Foundation *for* Healthy Communities

Suicide Screening & Intervention Strategy for New Hampshire Emergency Departments

This strategy is based on the best information available at time of development. Material presented in the training is designed to serve as a guideline only. It is not intended to define a standard of care and should not be construed as one. This first version of the strategy is designed for initial implementation planning. Updates will be provided based on feedback and input.

Suicide Screening and Intervention Toolkit for New Hampshire Emergency Departments

Release Date: December 2020

Executive Summary

Suicide is a public health crisis. It is the 10th leading cause of death nationally, but in NH it is the 8th leading cause of death for all ages. Suicide is ranked first in cause of death for ages 10-14 and second for ages 15-44.[1] One third of Americans know someone who died by suicide. Approximately one in four people have said they have thought about suicide, with many of these patients presenting in hospital Emergency Departments (ED).[2]

The ED is an essential source of support for many people with suicidal ideation. Although EDs are hectic and busy environments, they are designed to screen and treat emergency conditions and stabilize patients. EDs are ideal locations to save lives by screening for suicidal ideation and providing interventions when appropriate.

Suicide screening tools are designed to assist in determining a patient's level of risk and should be used as an extension of professional clinical judgment. The initial suicide screening should be brief and when combined with clinical judgment, as well as other factors such as collateral and other sources of information, can assist in determining next steps in patient care.

The Behavioral Health Clinical Learning Collaborative (Collaborative) members have examined suicide screening policies and interventions for the ED setting in both NH hospitals and nationally. The Collaborative created this toolkit to outline recommendations based on current evidence, experience and input from Collaborative members and stakeholders. The Collaborative members' aim is to provide information to help EDs identify, support and treat patients with suicidal ideation. The toolkit is strictly a guide for implementation.

Adopting a Uniform Approach to Screening

"…Our purpose (in the Behavioral Health Clinical Learning Collaborative) is to determine if the Columbia-Suicide Severity Rating Scale (C-SSRS) could be retrofitted with triage points in emergency departments that make sense to us and allow for a nurse/triage area to initially make a quick assessment of suicidality. From there, a determination via the triage points would be used to determine whether an additional assessment/community mental health involvement is needed. Our hope is that this could then be adopted throughout the state to lessen the burden on our limited resources while at the same time assisting the patients in the most effective way possible to get the help they need."

Dennis Walker, MSW, LICSW
Seacoast Mental Health Center
Behavioral Health Clinical Learning Collaborative Steering Committee

[1] https://www.cdc.gov/injury/wisqars/fatal.html
[2] https://today.yougov.com/topics/lifestyle/articles-reports/2018/09/13/americans-depression-suicide-mental-health

Behavioral Health Clinical Learning Collaborative

The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative (Collaborative) is a grant funded program designed to address the management and treatment of patients experiencing mental health crises in the emergency department setting and is funded by the Endowment for Health and New Hampshire Charitable Foundation. The Collaborative members consist of New Hampshire Emergency Department (ED) and Community Mental Health Center (CMHC) staff working together with community stakeholders to design and adopt strategies to assist in the immediate evaluation, management and treatment of patients with behavioral health emergencies while in the ED and their longer-term care pending transfer to appropriate level of care.

At the start of the Collaborative, the hospital and CMHC members determined the need for standardized screening tools. They agreed that having a lack of standardized methods and validated tools make professionals more risk averse and more likely to invoke subsequent steps that may be more intense than needed. The Collaborative members reviewed many tools and identified the Columbia-Suicide Severity Rating Scale (C-SSRS) as the preferred, validated, evidence-based suicide screening tool to use in the EDs. In addition, the C-SSRS was already adopted by the Community Mental Health Centers (CMHC) Emergency Services (ES) teams. In 2018, the ES teams saw over 33,000 patients who were suicidal or in crisis. The teams noted they did not have uniform ratings of suicide severity risk when using their current tools. The definition of an adverse event was unclear, as was determining the level of risk and treatment interventions. The ES teams selected the C-SSRS based on its ease of use and validity. In addition, when using the C-SSRS, facilities have shown reductions of 1:1 and psychiatric consults, ability to reduce suicide while reducing burden, and protection against liability.[3]

The Collaborative determined that many EDs already have access to the C-SSRS tool, but algorithms, next steps and protocols are missing in some facilities. The C-SSRS is simple, suitable for all populations, readily available (in EHR systems and paper), easily understood, and delivers outcomes that can assist in planning the next steps for a patient's care. It is also endorsed by the CDC and listed as a best practice by The Joint Commission.

The C-SSRS allows ED staff members to screen quickly for suicidality and provides clinical decision support to help determine next steps in the care continuum. The next steps may include discussing the potential risks with the patient, performing a psychiatric assessment, referring the patient to an outpatient behavioral health appointment, or detaining a patient involuntarily if imminent threat for suicide is suspected. Working together to standardize this screening process throughout the state will leverage our limited resources and help clinical systems understand the patient's risk level in a uniform and standardized manner. It will also help to clarify the patient status and determine the best resources and level of care needed. The Collaborative will continue to share lessons learned and provide feedback to and from their respective hospitals and CMHCs on their suicide screening programming in the ED setting.

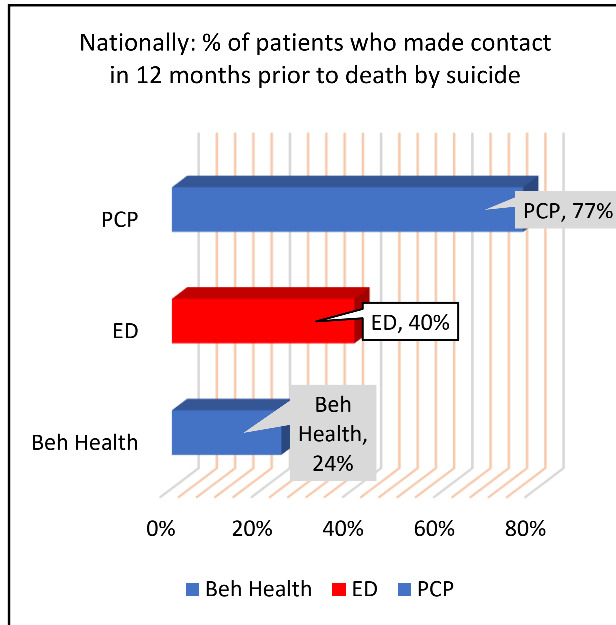
[3] https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/

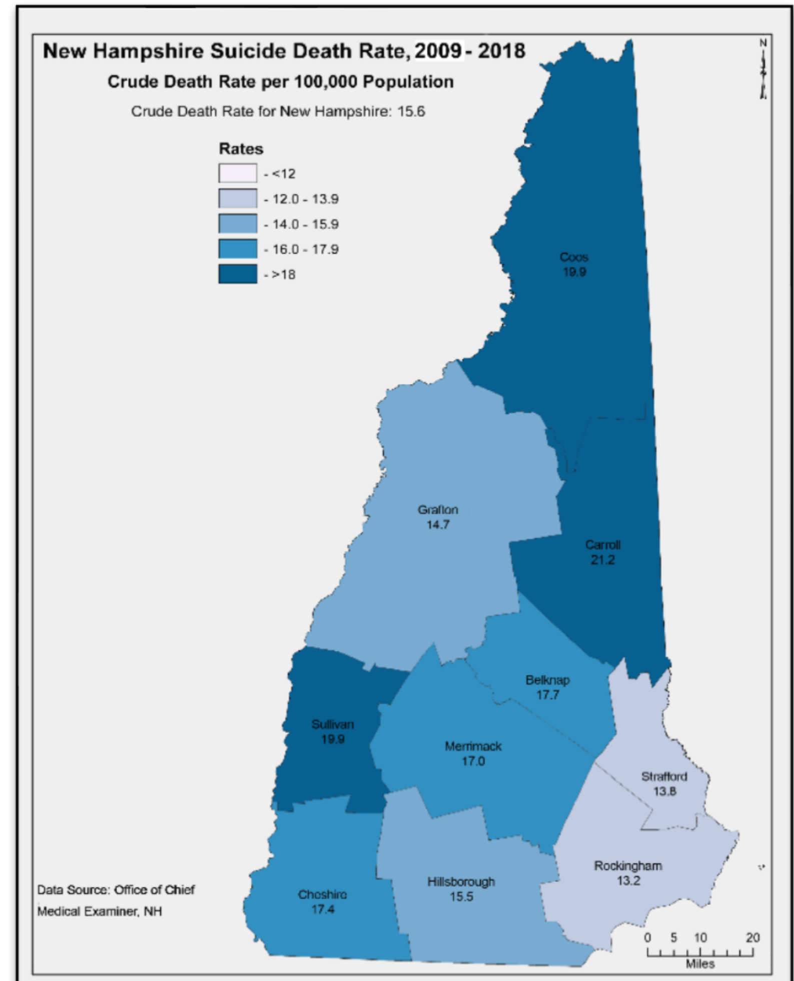
Suicide Prevention Strategy Starts with Screening – Role of Emergency Rooms

NH Crude Death rate – 15.6

According to the CDC (2018), suicide occurs at a rate of 13.4 per 100,000 individuals nationally, but in NH, that number is higher, at 15.6 individuals per 100,000. The ED staff can play a critical role in identifying patients at risk for suicide. Studies in the U.S. show that close to 40% of patients who died by suicide contacted an ED provider in the 12 months before their death.[4]

All NH hospital EDs have representation in the Collaborative and share its vision to develop a well-integrated service system that provides the most appropriate care for patients experiencing a psychiatric emergency. This toolkit is offered to help our NH EDs with improved screening and recognition of suicidal ideation, along with improved provider knowledge and attitudes. It can be used to assist in implementing or updating suicide screening protocols and intervention initiatives.





[4] Jason B. Luoma, Catherine E. Martin, Jane L. Pearson. Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. American Journal of Psychiatry. 2002;159(6):909-916.
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Benefits of Using a Suicide Screening Tool

With all the challenges and distractions in the ED, the ability to refer to a standardized screening protocol can help staff carry out clinical inquiry more effectively and consistently. Well defined algorithms offer decision support that can be engaged early in the process. Remember that screening tools are aids and understanding the limitations of tools is essential in using them correctly.

Asking the Right Questions
"Asking the right questions to determine suicide risk should be as routine as checking blood pressure — and, with the Columbia Protocol, it's just as quick. The Columbia Protocol — also known as the Columbia-Suicide Severity Rating Scale (C-SSRS) — also helps optimize healthcare resources by directing people to the right level of care." *https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/*

Who Should be Screened for Suicide?

One typical question is, “Who do we screen?” What is more appropriate, targeting specific patient populations, such as those with behavioral health conditions, or performing a universal screen of all patients who present in the ED? There are pros and cons to selecting either population, so EDs must examine their respective populations to make their own screening decisions. The following considerations can help develop the right approach:

- Universal screening removes the stigma associated with screening for suicidal ideation.
- Not all patients who have suicidal thoughts reveal their thoughts unless asked.
- If a system decides to select a targeted population to screen, it will still need a process to determine who to screen and who not to screen.
- Universal screening may be more straightforward than deciding who to screen.
- During the pandemic, more patients with comorbid and/or acute ailments may suffer from pain, depression, overwhelming societal challenges and increased the risk of self-harm, which supports a universal screening protocol.
- Universal screening can be resource-intensive and may disrupt the original reason for the ED visit if not related to suicide.

In summary, the EDs must select an approach that aligns with their vision and mission of care delivery and organizational resources (both screening and management).

Asking Questions about Suicide can be Difficult

Collaborative members identified confidence, empathy and patience as key qualities for those performing the screening for suicidal ideation in the ED setting. Formal training is not required to use the C-SSRS screening tool, however, the process of asking the questions and processing the answers necessitates practice and preparation. For example, maintaining a therapeutic alliance while managing patients who are upset when told they cannot leave the ED can be challenging.

Clinical staff performing the primary suicide screening must double-check their comfort levels when discussing suicidal ideation with patients, their family members as well as clinical partners. "Due to the intensive nature of treatment and emergency and inpatient settings, it may be easy to neglect interpersonal

aspects of care. Yet, people are at their most fragile and sensitive state in crisis settings, and they can benefit greatly from compassionate care."[5]

A suicide screening initiative is likely to be successful if the ED staff and organizational leadership align their approaches and goals for the screening. Providing strategic planning, training opportunities and supportive clinical practices are essential for the success of this approach. Ongoing education and discussion will allow clinicians and staff to remain vigilant and prepared. Case reviews and role-playing exercises can play impactful parts in recognizing signs and assessing symptoms. The team must also examine the ongoing impact of its interventions and decision-making based on their findings. Developing a common language and clarity on needs, matched with care levels, will improve patient care across all organizations.

Training is available from the Columbia Lighthouse Project:

> *Free Training for Communities and Healthcare*
> *Consisting of online options that can be completed in as little as 30 minutes, as well as pre-recorded webinars that are less than an hour long.*

It is important to review patient history, as it may not be their first time in the ED. Previous experiences with hospitals and health care professionals can influence patient reactions. The importance of finding the precise detail on the case is essential. Patients may feel ashamed or defensive. They may be unable or unwilling to answer questions. They may deliberately withhold information. Collateral sources, such as police officers, Emergency Medical Services (EMS) providers, friends, family, teachers, and others are often valuable resources, providing information regarding the patient's intentions. Ideally, one must obtain the patient's permission to consult with collateral sources. However, the law provides support to professionals, who, in good faith and guided by a specific clinical reason, may reach out to collateral sources irrespective of the patient's wishes.

Important Tips for Screening

- Documenting a brief opinion reflecting on a patient's capacity to participate in and understand the screening process is important.
- Empathetic engagement is vital in making sure that the patient will be confident in disclosing their inner feelings.
- Improving patients' comfort with items such as warm and/or weighted blankets, meeting their physical needs, and reassuring safety is essential.
- Patients must receive an appropriate explanation as to why such questions are asked. Scripting appropriately worded sentences can help start the conversation.
- Conversations must be non-threatening. Sitting at the person's eye level, giving appropriate time and space, and addressing their concerns help patients in emotional distress who may feel nervous disclosing their suicidal thoughts.
- Robotically asking screening questions can make patients wonder if the provider is checking a box or is genuinely concerned about them. It is better to let patients speak without too much interruption and look for opportunities to put in the screening questions at the right moment to maintain a sense of trust and respect.
- Practice and discuss with colleagues.

Collateral Counts

"*Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others.*"
Suicide Prevention Resource Center http://www.sprc.org/

[5] National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. (2014). The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. Washington, DC:

Primary Screening – How to Do It

The C-SSRS is a series of simple, straightforward questions that can become more detailed depending on the previous question's response. The C-SSRS is available in more than 100 languages and has various versions that are applicable in different settings. The screening tool recommended for initial screening in the emergency department is the *Screen for the Emergency Department,* or the *Screen*. In this version, questions 1 through 5 (Q1-Q5) are related to the patient's thoughts in the last month. Question 6 is related to behavior and has a more extended time range. Q1, Q2, and Q6 must be asked during each screen. If Q2 is "Yes", then Q3 through Q5 must be asked as well, but if Q2 is "no", then there is no need to ask Q3 through Q5. The screen is color-coded below, based on risk level. Red is considered high risk. The next level in descending order of concern is orange, which is considered moderate risk, and yellow is considered low risk. Based on feedback from the Columbia Lighthouse Project team, risk is fluid, so at the time of questioning, documentation should state the risk identified is low, moderate or high *at the time of the screening.*

Columbia-Suicide Severity Rating Scale: *Screen with Triage Points for Emergency Department*

Questions	Description	Answers	
		Yes	**No**
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Questions 1 focuses on the wish to be dead, not be alive anymore.	Low Risk	Move to Question 2
2. Have you actually had any thoughts of killing yourself?	Question 2 reflects on active thoughts of killing oneself.	Low Risk Ask Questions 3-6	Move to Question 6
If the answer is NO to both questions 1 and 2, then the screener moves on to Question 6.			

Questions	Description	Answers	
		Yes	No
3. Have you been thinking about how you might do this?	Question 3 examines the thought process of planning to take one's own life. The thoughts may not be specific, or there could be multiple plans. For example: "I thought about taking an overdose but I never made a specific plan as to when or where or how I would actually do it…and I would never go through with it."	Moderate Risk	Ask Question 4
4. Have you had these thoughts and had some intention of acting on them?	Question 4 focuses on the intent or decision to act on one's thoughts. **As opposed to** "I have the thoughts but I definitely will not do anything about them."	High Risk	Ask Question 5
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Question 5 examines the extent of the planning process. Partial and incomplete plans as well as fully developed plans can reflect intent. Note that the lethality of the plan is not part of a screen. Having a detailed plan is enough for Q5 to be a "yes."	High Risk	Ask Question 6
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	Question 6 looks at behavior. It is positive when the behavior was carried out, such as purchasing guns or purchasing or hoarding medicines to overdose. An actual attempt is also an example of such behavior. Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Within past 3 months High Risk Over 3 months ago Moderate Risk	Low risk identified

Triage Points for Screen Results

Once the screener determines level of risk, there is no clear mandate, but most systems using C-SSRS have similar triage approaches to the various color-coded outcomes. The hospital systems and EDs adopting C-SSRS must define their own clear clinical pathway, based on clinical needs, safety, frequency of such events, and resources available within and outside the system. Below are examples of triage points. Brief interventions in the ED may include trauma-informed approaches[6], safety planning[7], confirmed appointments with outpatient behavioral health provider at discharge, as well as follow up postcards or phone calls.[8]

Screen Result	Yes	No	Triage Points
Low (or No) Risk	Q1, Q2	Q3, 4, 5, 6	Behavioral Health Referral at Discharge
Moderate Risk	Q3 Q6 (Yes for more than 3 months)	Q4, Q5	Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
High risk	Q 4, 5 Q6 (within last 3 months)		Detain/Involuntary Emergency Admission (IEA) Safety Precautions Conduct Full Behavioral Health Assessment/Safety Evaluation

[6] https://store.samhsa.gov/product/Trauma-Informed-Care-in-Behavioral-Health-Services-Quick-Guide-for-Clinicians-Based-on-TIP-57/SMA15-4912
[7] Brown, Gregory K., Stanley, Barbara, Patient Safety Plan Template, 2008 https://www.sprc.org/resources-programs/patient-safety-plan-template
[8] https://www.nih.gov/news-events/news-releases/life-saving-post-er-suicide-prevention-strategies-are-cost-effective

Managing the Complexity of the Orange Zone

The yellow zone and the red zone are relatively easy to identify triage points; however, the orange zone can present a challenge. Considerations include:

- The risk is not imminent or severe, but of reasonable concern.
- The patient's right to choose or decline care.
- Concern by providers and hospitals that if something goes wrong, they may be held responsible.

The short-term anxiety of being held accountable often hinders the realization that the therapeutic alliance and confidence of a patient in a health care system is one of the most important safety factors. A patient unduly restrained or detained may lose faith in the health care system and never return for help in the future. Conversely, a correctly detained patient may develop confidence in the system. The most incorrect approach in identifying risk would be to base this decision on hospitals' risk aversion strategy or presence or absence of resources.

To understand this problem, one needs to differentiate between "due diligence" and "wishful thinking." A desire to correctly predict a risk is impossible but maintaining due diligence is entirely possible. A clinical example from a different medical discipline may be helpful. A patient who is obese, smokes, has a family history of cardiac disease, and has been diagnosed previously with coronary artery disease comes to the emergency department with chest pain. They are screened by exam, routine EKG and a troponin test. Suppose the screening exam concludes unstable angina but no active ST segment elevation and negative troponin. In that case, it is akin to wavering suicidal ideation or recent suicidal ideation, but the intent and plan are absent. At this point, one can say that the patient is at a moderately high risk of having a heart attack (or relatively at potential risk of worsening and developing acute/active suicidal ideation with intent and plan at a point in the future) but no imminent danger now. This patient does not require a cardiac cath, nor needs admission to the cardiac care unit. Instead, they need an outpatient appointment with a cardiologist as soon as possible. It means that there will be instructions, education and referral discussion, but not an admission. It is imperative to make sure that the patient also has the capacity to understand the level of risk when the clinician makes the recommendations.

An example of no risk identified (aligning with "no" on Q1, Q2 and Q6) would be when a person who came to the ED today had some shortness of breath last night. They have no shortness of breath now, no history of coronary artery disease, no chest pain, and a normal EKG. This person will be reassured and just asked to monitor themselves and check-in with their PCP.

An example of high risk would be when Troponin comes back as positive and there is ST Elevation. The presence of these findings indicates a cardiac consult, a cath lab, and admission to the hospital for observation and or treatment. The patient may just need medication adjustments, a stent, a coronary artery bypass, a pacemaker, or defibrillator placement.

In medical scenarios, even when there is a high risk, e.g., when a cancer patient or a cardiac patient declines lifesaving treatment, a proper evaluation of their capacity allows the providers to agree or disagree with their request of refusing treatment. Capacity assessment is a specific evaluation. The patient has to demonstrate that they understand the issue and the recommendations, can voice an opinion, and can show rational management of data. In psychiatric illness, an additional question begs an answer. A patient on the surface may appear to respond correctly to the capacity questions but still may not have capacity if they suffer from an emotional or mental health issue in which the illness affects their judgment. A full psychiatric evaluation answers this question.

In summary, a clinical team dealing with moderate risk should engage in the following:

- Screen using a standardized tool.
- Feel confident that the screen is reliable (see box below to consider screening accuracy).
- Assess and document that the patient can understand that there is a risk.
- Provide a clinical opinion as to the best intervention for the current condition. (It may be a discussion with Psychiatry Team/ Psych social worker or other provider as per hospital policy).
- Demonstrate a diligent (reasonable/acceptable) attempt to implement the necessary intervention.
- Provide an argument as to why the risk is not severe enough to take the next higher-level step. For example, why not a Cardiac Cath (or involuntary emergency admission)?
- Provide evidence that the patient was notified to return/seek help should symptoms worsen, or new symptoms appear.

The Role of Clinical Judgment in Suicide Screening

As mentioned above, C-SSRS is an aid and does not replace clinical judgment. Do not use the C-SSRS as a sole source in triage considerations. Other information such as clinical history, collateral information, and the patient's observed behavior must be considered alongside C-SSRS findings.

A question sometimes arises when people are asked to use their clinical judgment versus a screening result. The challenge here is that there are no clear definitions of clinical judgment. Such a situation happens when there is concern that the patient may not be reporting the truth. One way to think this through is to identify some constructs that experienced clinicians use to see above and beyond the screening tool's answers. These are summarized into four categories in the box below.

Screening Data May Not Be Accurate If:
❖ The patient's account is unreliable due to contradictory information and/or changing statements. ❖ The collateral informant's account does not corroborate the patient's statement. Collecting collateral information, in many cases, is as vital as interviewing the patient. ❖ Historical data is available about the patient's low reliability in assessing their own state of mind or reporting their thoughts accurately. ❖ The patient's behavior and observed affect do not match the stated internal experience. An example would be when the patient discards their severe injury and dismisses it as "nothing of concern." Another example would be when a patient says they are perfectly fine but, on observation, appear distressed, sad, or agitated.

Strategies to Consider for Successful Implementation

Creating a suicide screening process in the Emergency Department will require staff involvement, leadership buy-in and workflow analyses to consider where the screening is most feasible to implement. The strategies developed must include short and long-term goals, data collection planning and evaluations. The Collaborative members examined the use of the C-SSRS at both triage and nursing assessment. Although the screening is usually a quick process, some Collaborative members found the screening more effective during the nursing assessment vs. triage, as there is more time to establish rapport with the patient being screened. When enlisting buy-in from team members, focus on change champions who can lead the initiative and motivate their colleagues. Take a special interest in those who do not support the project. Ask for their feedback and perspective to understand from where their objections are based. Demonstrate how important the screening can be for both short and long-term care of the patient. Work with community partners, especially community mental health centers, on the initiative. Both community mental health centers and hospitals are using the C-SSRS, so the ability to share findings, properly assess and design interventions will be consistent and complementary.

Samples of workflows, toolkits and interventions:

- ICSI publication: ***Suicide Prevention in EDS Call to Action***
- Suicide Prevention Resource Center: ***Strategic Planning Approach for Suicide Prevention***

How Does Screening Lead to Assessments and Interventions?

It is essential to differentiate between screening and suicide risk assessment (SRA). Screening is a quick and straightforward process, allowing providers to determine if an SRA and additional interventions (such as patient detention, safety precautions, and treatment) are needed. A designated level of expertise performs the SRA (often a mental health provider). The SRA is a thorough process that further evaluates a person's thoughts, behaviors, acute and chronic risk and protective factors, and medical, psychiatric, and substance use history. The SRA and appropriate clinical actions can help to monitor distress and suicidal ideation over time, assist in diagnoses and make recommendations for safety and treatment of the condition leading to high acute risk. The screening and SRA must be a collaborative, consultative, and standardized practice between all parties involved in the patient’s care.

Can the Collaborative Make a Difference?

The Collaborative brings together experienced mental health and emergency care professionals who are working together while respecting each other’s competencies. The Collaborative has provided a forum for shared ideas, concerns and frustrations that has led to a level of consensus that can add uniformity to screening processes where previously screening was not uniformly in place. The C-SSRS screening process, along with the other priorities in the Collaborative, are being constructed by dedicated professionals who are working to provide a therapeutic entry point for patients with behavioral health emergencies. For far too long, the ED has represented a location for holding those deemed at highest risk, those with the greatest need for therapeutic intervention.

It is our hope and more directly our expectation that the Collaborative has positioned mental health services and acute care hospital emergency departments as partners in improving the lives of the many patients in New Hampshire who lack options for compassionate care.

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MNHealth Collaborative (ICSI), Call to Action: Suicide Prevention and Intervention in the Emergency Department (ED), Spring 2019

The NH Suicide Prevention Annual Report 2018

SAMHSA (Substance Abuse and Mental Health Services Administration) A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors, After an Attempt

Suicide Prevention Resource Center: Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments

Suicide Prevention Resource Center: Emergency Departments Website

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