

Strategies for Enhancing Treatment Interventions for Suicidal Crisis

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connections
HEALTH SOLUTIONS





- Friday. 4:30 PM. The phone rings.
- Your spouse's boss needs help with his brother.
- He's been texting family members about how he would be better off dead.
- They're afraid he might hurt himself.
- He might also have a drinking problem and need detox.



**BONA FIDE MENTAL
HEALTH EXPERT**

What do you advise?

CALL THE
PSYCHIATRIST/THERAPIST/CLINIC

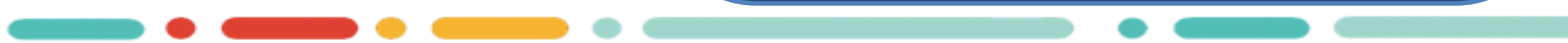
CALL 911



GO TO THE
EMERGENCY ROOM

GO TO THE
CRISIS CENTER

GO TO THE
DETOX CENTER



“It’s
easier
to get into
heaven
than access
psychiatric
care.”



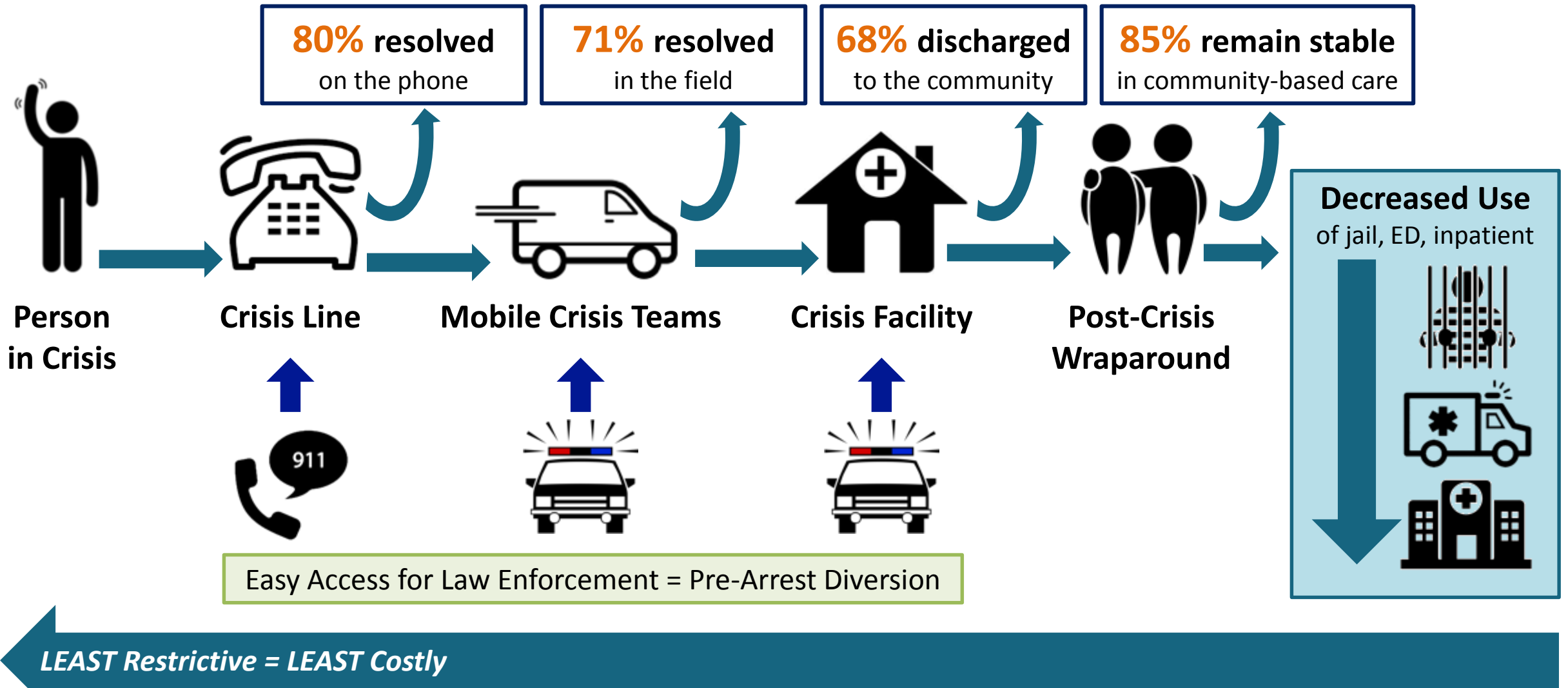
**A suicidal crisis is
an emergency.**

It requires a **systemic**
response with the
same quality and
consistency
as the response to heart
attack, stroke, fire, and other
emergencies.



- **A SYSTEMIC** response to suicidal crisis
- that delivers EVIDENCE-BASED care to people who need it
- with MEASURABLE OUTCOMES
- in the LEAST-RESTRICTIVE setting that can safely meet the person's needs
- (and by the way, the least-restrictive settings also tend to be the LEAST-COSTLY)

The Crisis Continuum



Schematic designed by Margie Balfour, Connections Health Solutions. Data courtesy Johnnie Gaspar, Arizona Complete Health
Data applies to southern Arizona geographical service area, last updated Sep 2019

Emergency Department

“PES (Psych ER)”

Where?

Locked or Unlocked?

“Crisis Residential”

Staffed by?

Environment
of Care

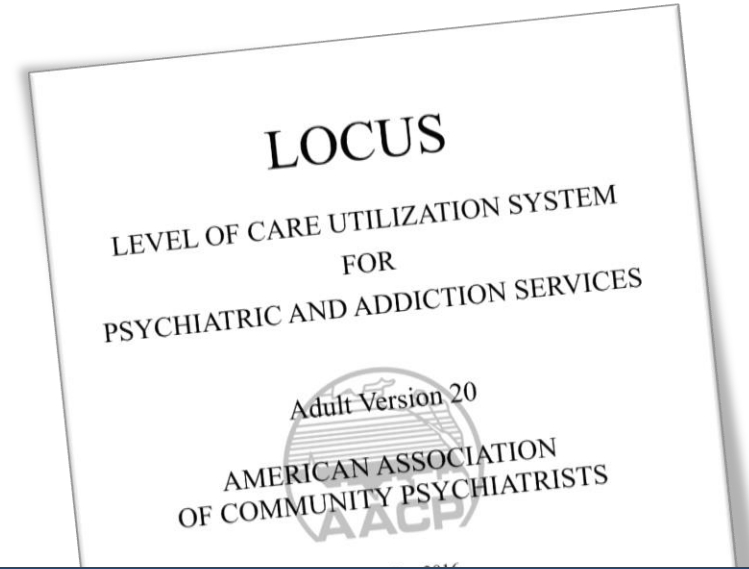
“Receiving Facility”

24/7 Staffing?

Ligature Safety?

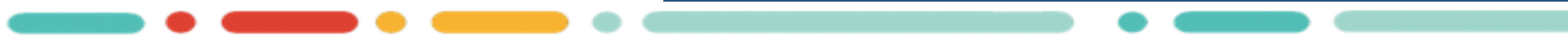
“Diversion Center”

“Crisis Respite”



**Level of Care Determination:
Across 6 Dimensions**

1. Risk of Harm
2. Functional Status
3. Medical, Addiction, and Psychiatric Co-Morbidity
4. Recovery Environment
(both level of stress and support)
5. Treatment and Recovery History
6. Engagement and Recovery Status

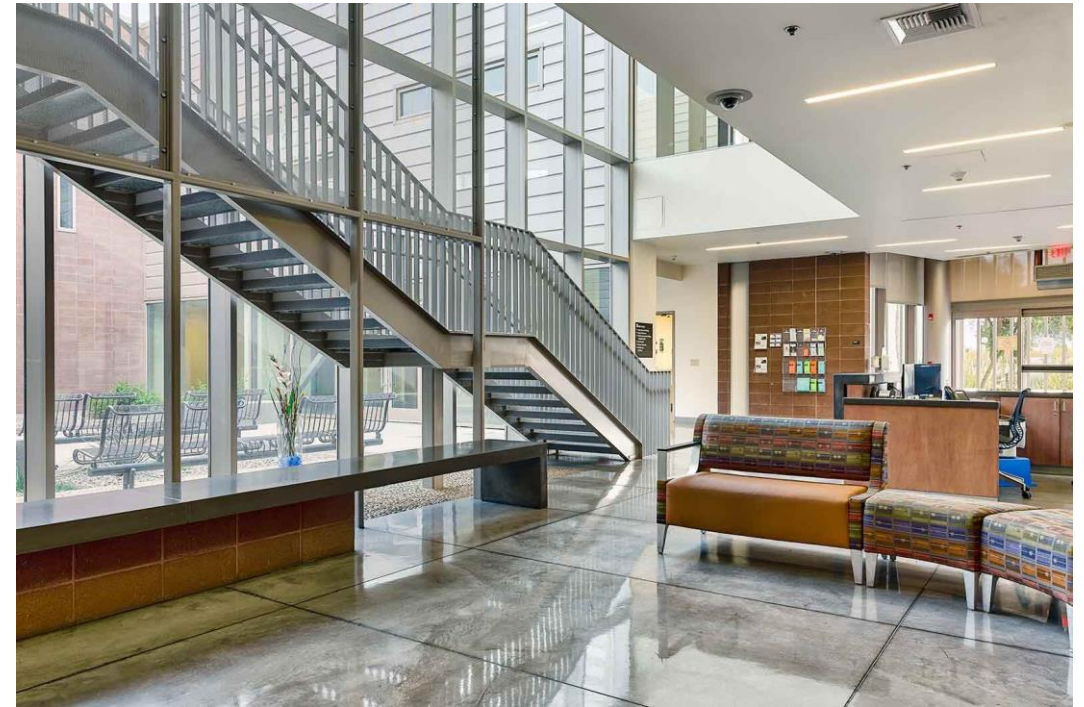


Where?

Emergency Room?



Crisis Facility?



In the ED: To screen or not to screen?



Joint Commission NPSG 15.01.01, EP 2

BH Facilities: “Screen all individuals served for suicidal ideation using a validated screening tool.”

Hospitals: “Screen all patients for suicidal ideation **who are being evaluated or treated for behavioral health conditions** as their primary reason for care using a validated screening tool.”

What about everyone else?

Universal Screening

In the month prior to suicide death:

20% had contact with a BH provider

45% had contact with a **non-BH** provider

ED-SAFE study: universal screening increased the detection rate:

from 2.9% to 5.2%

80% EDs report psych boarding

Only 17% of EDs have psychiatrists

Only 11% report any BH on call

Terrible patient experience

Boarding times range from hours to days

Loss of \$2300 for each boarded patient

Increased risk of harm to patient and staff



American Association for Emergency Psychiatry

Membership is a mix of psychiatry
and emergency medicine

“AAEP supports universal
suicide screening of patients in
the emergency setting
and appropriate funding for
screening and indicated
services.”

“The PHHS experience suggests that universal suicide risk screening is feasible in a large, diverse public hospital, with the potential of saving many lives, and does not represent the opening of a Pandora’s box.”

--Editorial commentary in *The Joint Commission Journal on Quality and Patient Safety*

The Joint Commission Journal on Quality and Patient Safety 2017; 44:1-3

Universal Suicide Risk Screening in the Hospital Setting: Still a Pandora’s Box?

Lisa M. Horowitz, PhD, MPH; Edwin D. Boudreaux, PhD; Michael Schoenbaum, PhD; Maryland Pao, MD; Jeffrey A. Bridge, PhD

The Joint Commission Journal on Quality and Patient Safety 2017; 44:4-11

Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System

Kimberly Roaten, PhD, CRC; Celeste Johnson, DNP, APRN, PMH CNS; Russell Genzel, MSN, RN, CEN; Fuad Khan, MD, MBA; Carol S. North, MD, MPE

Background: Many individuals who die by suicide present for nonbehavioral health care prior to death. The risk is often undetected. Universal suicide screening in health care may improve risk recognition. A quality improvement project involving a universal suicide screening program was designed and developed in a large safety-net health care system.

Methods: The steps in developing and implementing this quality improvement program were gathering intelligence, examining resources, designing the screening program, creating a clinical response, constructing an electronic health record screening protocol, clinical workforce education, and program implementation. This project used the Columbia-Suicide Severity Rating Scale, Clinical Practice Screener–Recent, and a preliminary clinical decision support system.

Results: Prevalence data on suicide risk levels are provided for 328,064 adult encounters from the first six months of the screening program. Approximately half of the screens were completed in the outpatient clinics, more than 90% in the emergency department (ED), and slightly less than 5% in the hospital inpatient units. The prevalence of a positive suicide screening was 1.6% in the inpatient units, and 2.1% in the ED. The prevalence of a positive suicide screening was 9.15 times higher than the outpatient prevalence. A new quality improvement program was developed and implemented in the safety-net health care system from universal screening was successfully implemented in the ED.

Screening Tools

COLUMBIA-SUICIDE SEVERITY RATING SCALE Screen Version - Recent

Ask questions that are bolded and underlined.	Past Month	
	YES	NO
Ask Questions 1 and 2		
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
How long ago did the Worst Point Ideation occur?		
	YES	NO
6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, 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.		
If YES, ask: <u>Was this within the past three months?</u>		

Patient Safety Screener 3 (PSS-3)

To be administered by primary nurse during primary nursing assessment.

Introductory script: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important."

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?

Yes No Patient unable to complete Patient refused

2. Over the past 2 weeks, have you had thoughts of killing yourself?

Yes No Patient unable to complete Patient refused

If patient responds yes, ascertain whether they are currently suicidal.

3. In your lifetime, have you ever attempted to kill yourself?

Yes No Patient unable to complete Patient refused

3a. When did this happen?

Within the past 24 hours (including today)
 More than 6 months ago

THE ED-SAFE SECONDARY SCREENER (ES)

This tool should be administered by the provider after a patient endorses two weeks (PSS Item 2= Yes) OR suicide attempt within the past 6 months).

A. Assess the following six indicators using all data available to you, collateral information, medical record review, and current observations.

1. Positive on both safety screener (PSS-3) items: active ideation with a plan
2. Recent or current **suicide plan***
3. Recent or current **intent** to act on ideation*
4. Lifetime psychiatric hospitalization
5. Pattern of excessive substance use
6. Current irritability, agitation, or aggression

Sum score (1 for each "Yes")
Anyone presenting with a current suicide attempt is an automatic Yes on Items 1, 2 and 3. Items 2, Plan and 3, Intent are critical items for interpretation.

B. *Critical item review:
• Item 2: Suicide plan present? Y N • Item 3: Intent present? Y N • Current

Check one box in each row for score (Section A) and critical item review (Section B)

A. Score	Mild risk	Moderate risk
	<input type="checkbox"/> 0 - 2	<input type="checkbox"/> 3 - 4
B. Critical items	<input type="checkbox"/> No current attempt <input type="checkbox"/> No suicide plan or intent	<input type="checkbox"/> No current attempt <input type="checkbox"/> Suicide plan or intent (not both) <input type="checkbox"/> Current attempt <input type="checkbox"/> Suicide plan and intent

Risk level based on **highest** level category: Mild Moderate High

Things to Consider

- Quick
- Simple to Use and Train
- Integrate into the workflow and EHR
- Clear protocols for positive screens, e.g.
 - which patients need further assessment by social work vs. psychiatrists
 - which can be treated voluntary vs. involuntary

Positive screens should lead to a more thorough risk assessment

Suicide Risk Assessment



What I think I do



What everyone wants me to do



What my friends think I do



What I actually I do

Effective risk assessment involves a lot of **collaboration**

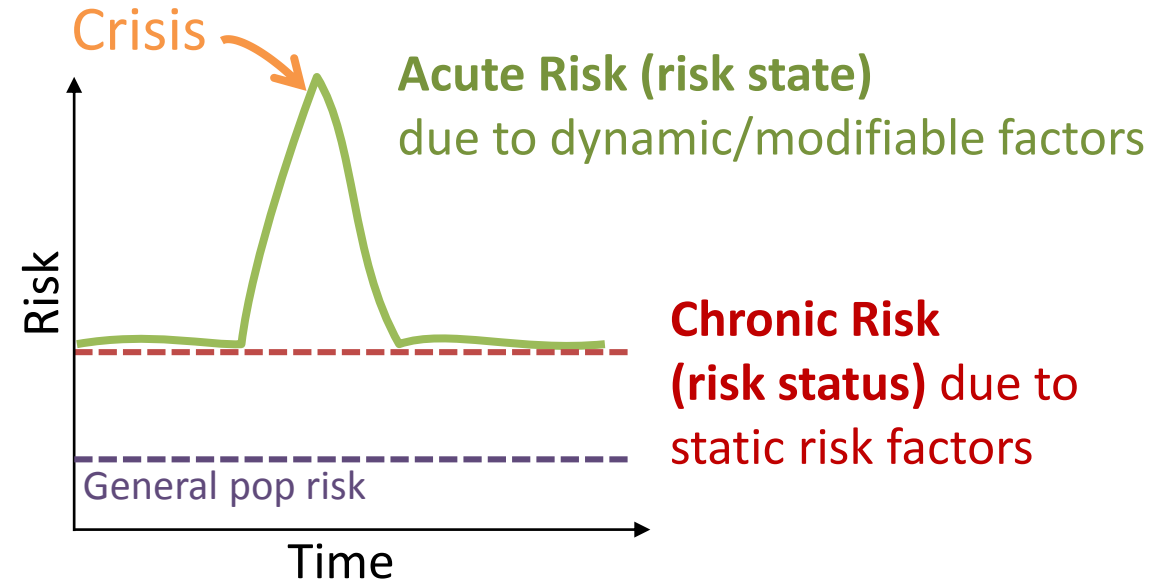
What to do with all of these risk factors?

Static Risk Factors

Male
 Age over 60
 Adolescent/post-puberty
 Caucasian
 Native-American
 Unmarried
 LGBT
 Prior suicide attempts
 Childhood trauma: abuse, neglect, parental loss
 Family history of suicide

Modifiable Risk Factors

Acute Stressor/Precipitant
 Significant Loss
 Interpersonal isolation
 Relationship problems
 Health Problems
 Legal Problems
 Housing Problems
 Other problems
 Access to means
 Firearms
 Large doses of unrestricted meds
 Substance use
 Intoxication
 Use of multiple substances
 Withdrawal
 Extended abuse of sedative/hypnotics
 Hopelessness
 Severity of accompanying symptoms
 Depression
 Anxiety
 Psychosis
 Anger
 Impulsivity
 Agitation

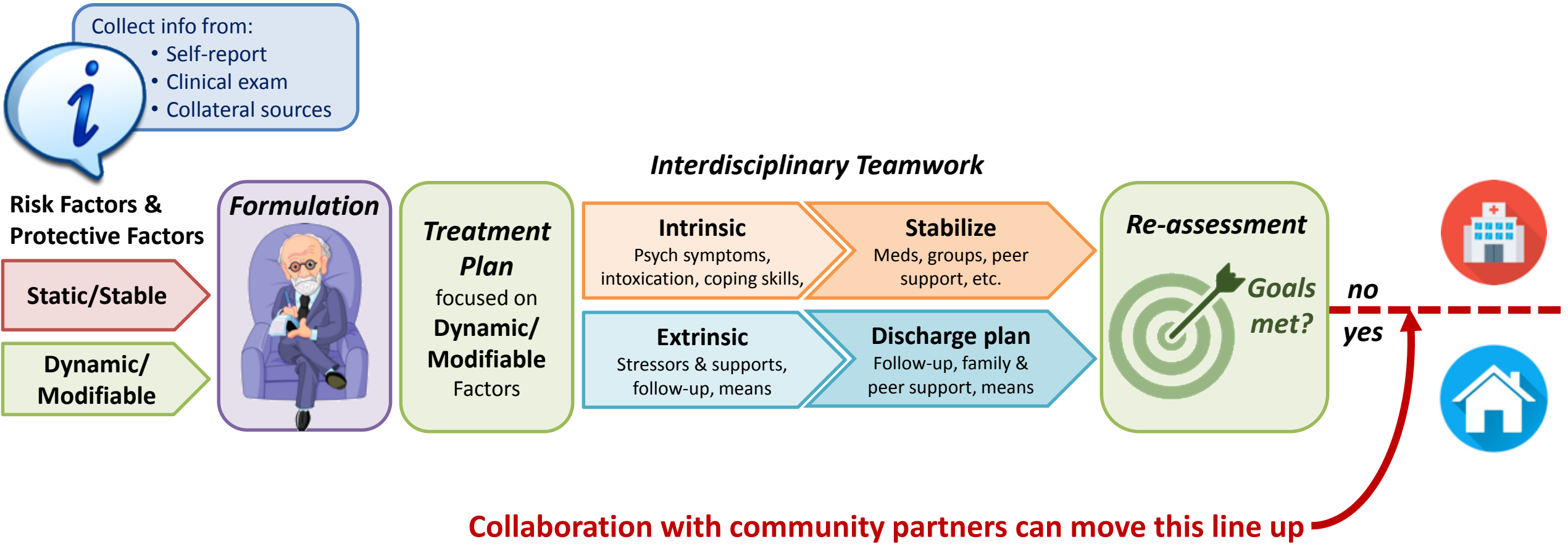


Protective Factors (how can we strengthen?)

children in the home, except among those with postpartum psychosis	positive social support
responsibility to others	positive therapeutic relationship
pregnancy	attachment to therapy, social or family support
deterrent religious beliefs, high spirituality and/or belief that suicide is immoral	hope for future
life satisfaction	self-efficacy
reality testing ability	supportive living arrangements
positive coping skills	fear of act of suicide
	fear of social disapproval

Framework for Suicide

Risk Assessment, Stabilization, & Discharge Planning



The Crisis Response Center

- Built with Pima County bond funds in 2011
 - Alternative to jail, ED, hospitals
 - Serving 12,000 adults + 2,400 youth per year
- **Law enforcement receiving center with NO WRONG DOOR**
(no exclusions for acuity, agitation, intoxication, payer, etc.)
- Services include
 - 24/7 urgent care clinic (adult length of stay 2 hours, youth 3 hours)
 - 23-hour observation (adult capacity 34, youth 10),
 - Short-term subacute inpatient (adults only, 15 beds, 3-5 days)
- Space for co-located community programs
 - peer-run post-crisis wraparound program, pet therapy, etc.
- Adjacent to
 - Banner University Medical Center (ED with Level 2 Trauma Center)
 - Crisis call center
 - Inpatient psych hospital for civil commitments
 - Mental health court

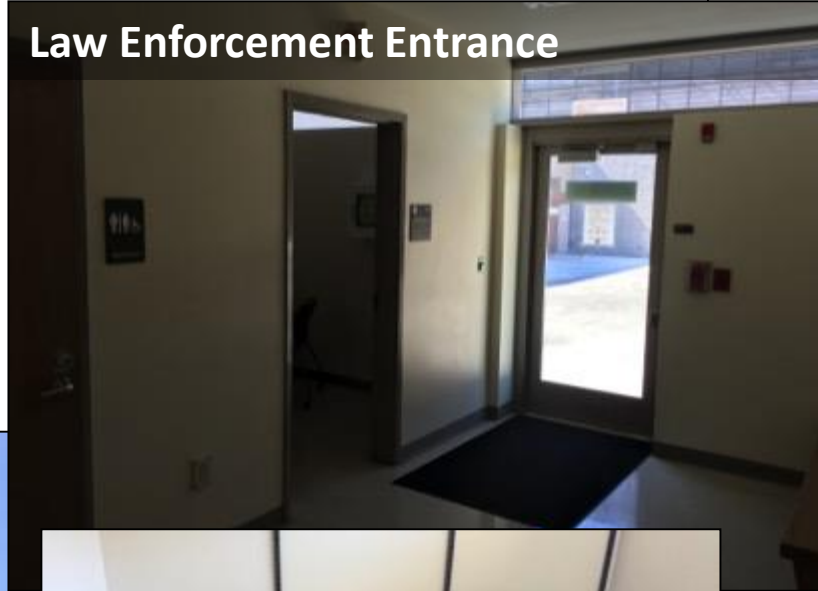


Crisis Response Center (CRC) in Tucson, AZ
ConnectionsAZ/Banner University Medical Center

Easy Access for Law Enforcement so we are the preferred alternative to drop off at jail or ED



Law Enforcement Entrance



Gated Sally Port

Crisis Response Center - Tucson AZ



The locked 23h obs unit provides a **safe, secure, and therapeutic environment:**

- Continuous observation
- Lack of means to hurt oneself or others
- Therapeutic milieu: Open area for therapeutic interactions with others
- As welcoming as possible



Crisis Response Center, Tucson AZ



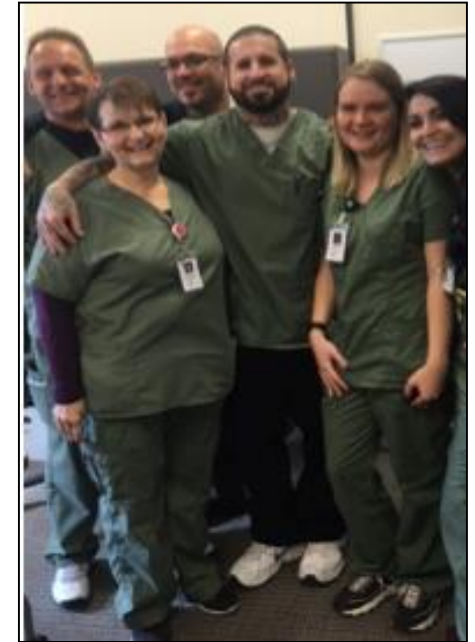
Urgent Psychiatric Center
Phoenix, AZ

23-Hour Observation Unit

- Interdisciplinary Teamwork
 - 24/7 psychiatric provider coverage (MD, NP, PAs)
 - Peers with lived experience, nurses, techs, case managers, therapists, unit coordinators
- Early Intervention
 - Median door to doc time is ~90 min
 - Interventions include medication, detox/MAT, groups, peer support, safety planning, crisis counseling, mindfulness
- Aggressive discharge planning
 - Collaboration and coordination with community & family partners
- ***Culture shift: Assumption that the crisis can be resolved***

60-70% discharged to the community the following day

Avoiding preventable inpatient admission, even though most met medical necessity criteria when they first presented



Peers with lived experience are an important part of the interdisciplinary team.

“I came in 100% sure I was going to kill myself but now after group I’m hopeful that it will change. Thank you RSS members!”

Safety Planning

SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
2. Clinician Pager or Emergency Contact # 555 822-9999
3. Clinician Name _____ Phone _____
4. Local Hospital ED City Hospital Center
5. Local Hospital ED Address 222 Main St
6. Local Hospital ED Phone 333-9000
7. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. _____



Safety Plan

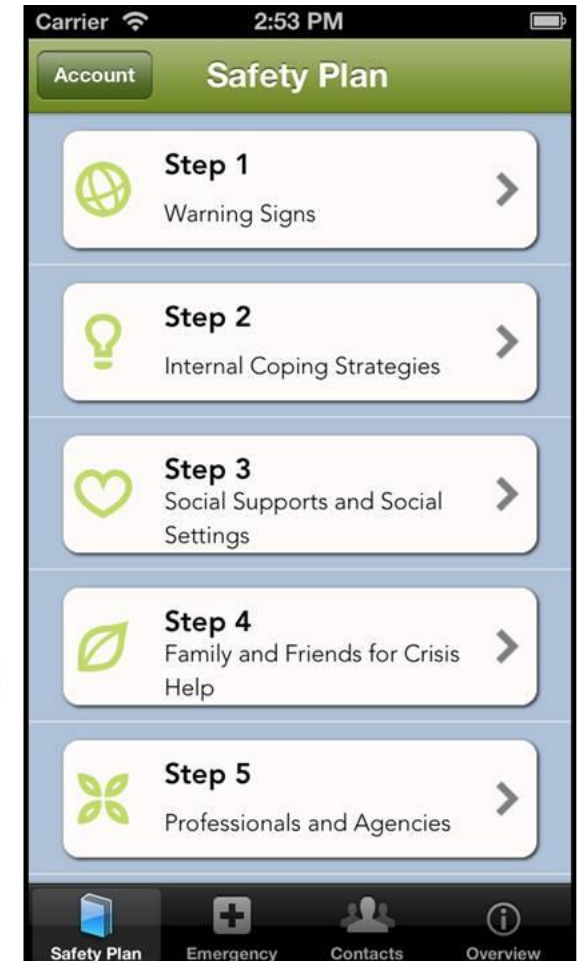
Name of App:
Safety Plan

App Developer:
Padraic Doyle

Writers:
Barbara Stanley and
Gregory Brown

Available:
iTunes (free of charge)

Funding:
NYS OMH Suicide
Prevention Center of
New York and
Columbia University

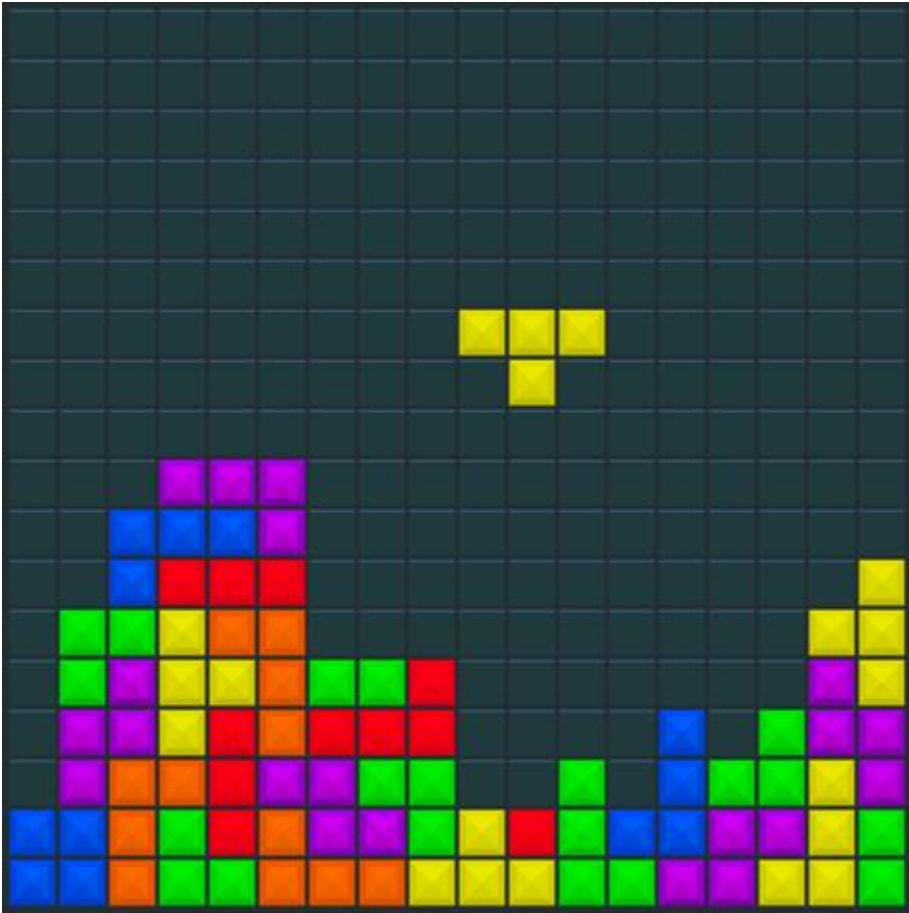


After the crisis...

- **Step-down programs**
 - Crisis Residential (in AZ, "Level 2" or "Brief Intervention Programs")
 - Residential substance use treatment
- **Post-crisis follow-up**
 - "Second responders" focused on housing, DCS involvement
 - Peer navigators: 45 days post-crisis peer services, transportation to appointments, picking up meds, getting benefits, etc.
 - Caring contacts: Follow-up calls and welfare checks
- **Outpatient services**
 - Behavioral health homes and specialty/SUD providers
 - Assisted Outpatient Treatment
- **Special plans** for "familiar faces" (high utilizers)



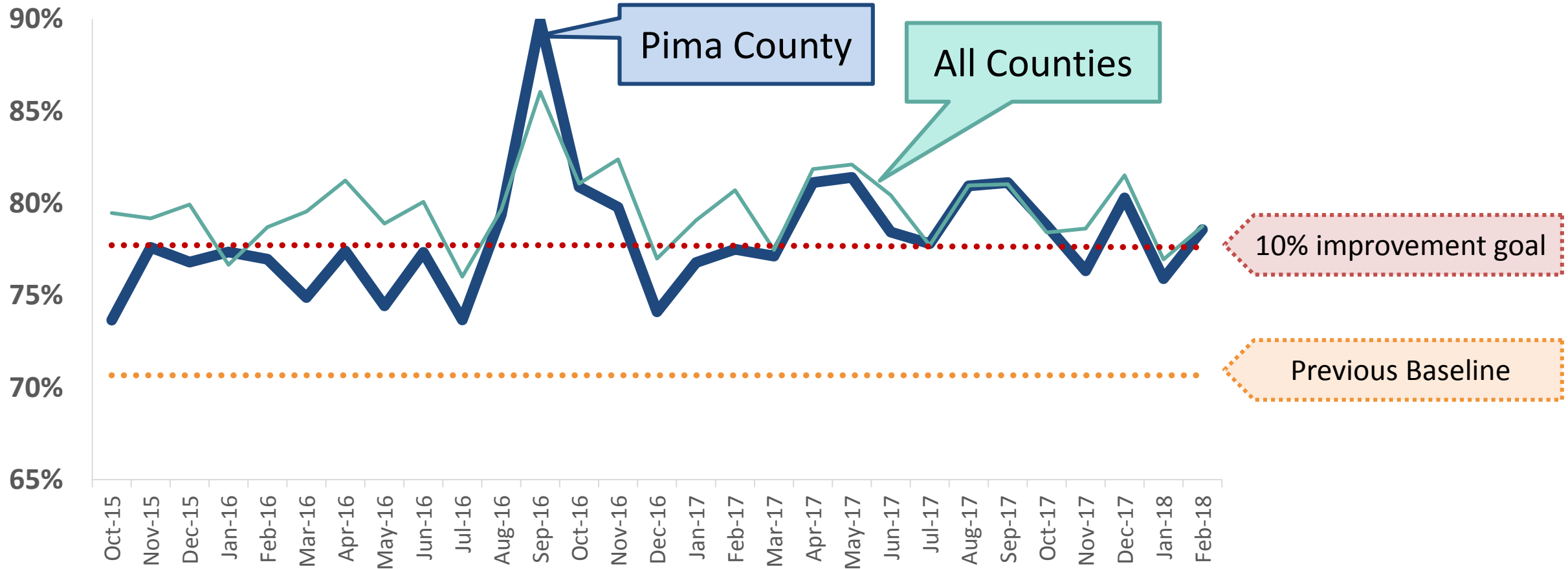
Putting it all together



- ED-SAFE study
- Screening alone did not decrease future suicide attempts
- But when screening combined with
 - Secondary screening tool administered by a physician
 - Safety planning tool
 - Follow-up phone calls
- Result was **30% fewer suicide attempts** compared to screening alone 😊

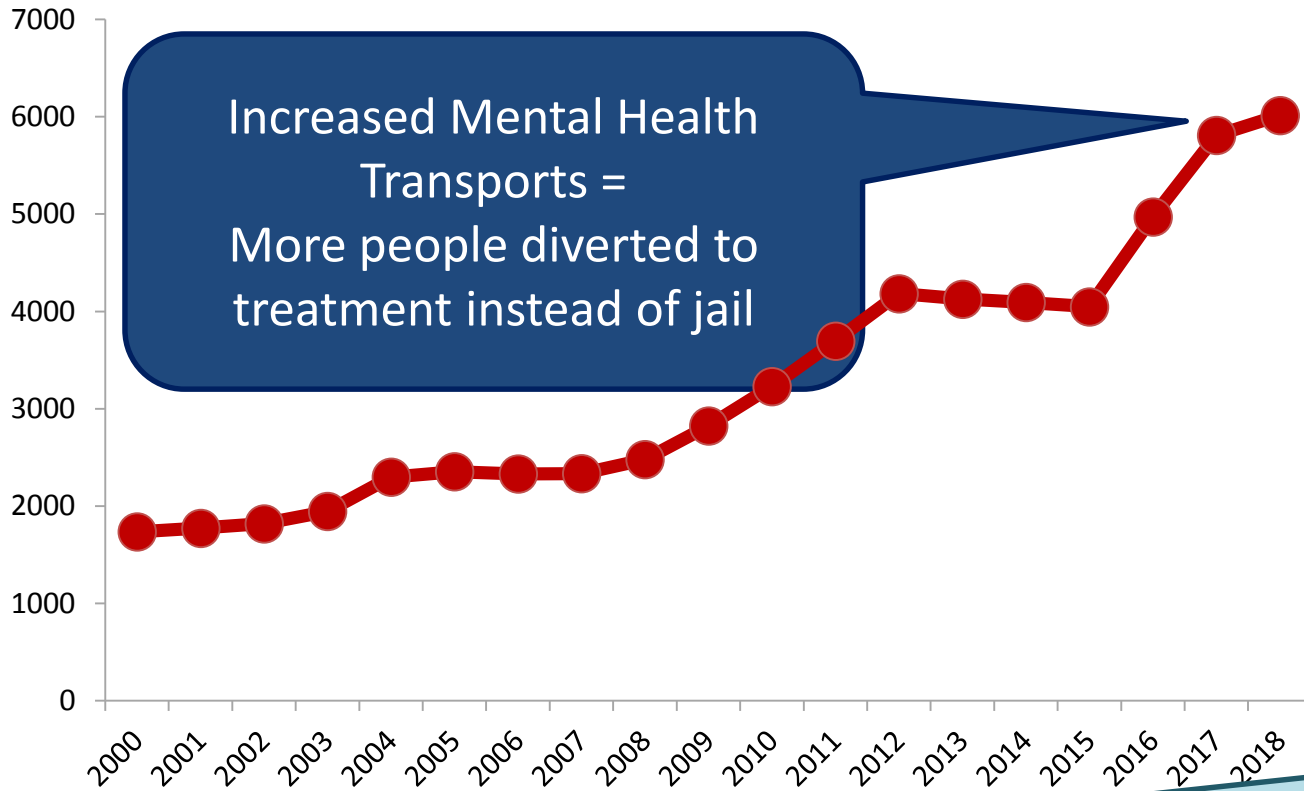
Continued Stabilization

Percent of Mobile Team Encounters with NO Inpatient Admission After 45 Days



MORE People Taken to Treatment...

Tucson Police Mental Health Transports per Year

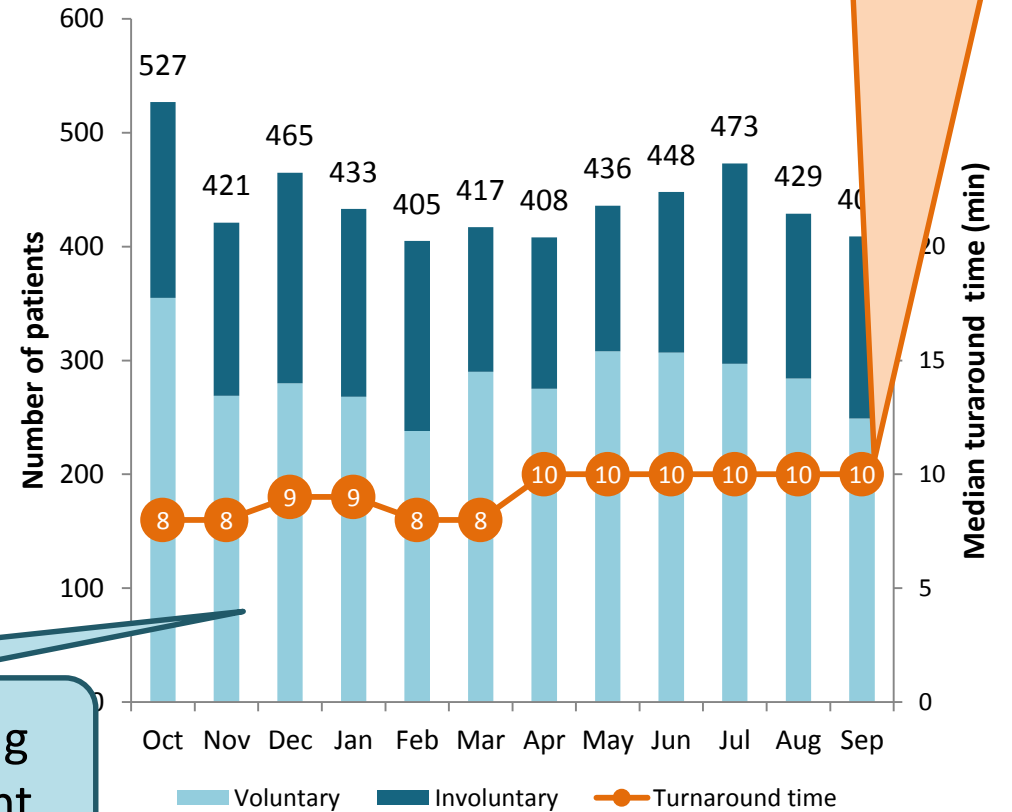


Increased Mental Health Transports = More people diverted to treatment instead of jail

Most drops are voluntary (light bars), meaning the officers are engaging people into treatment.

Cops like quick turnaround time (10 min) so that it's easier to bring people to treatment instead of jail.

Crisis Response Center Law Enforcement Drops (Adults)

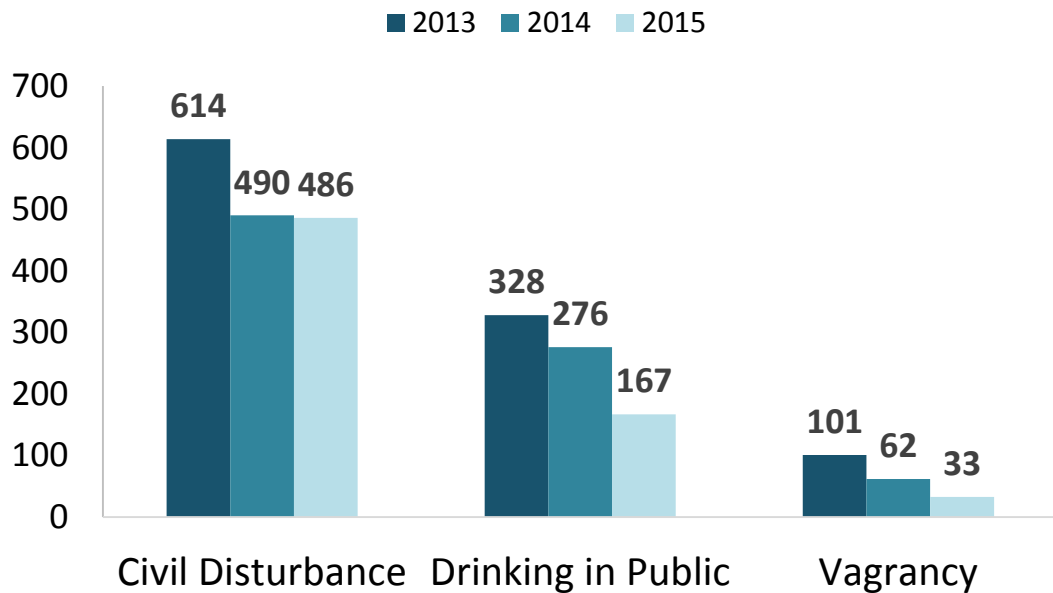


... and LESS Justice Involvement

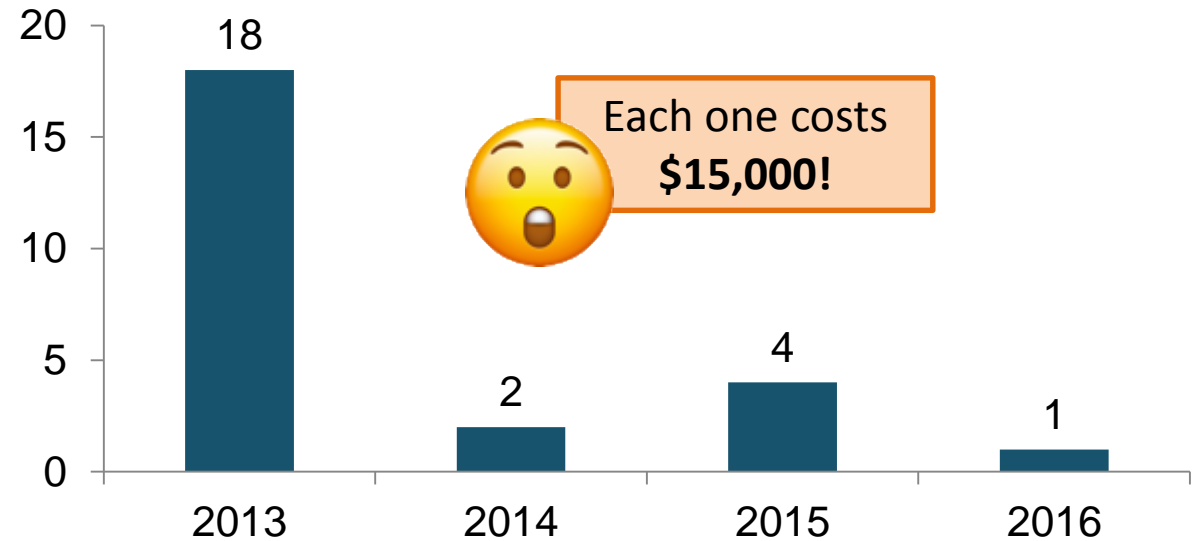
Fewer calls for low-level crimes that tend to land our people in jail.

Culture change in how law enforcement responds to mental health crisis.

TPD "Nuisance Calls" Per Year



Tucson Police Dept. SWAT deployments for Suicidal Barricade



Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. *Psychiatric Services*. 2017;68(2):211-212; <https://dx.doi.org/10.1176/appi.ps.68203>

Crisis Stabilization Aims for the Least-Restrictive (and least costly) Disposition Possible

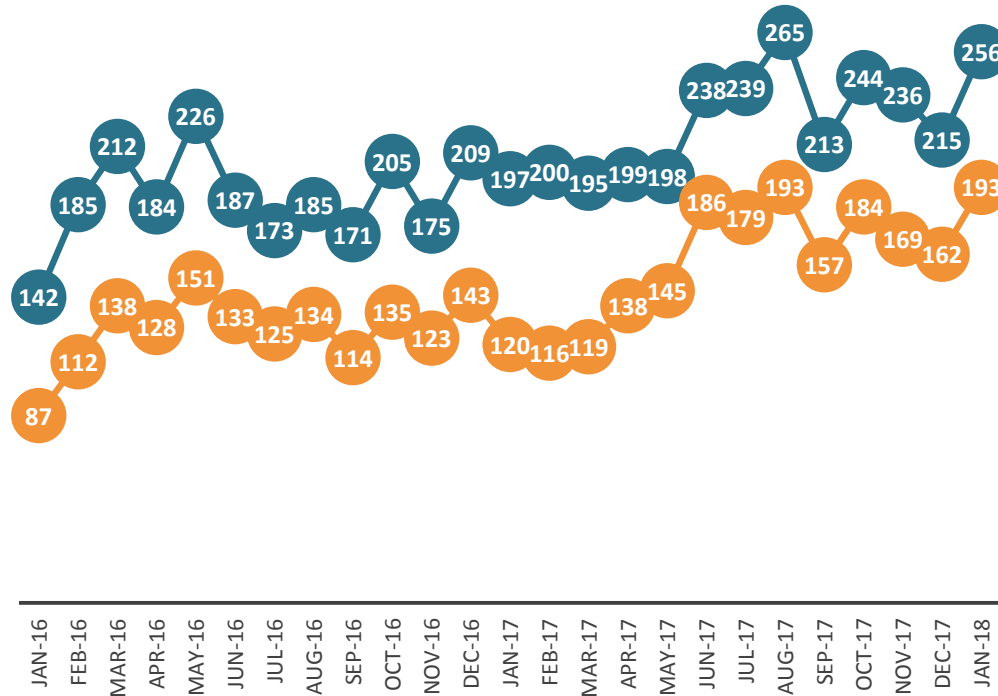
65%

**Discharged to Community
(Diversion from Inpatient)**

- People admitted to the 23-hour observation unit who are discharged to community-based care instead of inpatient admission.
- Most can be stabilized for community dispositions with early intervention, proactive discharge planning, and collaboration with families and other community supports



**CRC Dropped
Civil Commitment Applications**



Emergency Applications

Dropped after 24 hours

70%

Converted to Voluntary Status

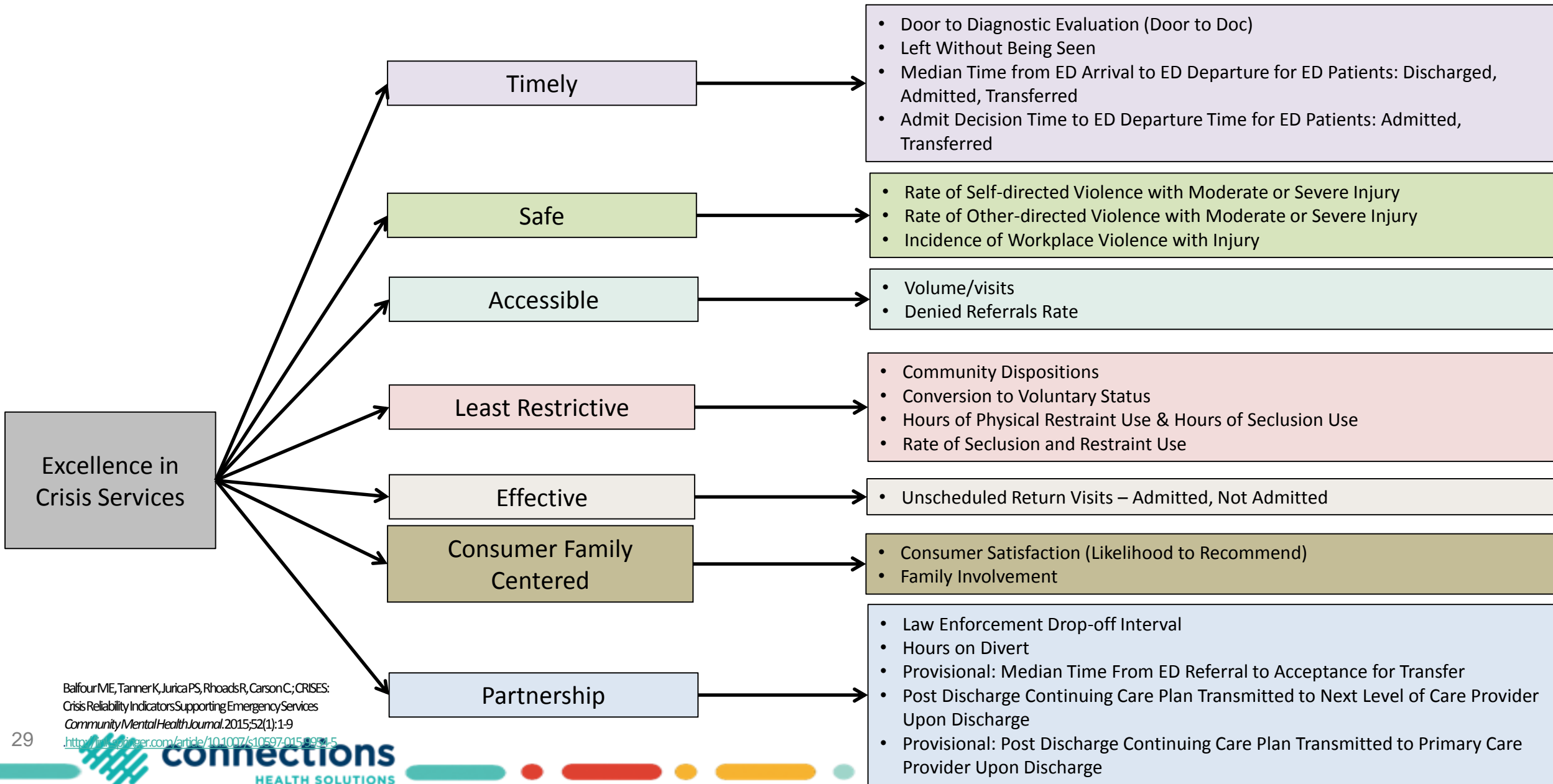
People under involuntary hold who are then discharged to the community or choose voluntary inpatient admission



Connections Crisis Facility KPIs

Metric	Outcome	Relevance
Urgent Care Clinic: Door-to-Door Length of Stay	< 2 hours	Patients get their needs met quickly instead of going to an ED or allowing symptoms to worsen.
23-Hour Obs Unit: Door-to-Doctor Time	< 90 min	Treatment is started early, which results in higher likelihood of stabilization and less likelihood of assaults, injuries and restraints.
23-Hour Obs Unit: Community Disposition Rate (diversion from inpatient)	60-70%	Most patients are able to be discharged to less restrictive and less costly community-based care instead of inpatient admission.
Law Enforcement Drop-Off Police Turnaround Time	< 10 min	If jail diversion is a goal, then police are our customer too and we must be quicker and easier to access than jail.
Hours of Restraint Use per 1000 patient hours	< 0.15	Despite receiving highly acute patients directly from the field, our restraint rates are 75% below the Joint Commission national average for inpatient psych units.
Patient Satisfaction Likelihood to Recommend	> 85%	Even though most patients are brought via law enforcement, most would recommend our services to friends or family.
Return Visits within 72h following discharge from 23h obs	3%	People get their needs met and are connected to aftercare. A multiagency collaboration addresses the subset of people with multiple return visits.

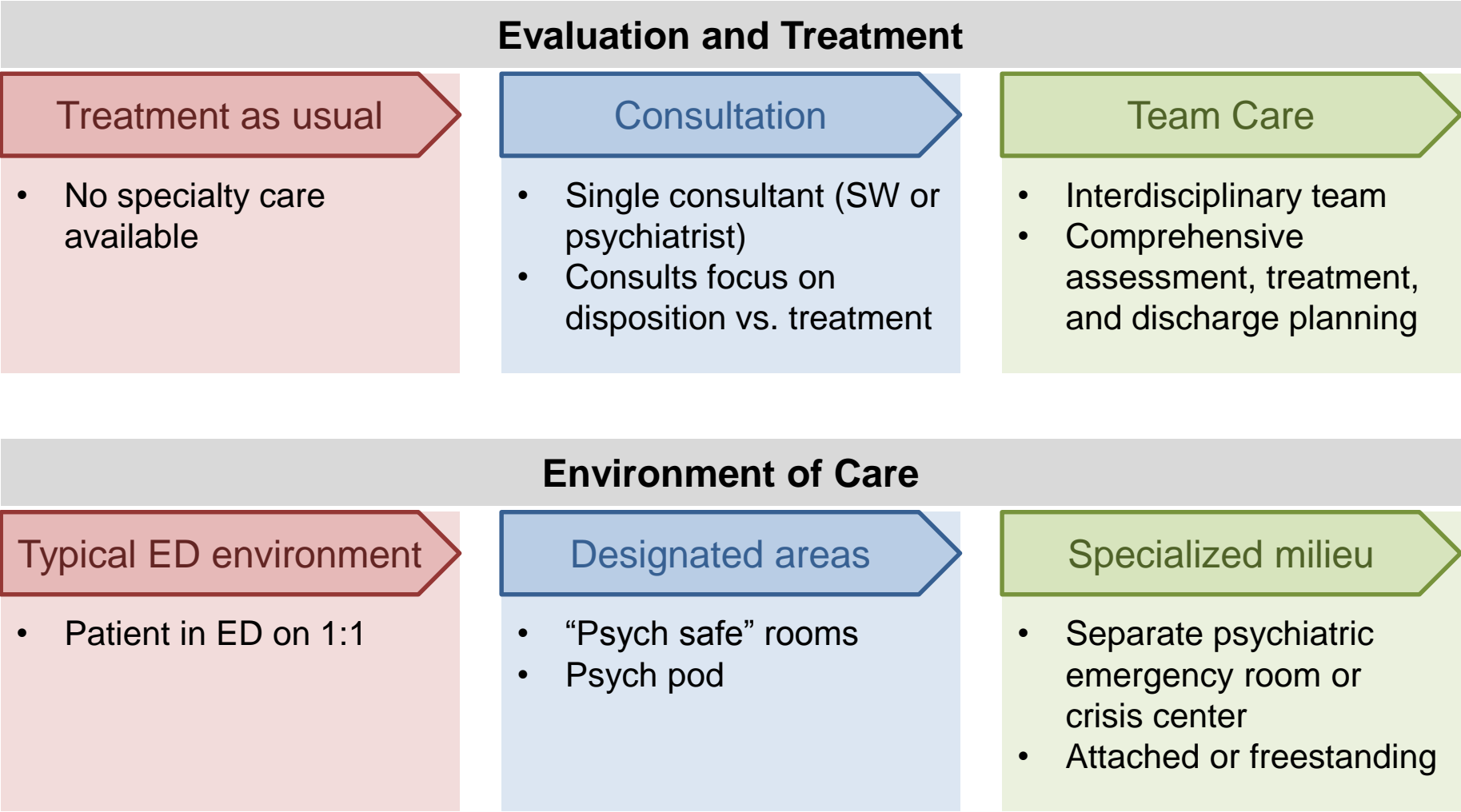
Outcome metrics for facility-based crisis services



Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C; CRISES: Crisis Reliability Indicators Supporting Emergency Services. *Community Mental Health Journal*. 2015;52(1):1-9

<http://jmh.sagepub.com/article/10.1007/s10597-015-9931-5>

A continuum of solutions with what you have



Give staff the tools they need

Clinical skills matched to the needs of the population that presents for care in the ED

- Does your ED require nursing staff to know how to check a fingerstick blood glucose?
- What about the following:



Competency	Example	Value
Risk assessment	Columbia-Suicide Severity Rating Scale (C-SSRS), ED-SAFE	Accurate identification of high risk patients
Verbal de-escalation	Crisis Prevention Institute, Therapeutic Options	Decrease assaults, injuries, restraints
Motivational Interviewing	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Identify and reduce substance misuse

Strategies for improving aftercare

Discharge planning that goes beyond giving a referral

- Knowledge of and relationships with local resources
- Address barriers to care
 - Financial eligibility screening, transportation, etc.
- Followup phone calls
 - In-house or partner with a crisis hotline
 - Reduces subsequent suicide attempts and improves rates of followup¹
- Peer support navigators
 - People with lived experience with mental illness and/or substance use
 - Improves engagement in the ED and increases rates of followup post ED discharge with both BH and primary care services²

1. Luxton DD, June JD, Comtois KA. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis*. 2013 Jan 1;34(1):32-41.
2. Griswold, KS, Pastore, P, Homish, GG, Henke, A, Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency? *Primary Psychiatry*. 2010 Jun;17(6):42-45.

Questions?

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