Strategies for Enhancing Treatment Interventions for Suicidal Crisis

Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
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.

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

Person in Crisis → Crisis Line → Mobile Crisis Teams → Crisis Facility → Post-Crisis Wraparound

- **80% resolved** on the phone
- **71% resolved** in the field
- **68% discharged** to the community
- **85% remain stable** in community-based care

Easy Access for Law Enforcement = Pre-Arrest Diversion

Decreased Use of jail, ED, inpatient

LEAST Restrictive = LEAST Costly

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)”

Locked or Unlocked?
Staffed by?

“Crisis Residential”
Environment of Care
Ligature Safety?

“Receiving Facility”

“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?

https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_5_6_19_Rev5.pdf
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
- 20% had contact with a BH provider
- 80% EDs report psych boarding
- Only 17% of EDs have psychiatrists
- Only 11% report any BH on call
- Boarding times range from hours to days
- Loss of $2300 for each boarded patient
- Increased risk of harm to patient and staff
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*
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
Suicide Risk Assessment

What I think I do

What my friends think I do

What everyone wants me to 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

**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

Collect info from:
- Self-report
- Clinical exam
- Collateral sources

Risk Factors & Protective Factors
- Static/Stable
- Dynamic/Modifiable

Formulation

Treatment Plan
focused on Dynamic/Modifiable Factors

Intrinsic
Psych symptoms, intoxication, coping skills,

Extrinsic
Stressors & supports, follow-up, means

Stabilize
Meds, groups, peer support, etc.

Discharge plan
Follow-up, family & peer support, means

Interdisciplinary Teamwork

Goals met?

Collaboration with community partners can move this line up
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
Easy Access for Law Enforcement so we are the preferred alternative to drop off at jail or ED
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
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

“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!”

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

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

10% improvement goal

Previous Baseline

Pima County

All Counties

Courtesy Johnnie Gaspar, Arizona Complete Health
MORE People Taken to Treatment...

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.
... and LESS Justice Involvement

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

**TPD “Nuisance Calls" Per Year**

<table>
<thead>
<tr>
<th>Category</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Disturbance</td>
<td>614</td>
<td>490</td>
<td>486</td>
</tr>
<tr>
<td>Drinking in Public</td>
<td>328</td>
<td>276</td>
<td>167</td>
</tr>
<tr>
<td>Vagrancy</td>
<td>101</td>
<td>62</td>
<td>33</td>
</tr>
</tbody>
</table>

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

**Tucson Police Dept. SWAT deployments for Suicidal Barricade**

- Civil Disturbance: 614 in 2013, 490 in 2014, 486 in 2015

Each one costs $15,000!

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

- **Timely**
  - Door to Diagnostic Evaluation (Door to Doc)
  - Left Without Being Seen
  - Median Time from ED Arrival to ED Departure for ED Patients: Discharged, Admitted, Transferred
  - Admit Decision Time to ED Departure Time for ED Patients: Admitted, Transferred

- **Safe**
  - Rate of Self-directed Violence with Moderate or Severe Injury
  - Rate of Other-directed Violence with Moderate or Severe Injury
  - Incidence of Workplace Violence with Injury

- **Accessible**
  - Volume/visits
  - Denied Referrals Rate

- **Least Restrictive**
  - Community Dispositions
  - Conversion to Voluntary Status
  - Hours of Physical Restraint Use & Hours of Seclusion Use
  - Rate of Seclusion and Restraint Use

- **Effective**
  - Unscheduled Return Visits – Admitted, Not Admitted

- **Consumer Family Centered**
  - Consumer Satisfaction (Likelihood to Recommend)
  - Family Involvement

- **Partnership**
  - Law Enforcement Drop-off Interval
  - Hours on Divert
  - Provisional: Median Time From ED Referral to Acceptance for Transfer
  - Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
  - Provisional: Post Discharge Continuing Care Plan Transmitted to Primary Care Provider Upon Discharge
A continuum of solutions with what you have

**Evaluation and Treatment**

<table>
<thead>
<tr>
<th>Treatment as usual</th>
<th>Consultation</th>
<th>Team Care</th>
</tr>
</thead>
</table>
| • No specialty care available | • Single consultant (SW or psychiatrist)  
• Consults focus on disposition vs. treatment | • Interdisciplinary team  
• Comprehensive assessment, treatment, and discharge planning |

**Environment of Care**

<table>
<thead>
<tr>
<th>Typical ED environment</th>
<th>Designated areas</th>
<th>Specialized milieu</th>
</tr>
</thead>
</table>
| • Patient in ED on 1:1 | • “Psych safe” rooms  
• Psych pod | • Separate psychiatric emergency room or crisis center  
• Attached or freestanding |
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:

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

Questions?

Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
margie.balfour@connectionshs.com