Discharge

Psychiatric Discharge Note



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Access/Outreach: Post-discharge Calls

- Treatment team obtains consent
- Outreach coordinator visits unit to introduce self
- Call occurs within 24 hours, with second attempt if needed
- Purpose: Confirm patient understanding of aftercare plan
- Algorithm used to facilitate access to care for safety related issues/emergencies

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Access/Outreach: Post-discharge Calls

- Outreach coordinator maintains log to identify trends
- What have we learned?
  - Most patients appreciate the follow-up call
  - Most common aftercare issues raised by patients:
    - Difficulty getting prescriptions filled
    - Don’t want to attend scheduled appointments
    - Did not feel ready for discharge
    - Scheduling errors
  - Urgent situations have been effectively managed with use of algorithm

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Other Related Improvement Activities In the Works

- Enhance team communication and documentation regarding MEANS REDUCTION
- CASCADE OUTREACH CALLS to all units
- Continued COLLABORATION with Ivy League Consortium of free-standing psychiatric hospitals regarding best practices

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Other Related Improvement Activities In the Works

- Re-evaluate suicide RISK ASSESSMENT tool
- Proactive clinical CASE CONFERENCES for high risk patients
- Use of ROOT CAUSE ANALYSES for completed suicides and serious attempts
- Ongoing staff EDUCATION regarding suicide prevention and lessons learned

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DOCUMENTATION

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Documentation of Risk Assessment

Do NOT document:

“Patient contracts for safety.“

Documentation of Risk Assessment

Instead, document:

- Protective factors and factors mitigating risk
- Specific indicators that the patient is not at risk for imminent self-harm
- Patient's plan to remain safe
- Future orientation/reasons for living
- Patient quotes when possible
- How the patient has changed/improved during treatment

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Concluding Summary

- Be aware of risk factors for suicide
- Know the elements of a comprehensive risk assessment and how to document them
- Reduce ligature points and access to potentially dangerous items within reason and as much as feasible
  - Utilize risk mitigation strategies, such as increased observation, limiting unsupervised access to private areas of the treatment area, etc.
- Remain vigilant and trust your instincts
  - The majority of serious inpatient suicide attempts were thwarted by direct care staff "trusting their gut" and checking on patients they were concerned about
- Key suicide-prevention interventions:
  - Thorough assessment
  - Means reduction
  - Good access to care
  - Post discharge outreach

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