Sentinel Event Alert

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Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[6] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

Who is at risk for suicide?
Much of what we know about the profile of individuals who have died by suicide and those who have attempted suicide comes from looking in the rearview mirror – at data compiled about suicide victims and attempts. Suicide may affect certain demographics – such as military veterans[14] and men over age 45 – more than others. It's important to identify the risk factors, rather than membership in a group, when considering suicide risk. Paying attention to risk factors matters because patients may not disclose suicide ideation voluntarily. Risk factors for suicide include:

- Mental or emotional disorders, particularly depression and bipolar disorder.[15] Up to 90 percent of suicide victims suffer from a mental or emotional disorder at the time of death.[16]
- Previous suicide attempts or self-inflicted injury; the risk of suicide is twice as high (100 percent higher) than general suicide rates for one year following a suicide attempt[6,15] and the higher risk continues beyond that.[6,11] The risk is even higher the first few weeks immediately following a suicide attempt.[8]
- History of trauma or loss, such as abuse as a child,[17] a family history of suicide,[17] bereavement[18] or economic loss.[18]
- Serious illness,[18] or physical or chronic pain or impairment.[18]
- Alcohol and drug abuse.[15]
- Social isolation[19] or a pattern/history of aggressive or antisocial behavior.[20]
- Discharge from inpatient psychiatric care,[21,22] within the first year after[10] and particularly within the first weeks and months after discharge.[23] While some depressed patients who attempt or die by suicide after inpatient psychiatric hospitalization express suicide ideation before or during hospitalization, other depressed patients who have received inpatient psychiatric treatment develop suicide ideation after discharge.[24]
- Access to lethal means coupled with suicidal thoughts.[18]

However, there is no typical suicide victim. Most individuals having these risk factors do not attempt suicide, and others without these conditions sometimes do. Therefore, there is a danger in considering only individuals with certain conditions or experiences in certain health care settings as being at risk for suicide. It's imperative for health care providers in all settings to better detect suicide ideation in patients, and to take appropriate steps for their safety and/or refer these patients to an appropriate provider for screening, risk assessment, and treatment.

Assessing suicide risk remains a challenge
The Joint Commission's Sentinel Event database* has reports of 1,089 suicides occurring from 2010 to 2014 among patients receiving care, treatment, and services in a staffed, around-the clock care setting or within 72 hours of discharge, including from a hospital's emergency department. The most common root cause documented during this time period was shortcomings in assessment, most commonly psychiatric assessment. In addition, 21.4 percent (165) of Joint Commission-accredited behavioral health organizations and 5.14 percent (65) of Joint Commission-accredited hospitals (for which the requirement was applicable) were rated non-compliant in 2014 with National Patient Safety Goal 15.01.01 Element of Performance 1 – *Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.*

Actions suggested by The Joint Commission
To accomplish the following suggested actions, The Joint Commission urges all health care organizations to develop clinical environment readiness by identifying, developing and integrating comprehensive behavioral health, primary care and community resources to assure continuity of care for individuals at risk for suicide.[12,25] Many communities and health care organizations presently do not have adequate suicide prevention resources, leading to the low detection and treatment rate of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their workflow and disrupt their schedule for the day to find treatment and assure safety for these patients.

DETECTING SUICIDE IDEATION IN NON-ACUTE OR ACUTE CARE SETTINGS
Primary, emergency and behavioral health clinicians all play crucial roles in detecting suicide ideation through the following three steps, which can be taken in non-acute or acute care settings:

1. Review each patient's personal and family medical history for suicide risk factors. These are listed in the "Who is at risk for suicide?" section of this alert.

* The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

2. Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool. A waiting room questionnaire including a question specifically asking if the patient has had thoughts about killing him or herself may help identify individuals at risk for suicide who otherwise may not have been identified. Research shows that a brief screening tool can identify individuals at risk for suicide[11,26-32] more reliably than leaving the identification up to a clinician's personal judgment or by asking about suicidal thoughts using vague or softened language. For example, a study using the Patient Health Questionnaire (PHQ-9)[33] found that those who expressed thoughts of death or self-harm were 10 times more likely to attempt suicide than those who did not report those thoughts.[26,31] Some practices use a shorter version called the PHQ-2,[34] which asks two questions about depression symptoms, and some add an additional question about suicidal thoughts and feelings. If a patient answers "yes" to any of these questions, the PHQ-9 is administered.[35] Other brief screening tools include the Emergency Medicine Network's ED-SAFE Patient Safety Screener[36] for emergency departments and the Suicide Behaviors Questionnaire-Revised (SBQ-R).[37]

3. Review screening questionnaires before the patient leaves the appointment or is discharged. To determine the proper immediate course of treatment, conduct or refer for secondary screening and assessment patients determined to be at risk for suicide. Useful secondary screeners include the Suicide Prevention Resources Center's Decision Support Tool[38] and the Emergency Medicine Network's ED-SAFE Patient Safety Secondary Screener[39] for emergency departments. The SAFE-T[20] Pocket Card and the Columbia-Suicide Severity Rating Scale (C-SSRS)[40] can be used for in-depth screening and assessment.

For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others.[38]

TAKING IMMEDIATE ACTION AND SAFETY PLANNING

During the following two steps, behavioral health clinicians are generally added to the care team via consultation or referral. The care team should:

4. Take the following actions, using assessment results to inform the level of safety measures needed.

- **Keep patients in acute suicidal crisis** in a safe health care environment under one-to-one observation. Do not leave these patients by themselves. Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources. Check these patients and their visitors for items that could be used to make a suicide attempt or harm others. Keep these patients away from anchor points for hanging and material that can be used for self-injury.[41] Some specific lethal means that are easily available in general hospitals and that have been used in suicides include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.[42,43]
- **For patients at lower risk of suicide,** make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment,[8] rather than leaving it up to the patient to make the appointment.
- **For all patients with suicide ideation:**
  - **Give every patient** and his or her family members the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as to local crisis and peer support contacts.[44]
  - **Conduct safety planning**[44] by collaboratively identifying possible coping strategies with the patient and by providing resources for reducing risks.[12,44] A safety plan is not a "no-suicide contract" (or "contract for safety"), which is not recommended by experts in the field of suicide prevention.[44] Review and reiterate the patient's safety plan at every interaction until the patient is no longer at risk for suicide.[38]
  - **Restrict access to lethal means.** Assess whether the patient has access to firearms or other lethal means, such as prescription medications and chemicals, and discuss ways of removing or locking up firearms and other weapons during crisis periods. Restricting access is important because many suicides occur with little planning during a short-term

crisis, and both intent and means is required to attempt suicide.[46] The Harvard T.H. Chan School of Public Health's Means Matter website provides helpful advice on means restriction.[46]

BEHAVIORAL HEALTH TREATMENT AND DISCHARGE

Behavioral health clinicians manage the patient's evidence-based treatments and discharge plans, as well as coordinate care transitions and follow-up care with the patient's other providers.

5. Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient involving the patient's other providers, family and friends as appropriate. Suicide risk, by nature, is very dynamic – changing according to personal events, a person's level of desperation, and available interventional resources.[47] Treatment of individuals at risk for suicide requires a collaborative approach that acknowledges the ambivalence – the desire to find a solution to their pain versus the innate desire to live – that these patients often feel.[48] A valuable support to traditional risk assessment is to use a risk formulation model – drawn from prevention research[49] and violence assessment[50] – that can help providers to understand a patient's current thoughts, plans, access to lethal means, and acute risk factors. This understanding can be used to develop personalized care and both short- and long-term safety plans for patients struggling with thoughts of suicide.

6. To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality.[12] Traditionally, behavioral health clinicians often have treated the underlying depression or other mental health disorders in patients but have not directly addressed suicide risk. Providing direct treatment of suicide risk using evidence-based interventions is vital. Hospitalization is often necessary for a patient's immediate safety, but hospitalization used solely as a containment strategy may be ineffective or counterproductive[51-53] and considered by the patient as a disincentive or penalty for expressing suicidal thoughts.[54] Evidence-based clinical approaches that help to reduce suicidal thoughts and behaviors include: 1) Cognitive Therapy for Suicide Prevention (CBT-SP),[55-56] 2) the Collaborative Assessment and Management of Suicide (CAMS),[19,57] and 3) Dialectical Behavior Therapy (DBT).[58] In addition, Caring Contacts[59-61] has a growing body of evidence as a post-discharge suicide prevention strategy. See an overview of these and other evidence-based interventions, which emphasize ***patient engagement, collaborative assessment and treatment planning, problem-focused clinical intervention to target suicidal "drivers," skills training, shared service responsibility,[12] and proactive and personal clinician involvement in care transitions and follow-up care, such as:***

- Engaging the patient and family members/significant others in collaborative discharge planning to promote effective coping strategies.
- Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient's well-being.
- Determining how often patients will be called and seen.
- Establishing real-time telephone or live contact with at-risk patients who don't stay in touch or show up for an appointment, rather than having staff or resources just leave reminder messages or emails.
- Directly addressing patients' thoughts about suicide at every interaction.[62]
- Using motivational enhancement to increase the likelihood of engagement in further treatment.[44]

EDUCATION AND DOCUMENTATION

These recommendations are relevant to all care providers and settings.

7. Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation. Develop a process for how staff can sensitively respond to a patient with suicidal thoughts and feelings in a way that is appropriate to their role and professional training.[63] Education for staff should cover environmental risk factors; finding help in emergencies; and policies for screening, assessment, referral, treatment, safety and support of patients at risk for suicide. The Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention developed "Suicide Prevention and the Clinical Workforce: Guidelines for Training."[64] "Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments,"[38] The Joint Commission's Standards BoosterPak™ Suicide Risk for National Patient Safety Goal 15.01.01, the QPR Institute and the VA/DoD Clinical Practice Guideline for Assessment and Management of

Patients at Risk for Suicide (2013)[14] also are good resources.

8. Document decisions regarding the care and referral of patients with suicide risk.
Thoroughly document every step in the decision-making process and all communication with the patient, his or her family members and significant others, and other caregivers. Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible, including the content of the safety plan and the patient's reaction to and use of it; discussions and approaches to means reduction; and any follow-up activities taken for missed appointments, including texts, postcards, and calls from crisis centers. Be generous in documentation, as it becomes the main method of communication among providers. For a documentation checklist, see Page 21 of Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.[38]

Related Joint Commission requirements
The advice provided in this alert applies universally to all patients in all settings. In addition, since the risk of suicide increases after discharge from emergency departments and inpatient settings, it's important for health care organizations to incorporate appropriate transition and follow-up actions in accordance with Provision of Care, Treatment, and Services accreditation requirement PC.04.01.01 – *The organization has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer*.

Joint Commission requirements related to detecting and treating patients with suicide ideation	Hospital	Ambulatory	Behavioral health	Home care	Nursing care center	Office-based surgery
Care, Treatment, and Services						
CTS.02.01.01			✔			
Environment of Care						
EC.02.01.01			✔			
EC.02.06.01	✔					
National Patient Safety Goal						
NPSG.15.01.01, EPs 1, 2, 3	✔		✔			
Performance Improvement						
PI.01.01.01			✔			
Provision of Care, Treatment, and Services						
PC.01.01.01 EP 24	✔					
PC.01.02.01	✔					
PC.01.02.13	✔					
PC.04.01.01	✔	✔		✔	✔	✔

See the content of these standards on The Joint Commission website, posted with this alert.

Resources
Zero Suicide Toolkit, from the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention

ED-SAFE Materials, from the Emergency Medicine Network

Caring for Adult Patients with Suicide Risk – A Consensus Guide for Emergency Departments, and Quick Guide for Clinicians, from the Suicide Prevention Resource Center

Means Matter website, from the Harvard T.H. Chan School of Public Health

Mental Health Environment of Care Checklist – For reviewing inpatient mental health units for environmental hazards, from the VA National Center for Patient Safety.

QPR Institute – Suicide prevention courses and training for professionals, institutions, and the public, on site or through a self-study program.

SAFE-T Pocket Card for Clinicians – Five-step evaluation and triage for suicide assessment

Suicide Prevention and the Clinical Workforce: Guidelines for Training, from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, from the Department of Veterans Affairs, Department of Defense, June 2013.

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