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Strategies for Enhancing Treatment Interventions for Suicidal Crisis

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- 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?

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CALL THE PSYCHIATRIST/THERAPIST/CLINIC

CALL 911

GO TO THE
EMERGENCY ROOM

GO TO THE
CRISIS CENTER

GO TO THE
DETOX CENTER

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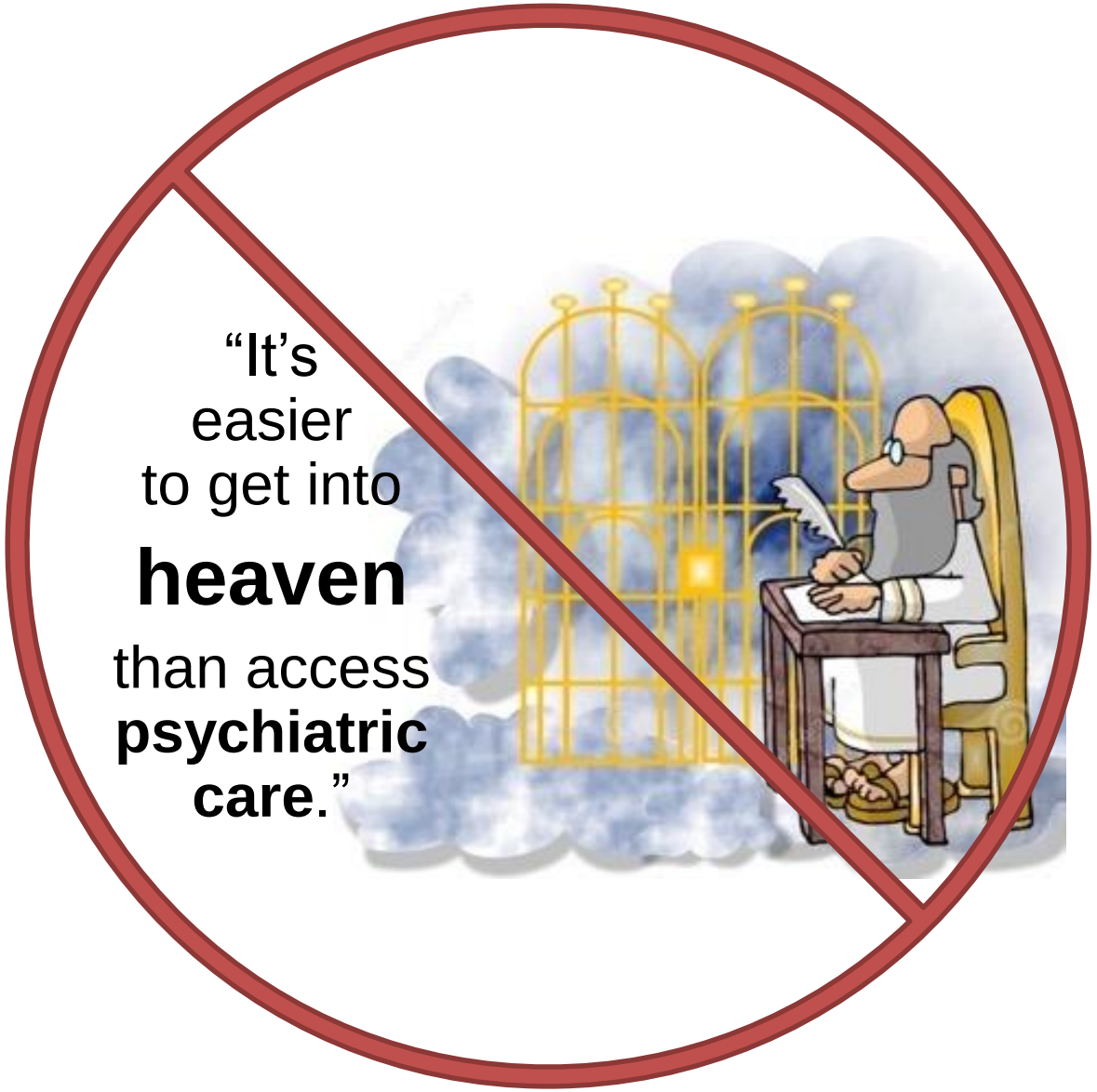

A suicidal crisis is an emergency.

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

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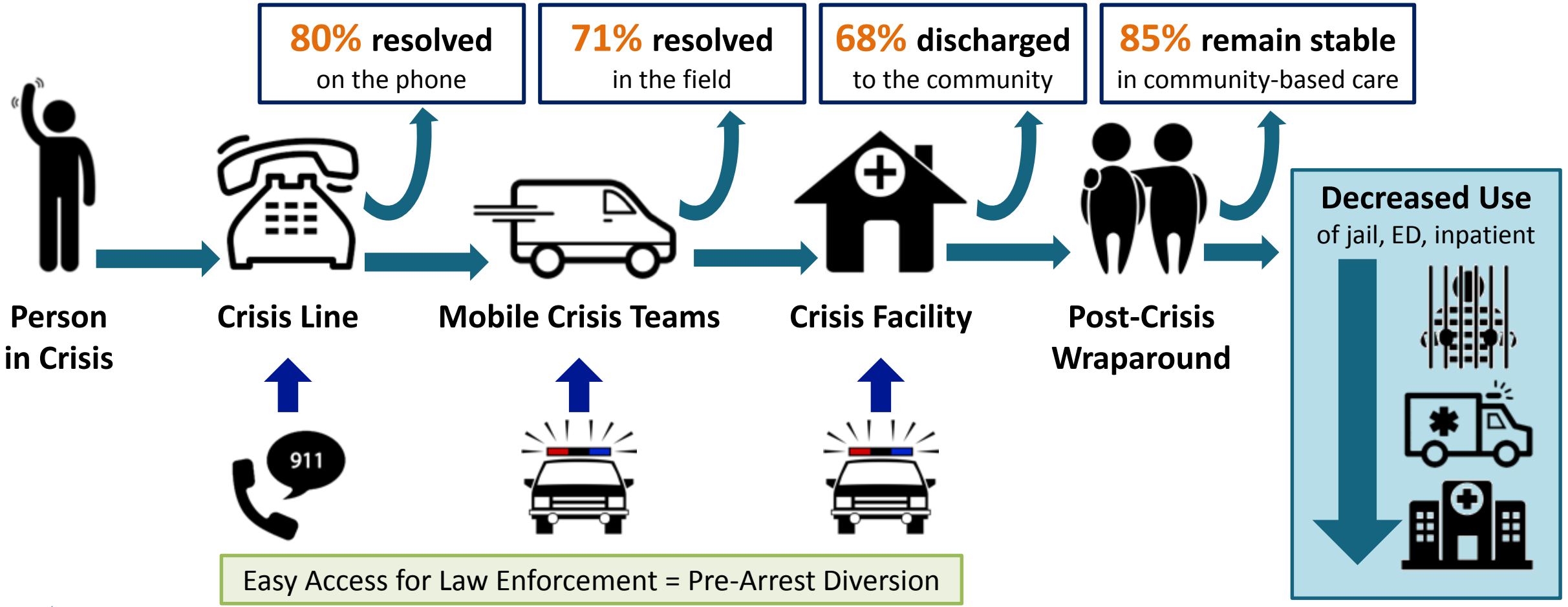
- **A SYSTEMIC response to suicidal crisis**
- that delivers EVIDENCE-BASED care to people who need it
- with MEASURABLE OUTCOMES
- in the LEAST-RESTRICTIVE setting that can safely meet the person's needs
- (and by the way, the least-restrictive settings also tend to be the LEAST-COSTLY)

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

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Where?

Emergency Department

"PES (Psych ER)"

Locked or Unlocked?

"Crisis Residential"

Staffed by?

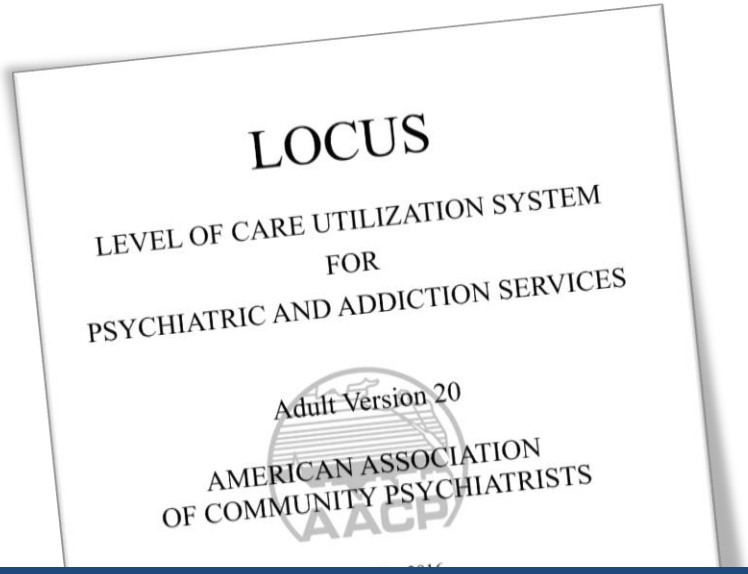
Environment of Care Ligature Safety?

"Receiving Facility"

"Diversion Center"

24/7 Staffing?

"Crisis Respite"



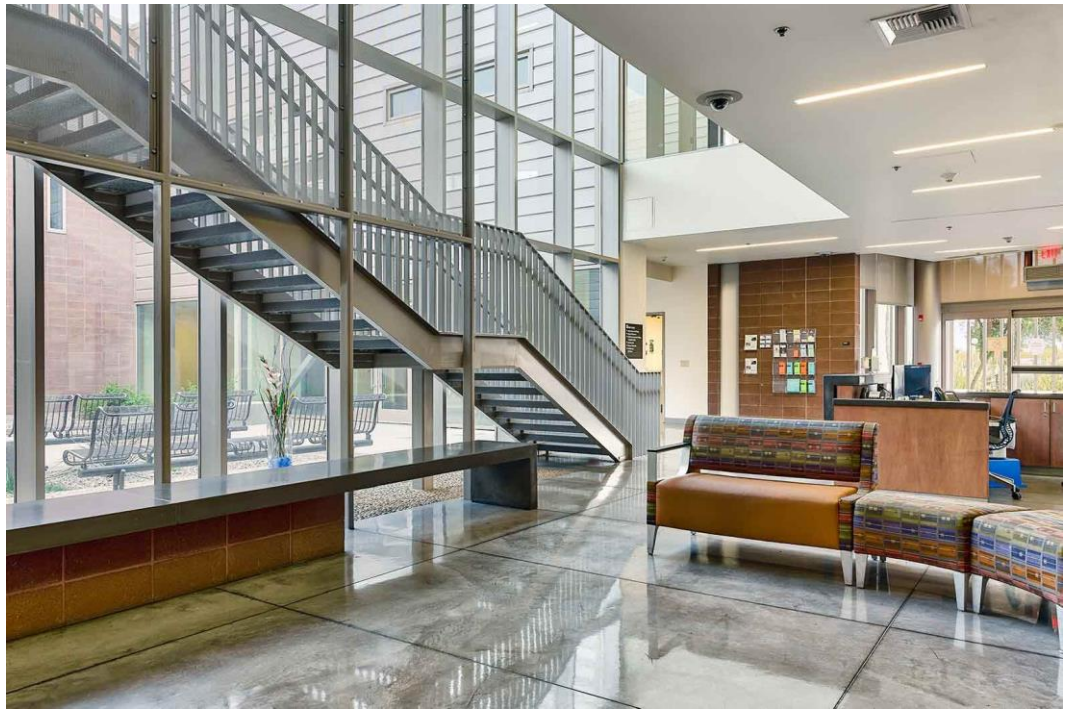
Level of Care Determination: Across 6 Dimensions

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?

https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_5_6_19_Rev5.pdf

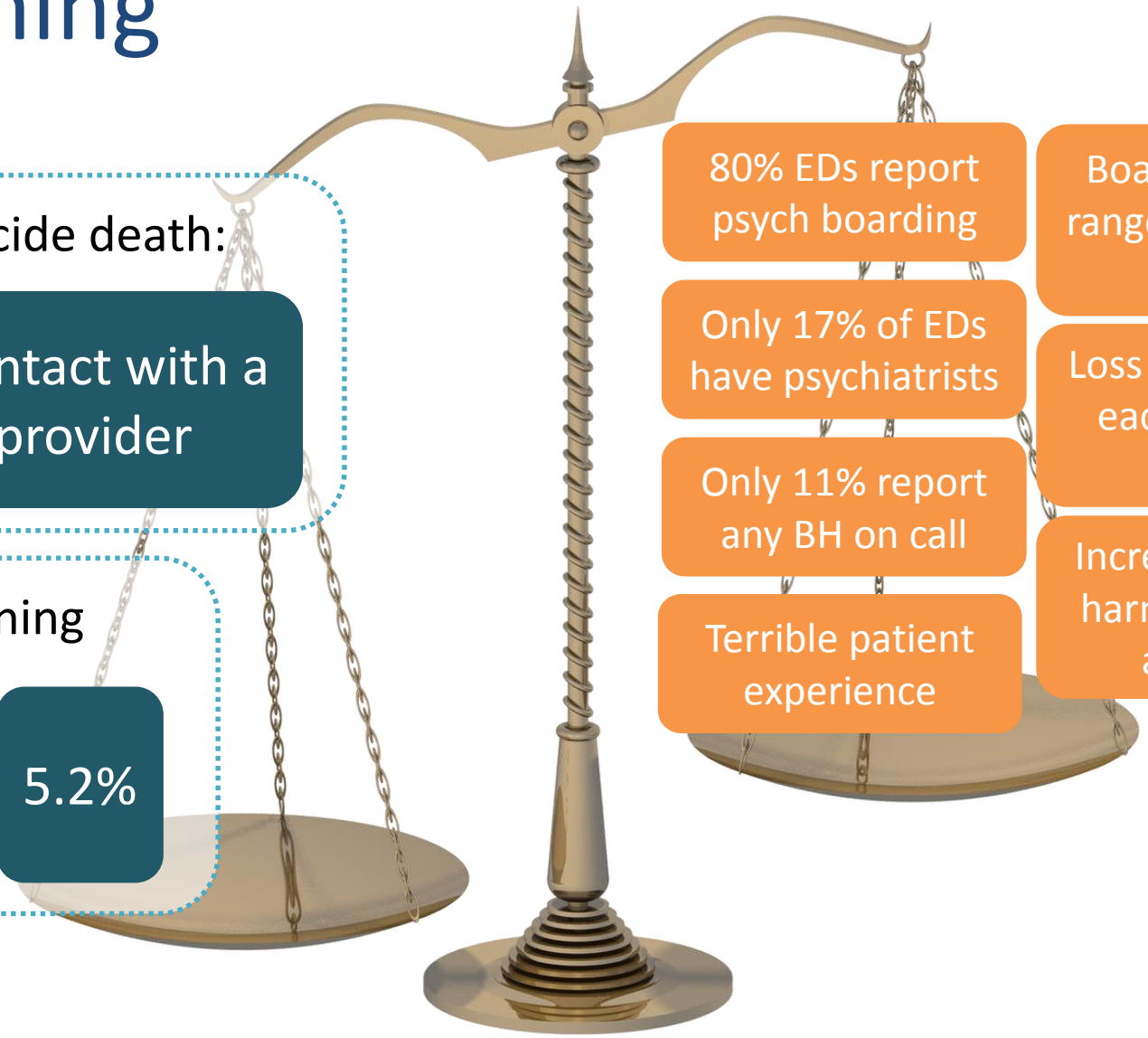
Universal Screening

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%



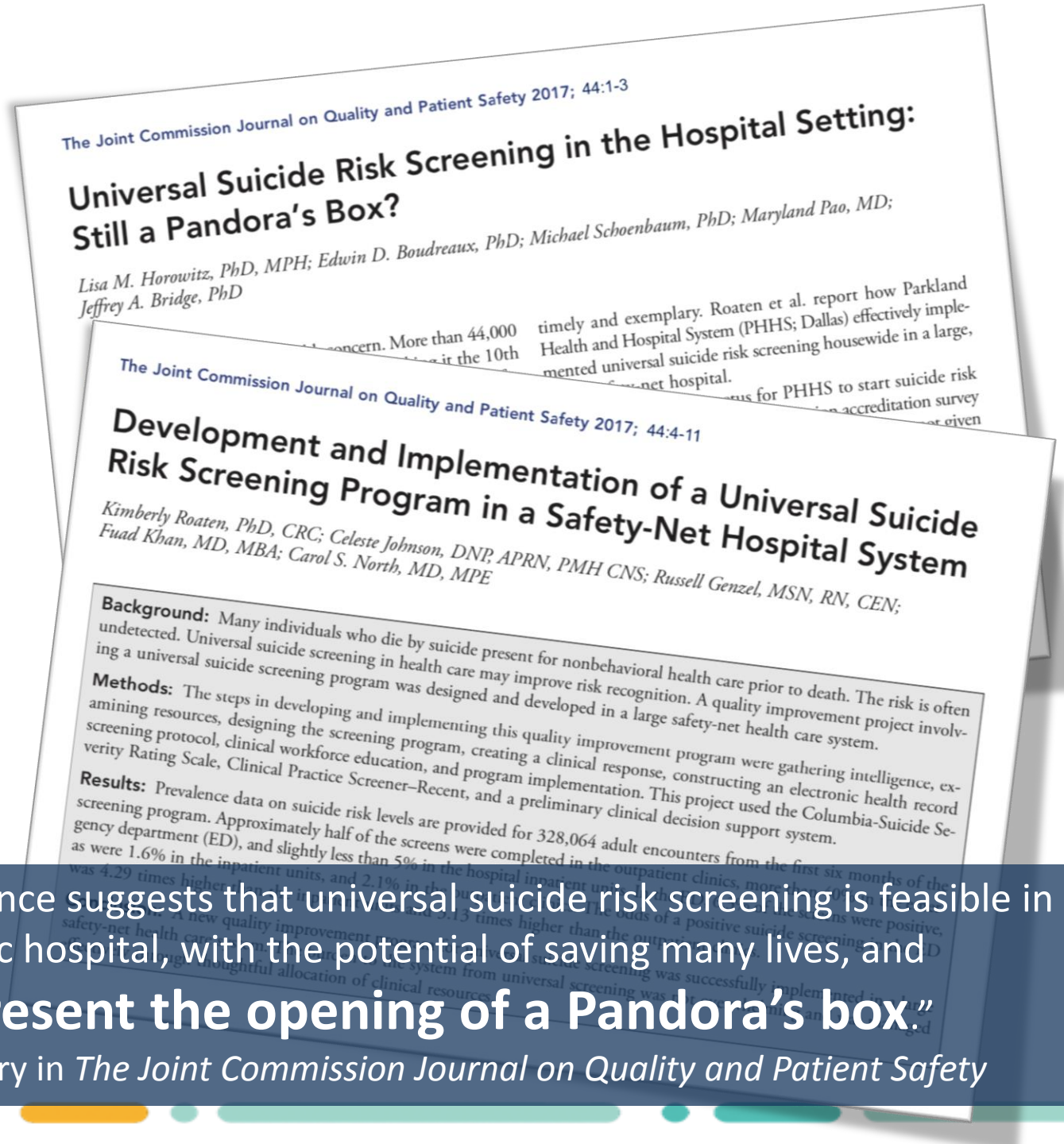
- 80% EDs report psych boarding
- Only 17% of EDs have psychiatrists
- Only 11% report any BH on call
- Terrible patient experience

- 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*

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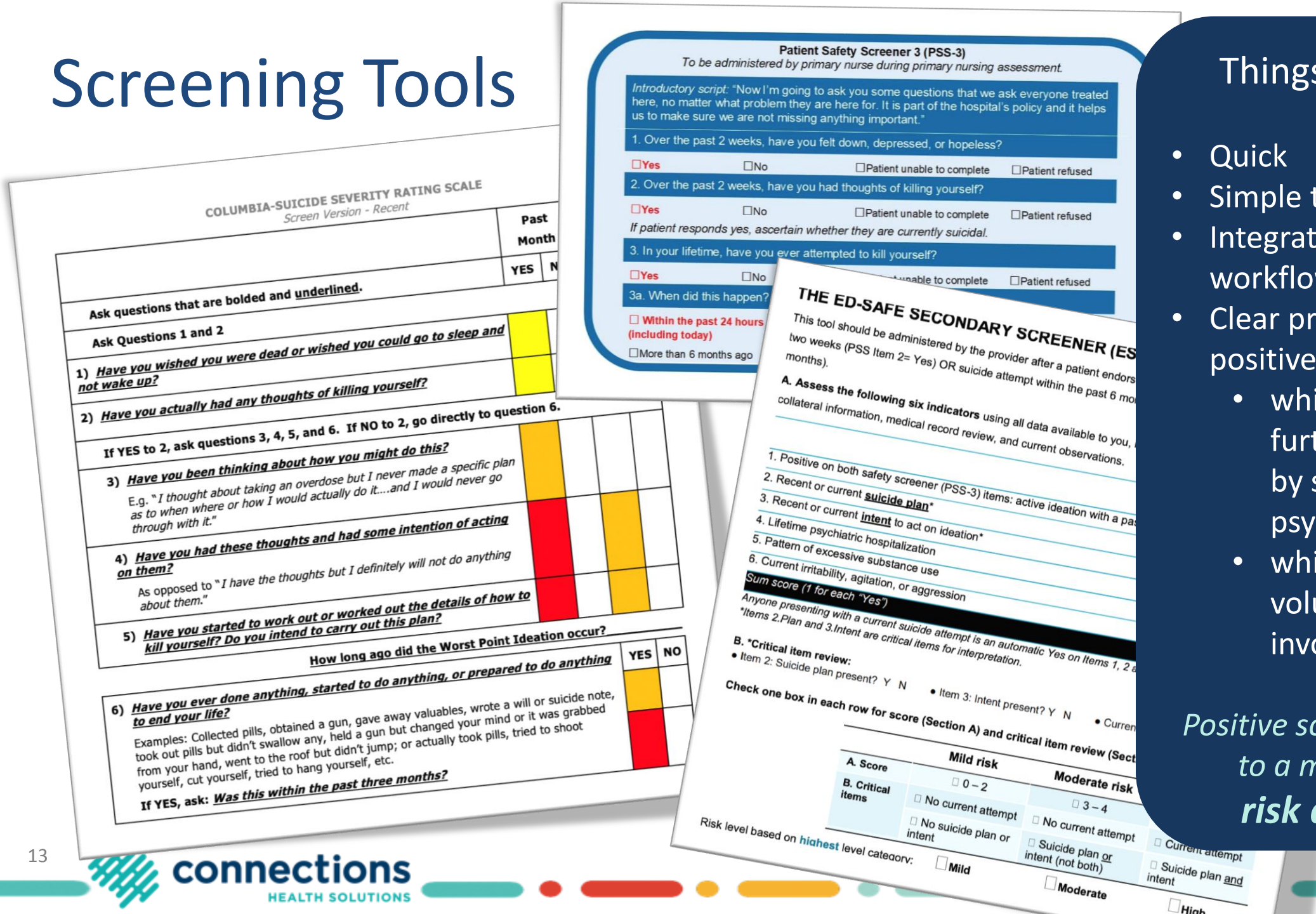
Screening Tools



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***

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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**

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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

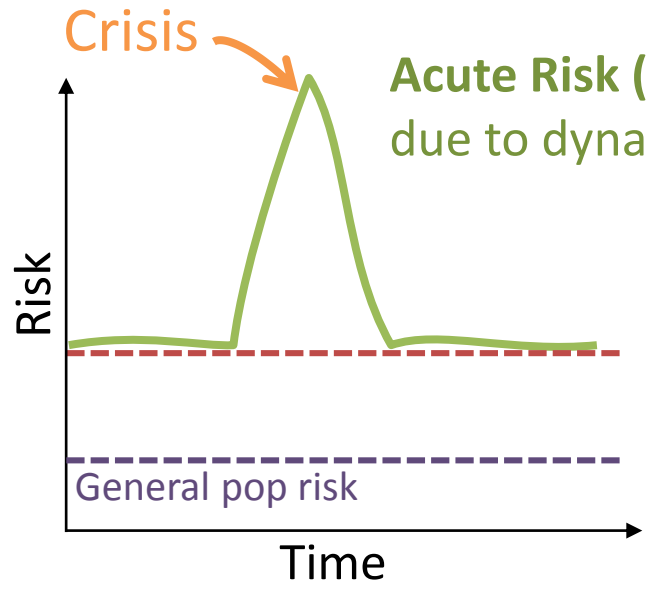
Acute Stressor/Precipitant
- Significant Loss
- Interpersonal isolation
- Relationship problems
- Health Problems
- Legal Problems
- Housing Problems
- Other problems

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



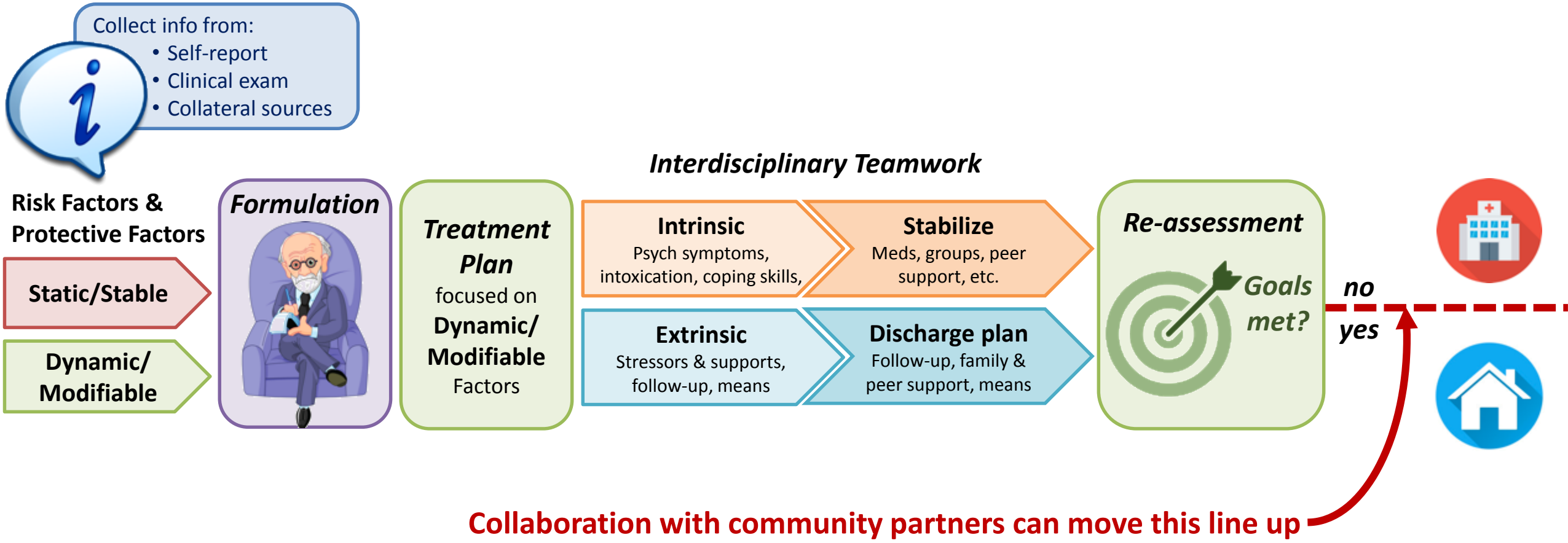
Acute Risk (risk state) due to dynamic/modifiable factors

Chronic Risk (risk status) due to static risk factors

Protective Factors (how can we strengthen?)

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

Framework for Suicide Risk Assessment, Stabilization, & Discharge Planning



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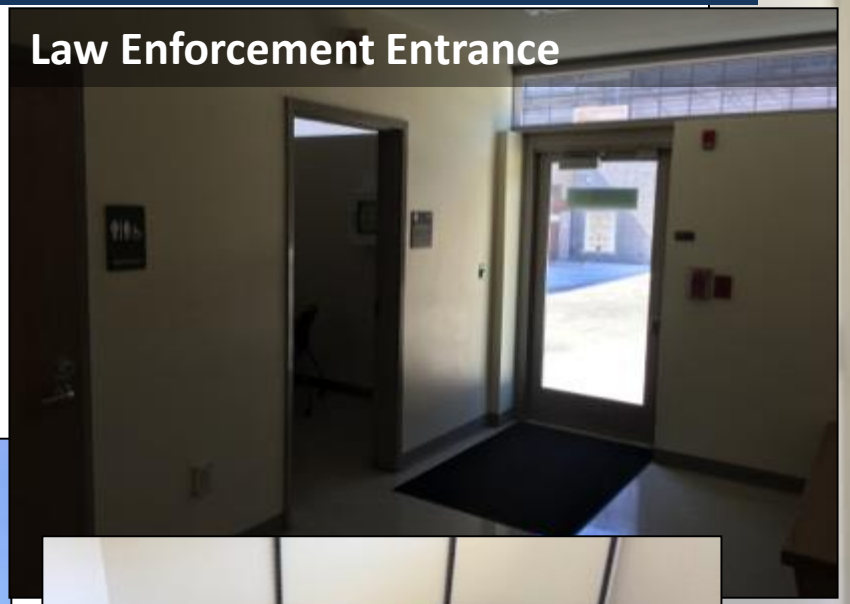
The Crisis Response Center

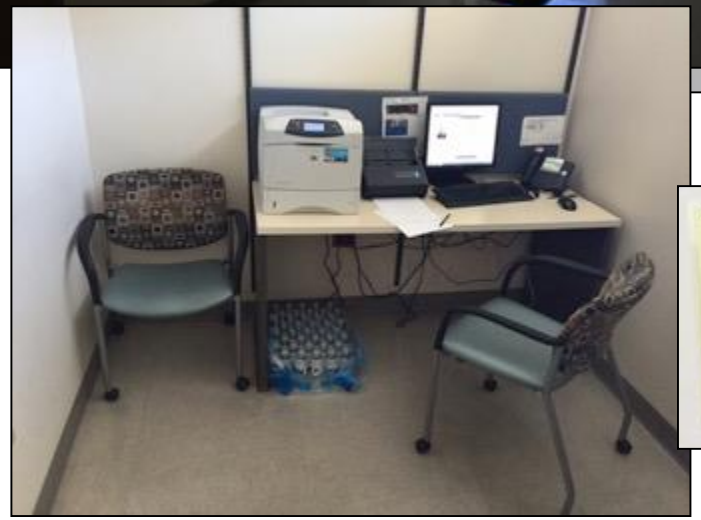
- Built with Pima County bond funds in 2011
  - Alternative to jail, ED, hospitals
  - Serving 12,000 adults + 2,400 youth per year
- **Law enforcement receiving center with NO WRONG DOOR**
  (no exclusions for acuity, agitation, intoxication, payer, etc.)
- Services include
  - 24/7 urgent care clinic (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

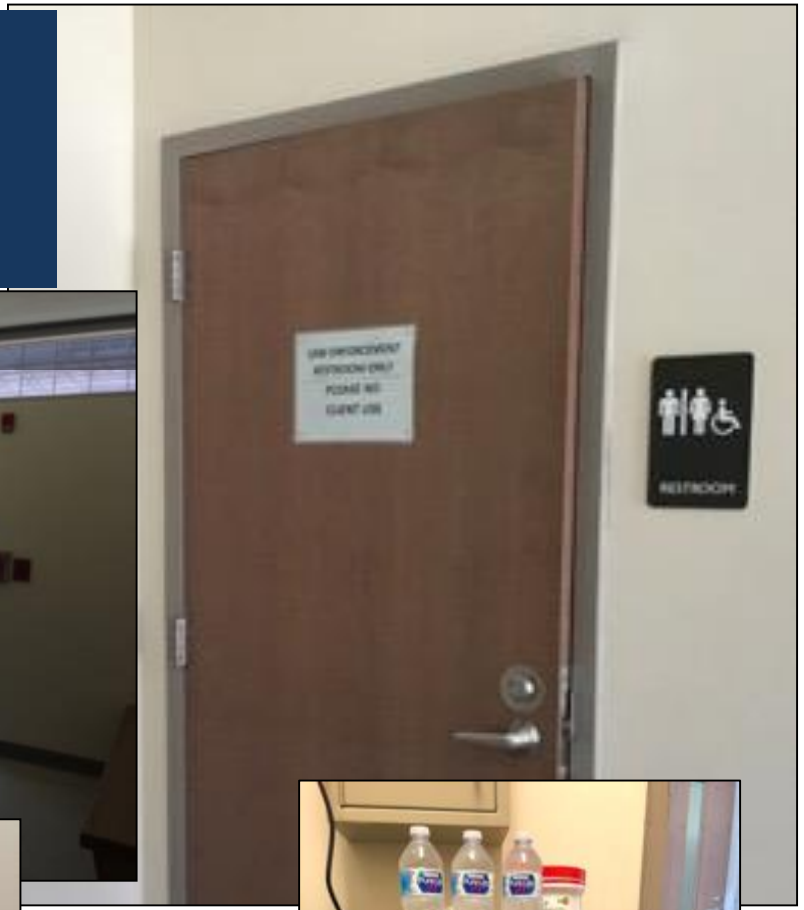
Crisis Response Center (CRC) in Tucson, AZ
ConnectionsAZ/Banner University Medical Center

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





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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

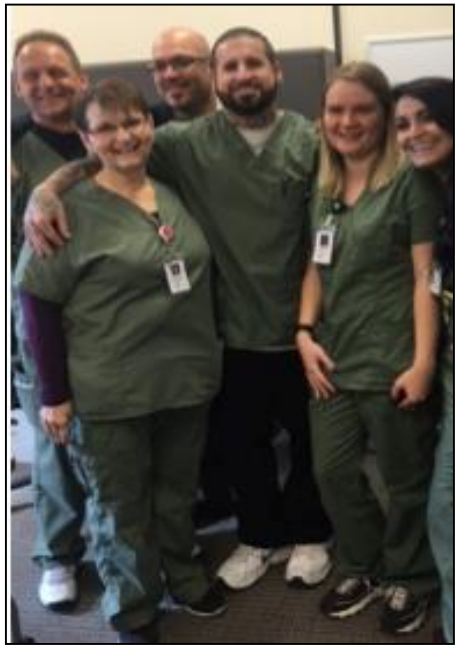
Urgent Psychiatric Center
Phoenix, AZ

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 <u>can be</u> resolved***

60-70% discharged to the community the following day

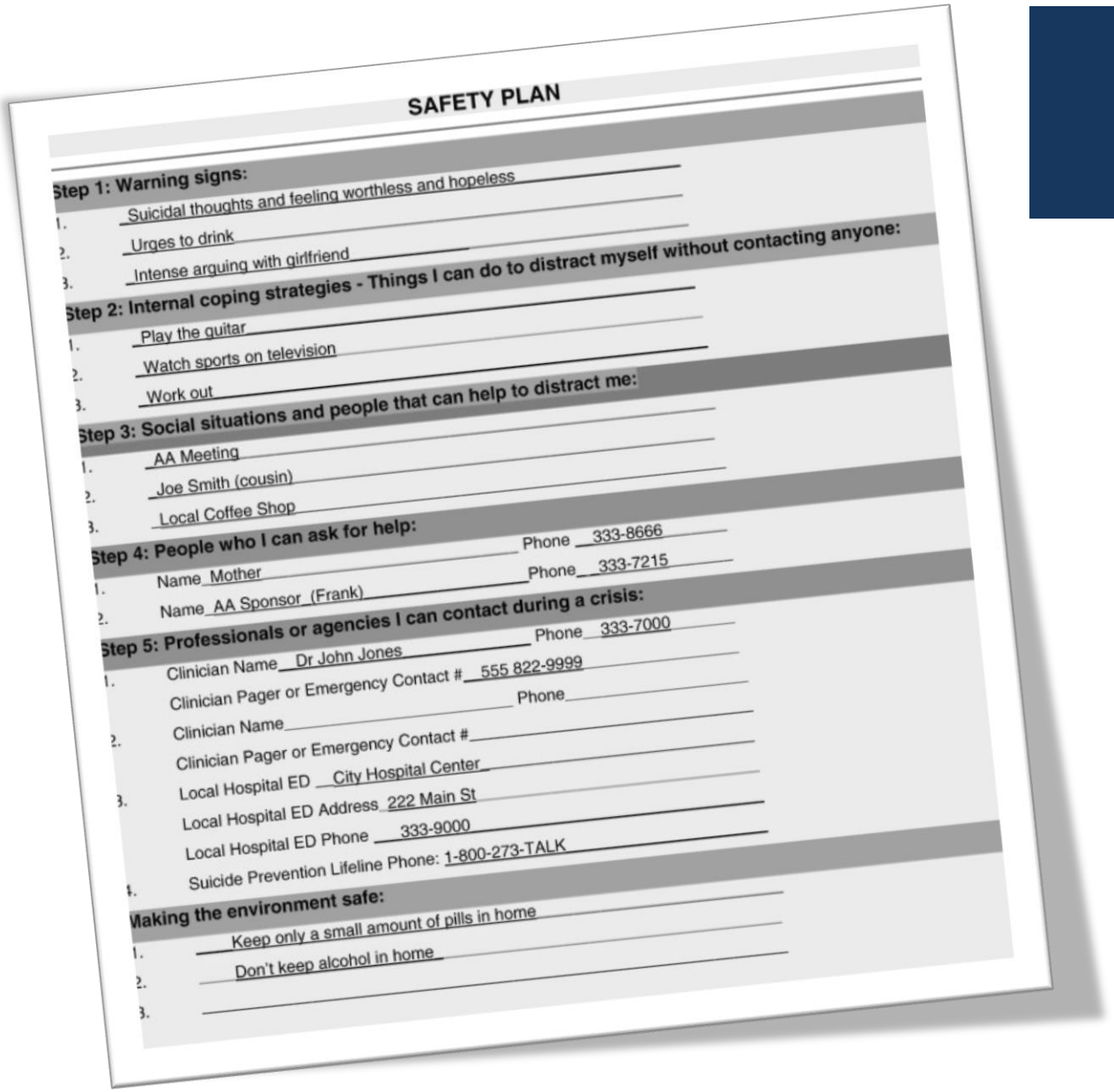
Avoiding preventable inpatient admission, even though most met medical necessity criteria when they first presented



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
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. 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

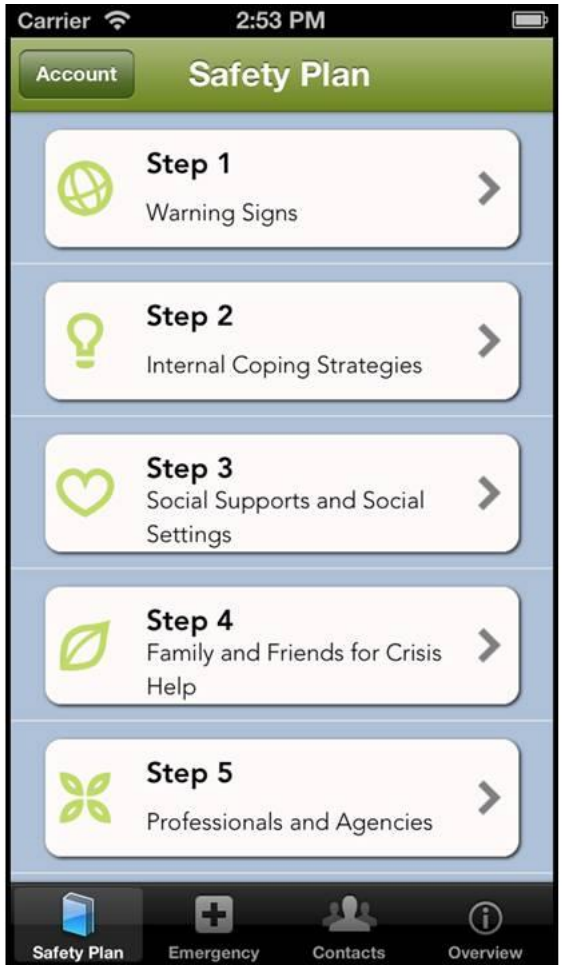
Name of App:
Safety Plan

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



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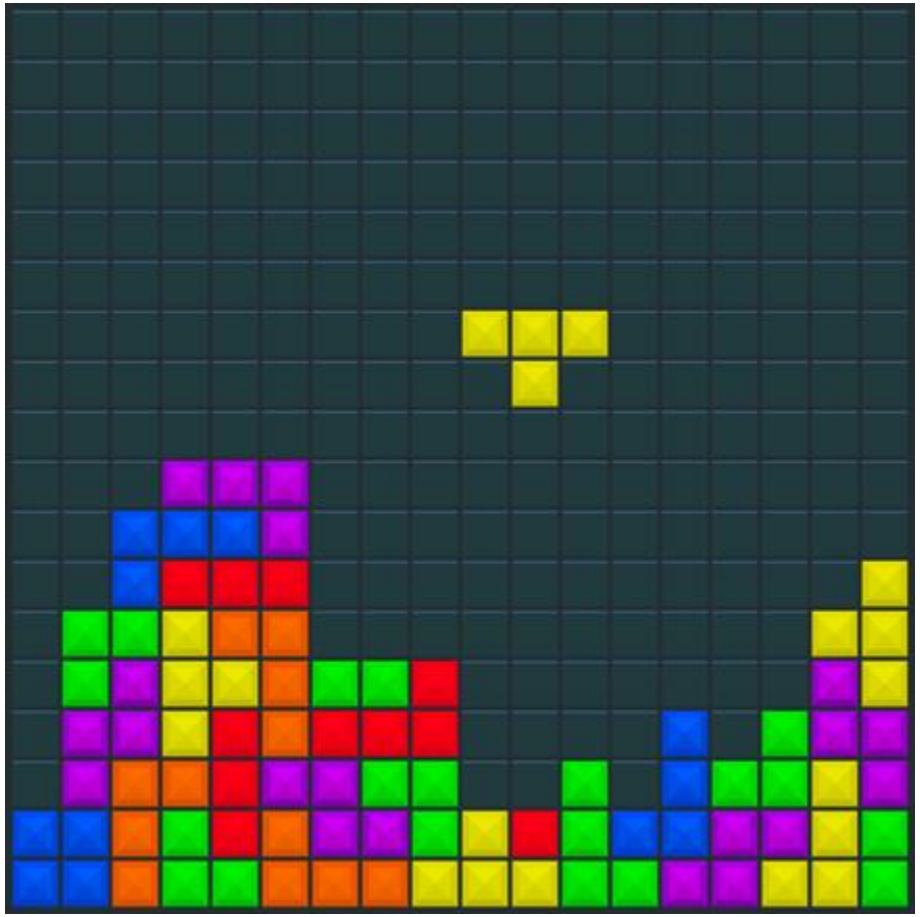
Stanley B. & Brown G.K. (2012). A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256-64.

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

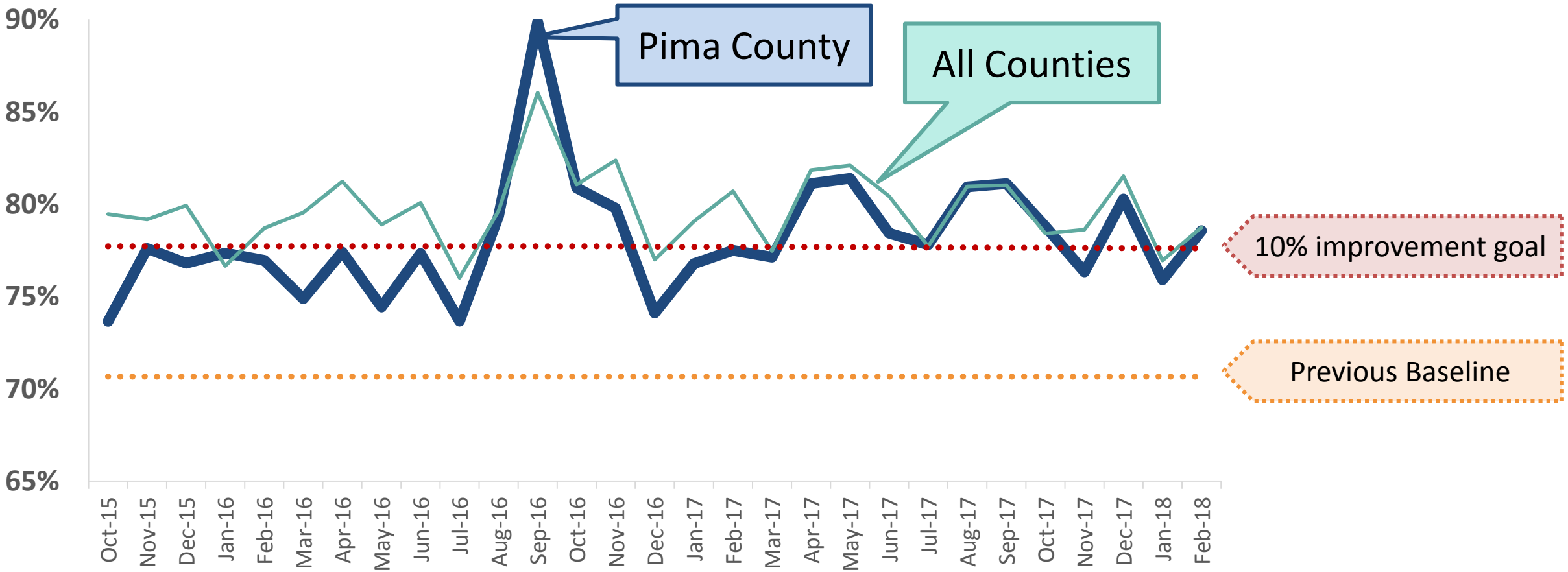


- ED-SAFE study
- Screening alone did not decrease future suicide attempts
- But when screening combined with
  - Secondary screening tool administered by a physician
  - Safety planning tool
  - Follow-up phone calls
- Result was **30% fewer suicide attempts** compared to screening alone ☺

Miller IW et al. Suicide Prevention in an Emergency Department Population The ED-SAFE Study. *JAMA Psychiatry*. 2017 Jun 1;74(6):563-570.

Continued Stabilization

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



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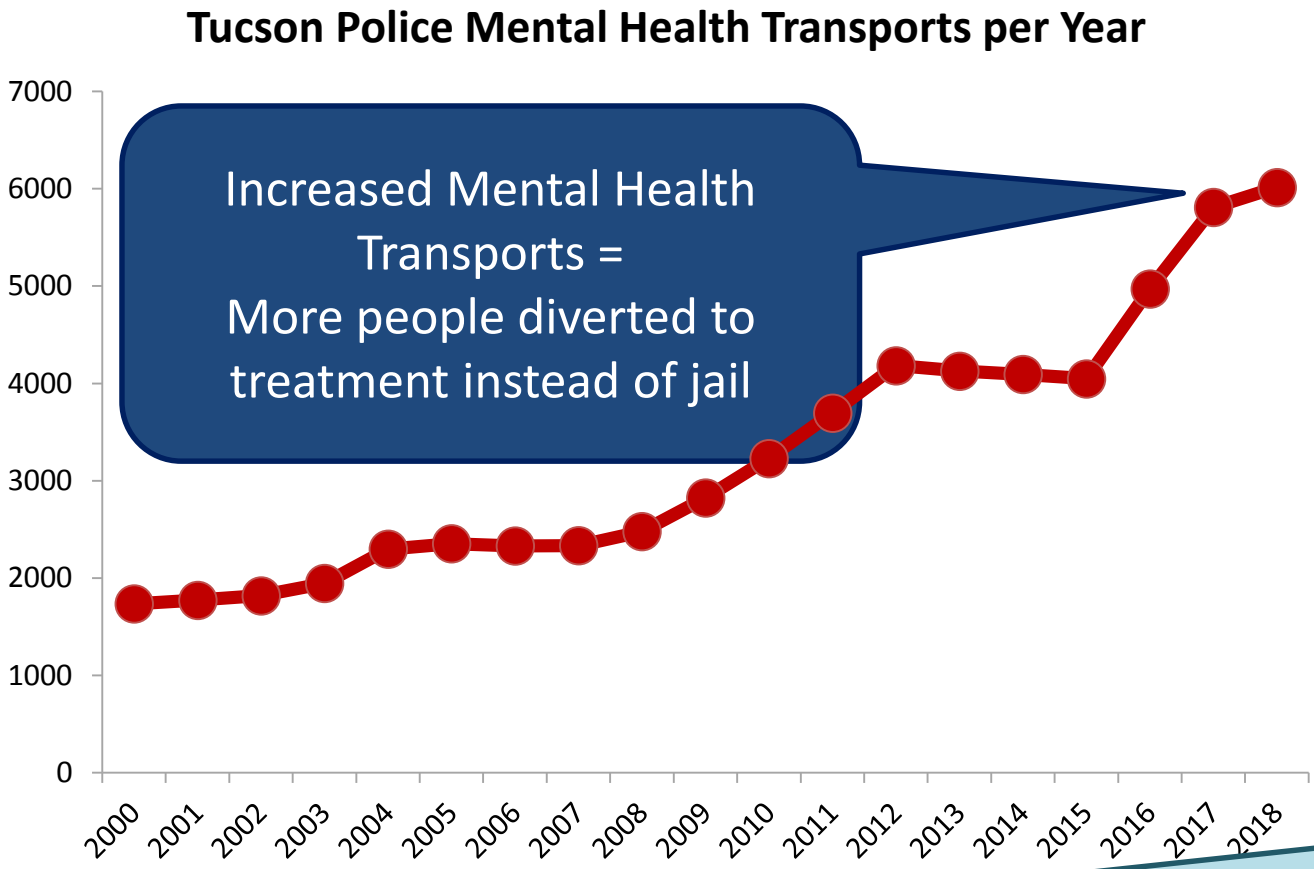
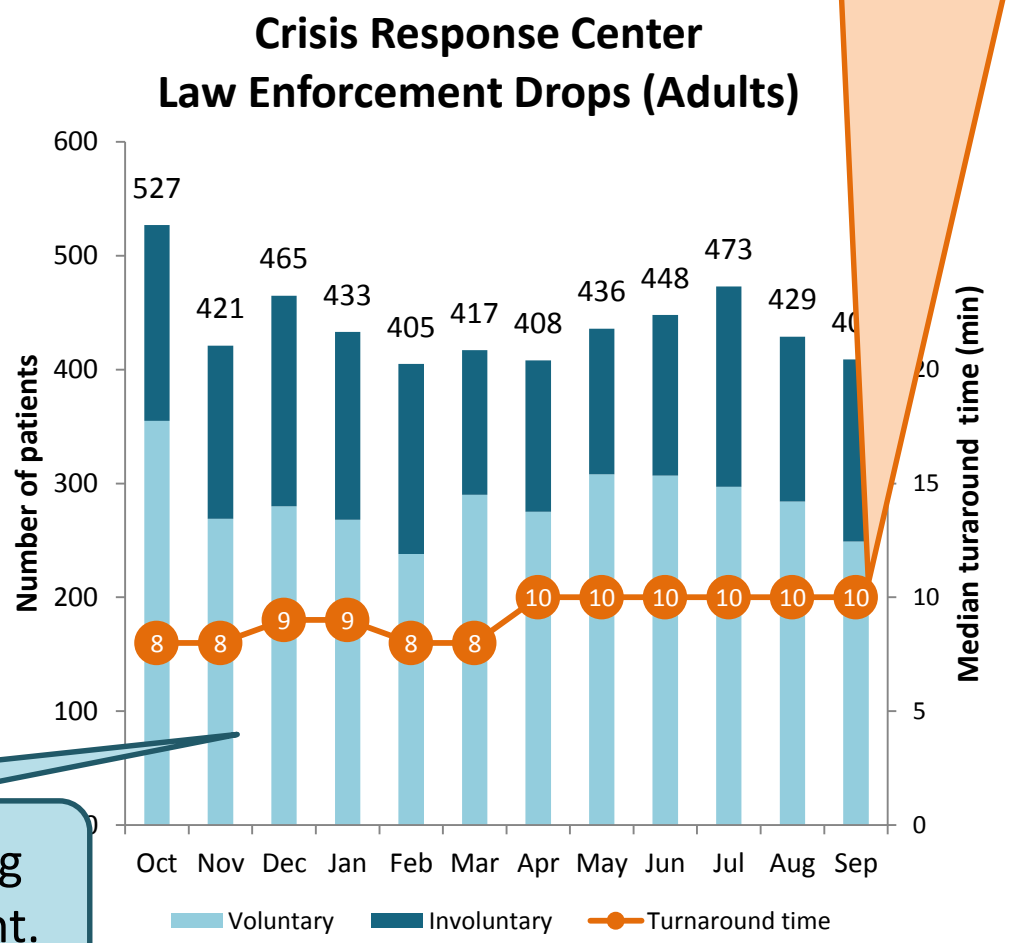
Courtesy Johnnie Gaspar, Arizona Complete Health

MORE People Taken to Treatment…



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

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



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

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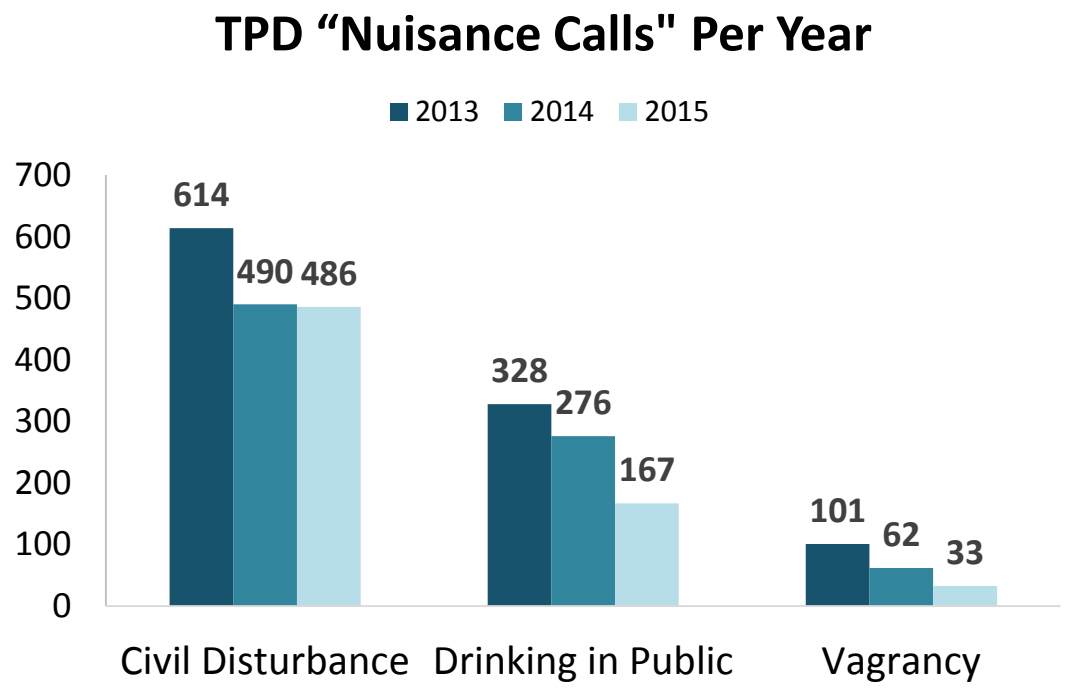
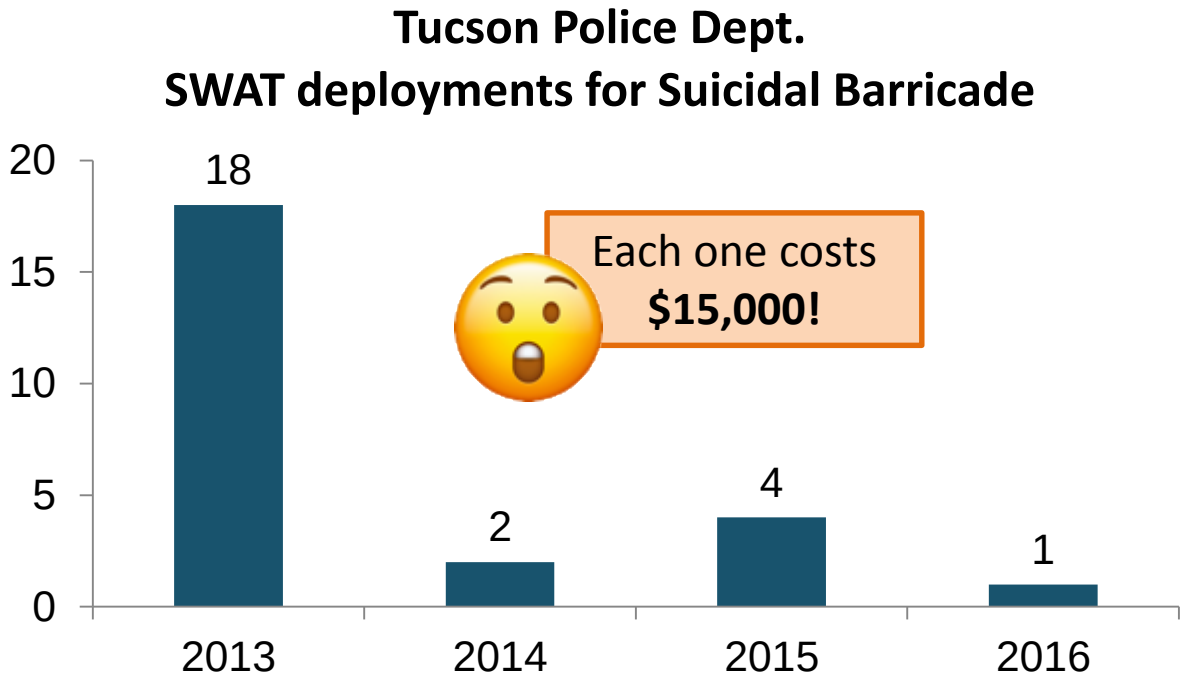
… and LESS Justice Involvement

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.





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

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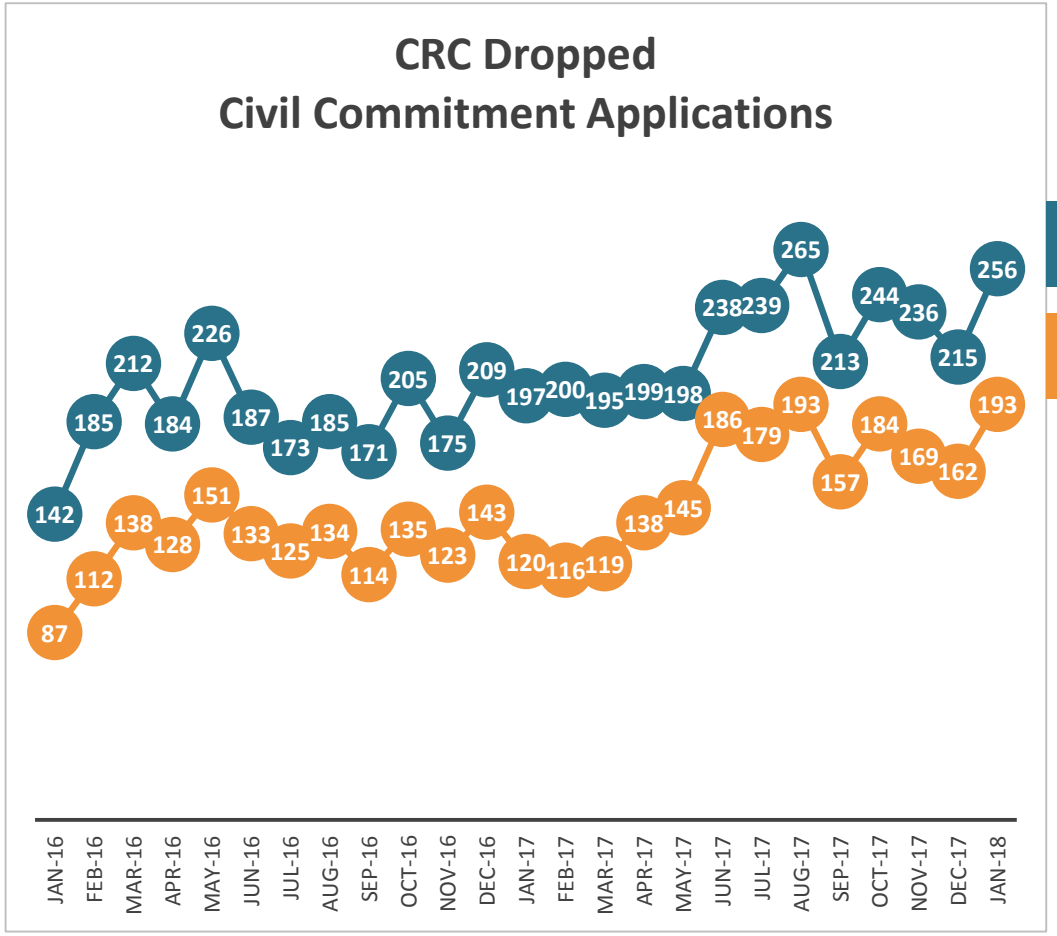
Crisis Stabilization Aims for the **Least-Restrictive** (and least costly) Disposition Possible

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



70%
Converted to Voluntary Status

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

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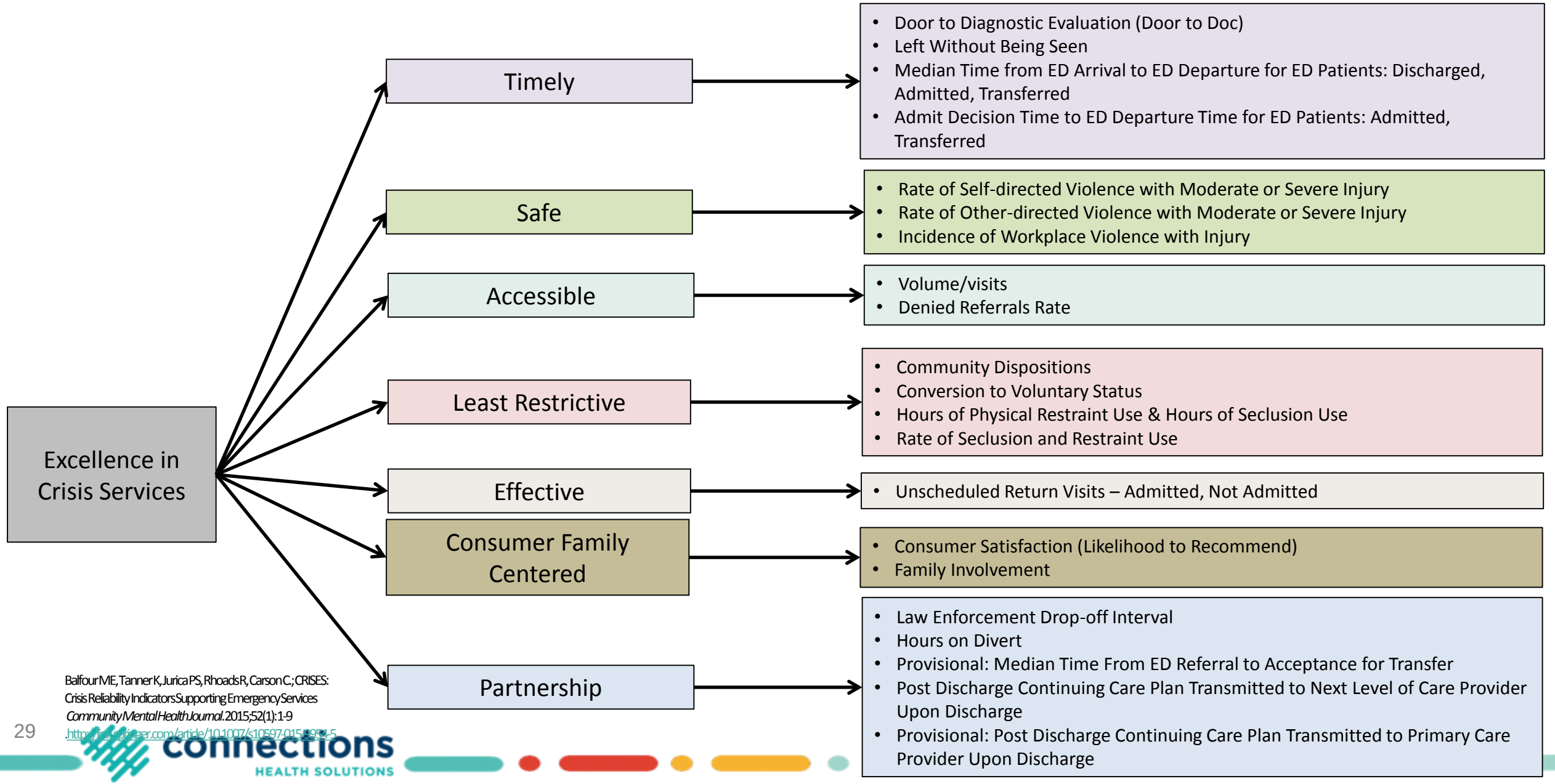
Connections Crisis Facility KPIs

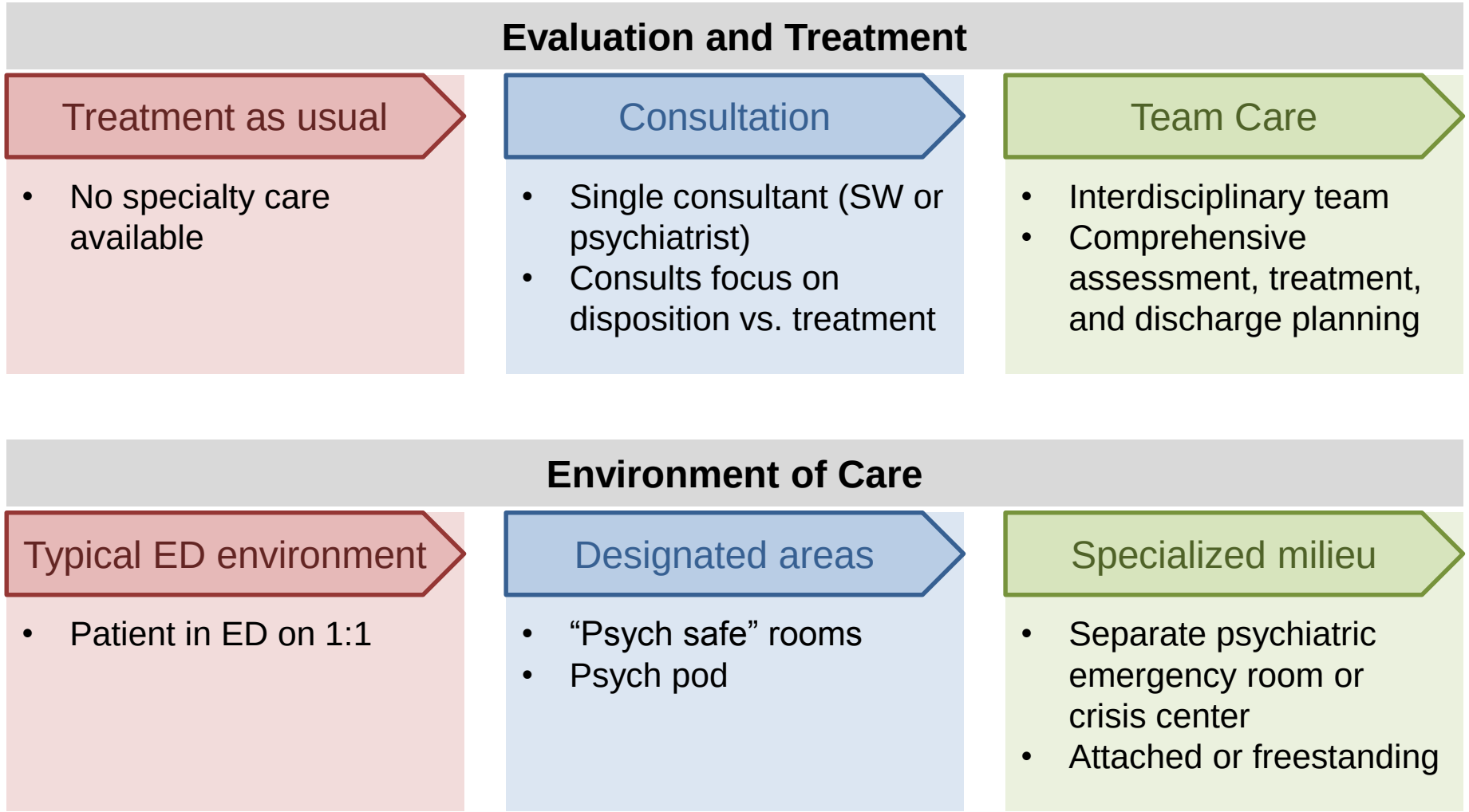
Metric	Outcome	Relevance
Urgent Care Clinic: Door-to-Door **Length of Stay**	**< 2 hours**	Patients get their needs met quickly instead of going to an ED or allowing symptoms to worsen.
23-Hour Obs Unit: **Door-to-Doctor Time**	**< 90 min**	Treatment is started early, which results in higher likelihood 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://link.springer.com/article/10.1007/s10597-015-9974-5

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 followup[1]
- 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 services[2]

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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