Secondary Suicide Screening in Acute Care Settings
Screening for Suicide Risk Saves Lives!

• **Goal:**
  • Improve front-line clinician proficiency in conducting secondary screening and risk stratification of patients detected as being at non-negligible risk of suicide as part of primary screening.

• **Objectives:**
  • Learn the importance of suicide risk screening.
  • Learn how to use the ED-SAFE Patient Secondary Screening tool (ESS-6), including scoring and stratification.
How Do We Prevent Suicide?

• What proportion of healthcare visits before a suicide death are not for mental health?

60%

• We need to detect risk before the individual acts!

How? By screening all patients for suicide risk
Universal Screening to Detect and Stratify

- Primary Screening
  - Detects if non-negligible risk exists using specific criteria

- Secondary Screening
  - Stratifies risk to drive clinical action and risk mitigation
General Tips for Universal Primary and Secondary Screening

- Screen all patients, regardless of presenting complaint
- Provide rationale, be attentive
- Assess all indicators (don’t skip items)
- Use collateral info too
- Have clear strata, risk mitigation plans
# Introductory script:
"Because some topics are hard to bring up, we ask these same questions of everyone."

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
   - [ ] Yes
   - [ ] No
   - [ ] Refused
   - [ ] Patient unable to complete

2. Over the past 2 weeks, have you had thoughts of killing yourself?
   - [x] Yes
   - [ ] No
   - [ ] Refused
   - [ ] Patient unable to complete

3. Have you ever attempted to kill yourself?
   - [ ] Yes
   - [ ] No
   - [ ] Refused
   - [ ] Patient unable to complete
   When did this last happen?
   - [ ] Within the past 24 hours (including today)
   - [ ] Within the last month (but not today)
   - [ ] Between 1 and 6 months ago
   - [ ] More than a six months ago
   - [ ] Refused
   - [ ] Patient unable to complete

Yes to Red = Positive Suicide Risk
Secondary Screener

- **Purpose** = initial risk stratification for clinical decision making and mitigation

- **Indicators**, not “items”

- **Use all data:**
  - Self report
  - Collateral (family, EMS/Police)
  - Chart review
  - Observation

- High
- Moderate
- Mild
ED-SAFE Patient Secondary Screener (ESS-6)

1. Positive on both safety screener (PSS-3) items – active ideation with a past attempt
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

2. Recent or current suicide plan
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

3. Recent or current intent to act on ideation
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

4. Lifetime psychiatric hospitalization
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

5. Pattern of excessive substance use
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

6. Current irritability, agitation, or aggression
   - Yes
   - No
   - Unable to complete
   Notes: ______________________________

- Six indicators
- Each “Yes” = 1
Positive on both safety screener (PSS-3) items - active ideation with a past attempt

- Did the patient screen positive on both primary screening (PSS-3) items - active ideation with a past attempt in 6 months?

- Presenting with a current attempt = automatic Yes

- May need to review primary screening results
Secondary Screener: Indicator 2

• Recent or current suicide plan

• Has the individual begun a suicide plan?

• Presenting with current attempt = automatic **Yes**

• Suggested wording: Have you been thinking about how you might kill yourself?
Secondary Screener: Indicator 3

• **Recent or current intent to act on ideation**

• Has the individual recently had intent to act on his/her ideation?

• Presenting with current attempt = automatic **Yes**

• Consider specifying if intent is recent or current

• Suggested wording: Have you had some intention of acting on your thoughts?
Secondary Screener: Indicator 4

• **Lifetime psychiatric hospitalization**

• Has the patient ever had a psychiatric hospitalization?

• Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?

• Consider hospitalization for either mental health or substance abuse as a psychiatric hospitalization.
Secondary Screener: Indicator 5

- Pattern of excessive substance use
  
  - Does the patient have a pattern of excessive substance use?
  
  - If intoxication is present during visit = automatic Yes
  
  - Suggested wording: Has drinking or drug abuse ever been a problem for you?
  
  - Or administer CAGE or other standardized substance use screener or substance use problem
Secondary Screener: Indicator 6

- Current irritability, agitation, or aggression

- Is the patient irritable, agitated, or aggressive?

- Source: Primarily observations, collateral information, medical records review

- Suggested wording: Are you having thoughts of hurting other people?
Instructions for Use

- **Step 1** = Add the indicators (each “Yes” = 1)
  - Score = Sum (Range: 0 to 6)

- **Step 2** = Critical item review
  - Attempt? Plan? Intent?
  - Note critical items

- **Step 3** = Check strata level for score and critical items
  - Stratum = Highest level checked
## Stratification

<table>
<thead>
<tr>
<th>Negligible</th>
<th>Mild</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>No score (primary screener was negative)</td>
<td>□ Score: 0 - 2</td>
<td>□ Score: 3 - 4</td>
<td>□ Score: 5 - 6</td>
</tr>
<tr>
<td>□ No current attempt</td>
<td>□ No current attempt</td>
<td>□ No current attempt</td>
<td>□ Current attempt</td>
</tr>
<tr>
<td>□ Not applicable</td>
<td>□ No intent or plan</td>
<td>□ Intent or plan (not both)</td>
<td>□ Intent and plan</td>
</tr>
</tbody>
</table>

*Strata = Highest level checked*

Consider other factors that may affect patient safety, such as altered mental status, intoxication, and legal hold status.
This patient is in the **High** risk group because he had suicidal intent **and** had begun a plan.

Highest level for any of the criteria = stratum
Stratification Example 2

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Score: 0 - 2</td>
<td>□ Score: 3-4</td>
<td>□ Score: 5 - 6</td>
</tr>
<tr>
<td>✓ No current attempt</td>
<td>□ No current attempt</td>
<td>□ Current attempt</td>
</tr>
<tr>
<td>✓ No intent or plan</td>
<td>□ Intent or plan (not both)</td>
<td>□ Intent and plan</td>
</tr>
</tbody>
</table>

- This patient is in the **Moderate** risk group because she obtained a low score and had no attempt, intent or plan, but was on involuntary behavioral health hold.
- Highest level for any of the criteria = stratum
## Mitigation and Recommended Care

<table>
<thead>
<tr>
<th><strong>Mild</strong></th>
<th><strong>Moderate</strong></th>
<th><strong>High</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Constant observation <em>not</em> required</td>
<td>✓ Constant observation (1: several), make room safe recommended</td>
<td>✓ Constant observation (1:1), make room safe or ligature resistant room recommended</td>
</tr>
<tr>
<td>✓ Behavioral health evaluation voluntary</td>
<td>✓ Behavioral health evaluation recommended</td>
<td>✓ Behavioral health evaluation recommended</td>
</tr>
<tr>
<td>✓ Suicide Prevention and Mental Health discharge resources</td>
<td>✓ Suicide Prevention and Mental Health discharge resources</td>
<td>✓ Suicide Prevention and Mental Health discharge resources</td>
</tr>
<tr>
<td>✓ Safety plan recommended at discharge</td>
<td>✓ Safety plan recommended at discharge</td>
<td>✓ Safety plan recommended at discharge</td>
</tr>
</tbody>
</table>
Remember: **How** Screening is Done is as Important as the Questions Asked

- Attentive, empathic, non-judging clinician
- Better disclosure, honest report

Improved detection, lives saved!
Thank you!