Medical Control Guideline: EVALUATION AND CARE OF PATIENTS AT RISK OF SUICIDE

DEFINITIONS:

Suicide Risk Screening: A standardized method to identify individuals who may be at risk for suicide, and to estimate a patient's current level of risk for suicide by asking specific questions about a patient's thoughts and behaviors.

The Columbia Suicide Severity Rating Scale (C-SSRS, https://cssrs.columbia.edu/) (*MCG 1306.1*) is an example of a commonly used, evidence-based method of suicide risk screening that can be administered by a variety of personnel, such as all healthcare personnel, law enforcement personnel, educators, clergy, and the lay public.

Suicide Risk Assessment: A thorough and systematic evaluation that is typically performed after suicide risk screening. A trained mental health clinician (e.g., a psychiatrist, social worker, or psychologist in an ED or PUCC setting) performs a detailed clinical assessment to confirm suspected suicide risk, to estimate the immediate danger, and to delineate treatment. Assessment takes into account chronic and acute risk factors, protective factors, and medical and mental health history.

Suicidal Ideation (SI): Thoughts of death or ending one's life. Different types of SI include the following (in increasing level of severity):

Passive SI: A wish to be dead or to go to sleep and not wake-up	**(C-SSRS Q1)**
Active SI: Actual thoughts of wanting to kill oneself	**(C-SSRS Q2)**
Suicide Method: Contemplation of one or more ways or means of ending their life, *without* formulating a specific plan	**(C-SSRS Q3)**
Suicidal Intent: Intention to act on suicidal thoughts or behaviors, with the specific goal to kill oneself or to die	**(C-SSRS Q4)**
Suicide Plan: Specific thoughts of converting a method to a plan, such as deciding on the timing, location, and/or preparations to end their life (e.g., gathering pills, acquiring a weapon, writing a suicide note, researching the location for a traumatic/deadly injury)	**(C-SSRS Q5)**

Suicide Attempt: A self-injurious behavior where a person specifically intends to die **(C-SSRS Q6)**

Suicide: Death caused by self-injurious behavior with any intent to die as a result of that behavior. (Note: The following terms are discouraged from use: "completed suicide", "successful suicide", and "failed suicide". Preferred terms are "suicide" and "suicide attempt".)

Self-injurious behaviors: Behaviors in which a person intentionally harms themselves, with or without intent to die (a patient's intent to die must be specifically asked, or implied). For example, patients may "self-harm" (e.g., cutting, burning, or punching oneself), without intent to die, as a way of attempting to cope with emotional distress or psychological pain.

Suicidal behaviors: Self-injurious behavior *with the intent to die*.

Safety Planning: Interventions made by healthcare personnel, first responders, or others, to reduce the patient's risk of suicide or self-harm.

5150 / 5585 (AKA "Hold", "Psychiatric Hold", "Mental Health Hold", or "LPS Hold"): Refers to California Welfare and Institutions Code (WIC) section 5150 et seq. which describes the legal standard for involuntary detainment and evaluation of a person who, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled. "5150" refers to the code for adult patients, "5585" refers to the code for minors (under age 18).

Danger to Self: The term used in CA WIC 5150 et seq, to define probable cause for detaining a patient involuntarily for the purpose of evaluation, who as a result of a mental illness poses a risk to themselves (e.g., has suicidal ideation or behavior).

LPS-Evaluator: An individual that is authorized under CA WIC 5150 et seq. to evaluate and place a patient on a 5150/5585 hold application, such as all law enforcement (LE) personnel and clinicians who are LPS-authorized by the County Department of Mental Health. Examples include: Psychiatric Emergency Team (PET), Psychiatric Mobile Response Team (PMRT), Mental Evaluation Team (MET), Systemwide Mental Assessment Response Teams (SMART), or others). LPS refers to "Lanterman-Petris-Short", the names of the original state legislators who authored the CA WIC 5150 et seq. code.

LPS facility: Treatment facilities that are specifically designated by the county for mental health evaluation and treatment, approved by the State Department of Health Care Services, and licensed as a health facility as defined in the CA Health and Safety Code (subdivision (a) or (b) of Section 1250 or 1250.2).

Against Medical Advice (AMA): A patient, or a legal representative of a patient, who has decision-making capacity and who refuses treatment and/or transport for an emergency medical condition as advised by EMS providers, physician on scene, and/or Base personnel.

Decision-Making Capacity: The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits, and having the ability to make and communicate a decision regarding the proposed health care in the patient's primary language, if feasible. A person has decision-making capacity if they are able to:

- Communicate the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and
- Relate the above information to their personal values, and then make and convey a decision.

A person may lack decision-making capacity as follows:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental or medical disorder),
- Legally determined to lack capacity (i.e. persons who are deemed incompetent by a Court, or a person under conservatorship)

9-8-8: The three digit emergency number for the 24/7 National Suicide and Crisis Lifeline that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

PRINCIPLES:

1. Psychiatric emergencies (including those related to mental health and substance abuse) are emergent clinical conditions, and as such are best treated by EMS personnel who are trained, equipped, and experienced to evaluate and manage such patients.

2. Suicide risk screening, through history taking and assessment, can be performed by EMS personnel during the evaluation of patients who express suicidal ideation or behaviors. Several suicide risk screening tools, which are evidence-based and validated in other settings, may be used to assist.

3. CA WIC 5150 et seq. defines the situations when a patient may be involuntarily detained and transported on a psychiatric hold, and who is authorized to issue a psychiatric hold.

GUIDELINES:

1. Evaluate the patient for medical conditions immediately if the patient has made a suicide attempt or is suspected of making a suicide attempt. Manage medical conditions with the appropriate treatment protocol based on provider impression.

2. Evaluate primary psychiatric crises by obtaining relevant clinical history and managing per treatment protocol (*TP 1209 or 1209-P, Behavioral/Psychiatric Crisis*).

3. Establish rapport with the patient to facilitate trust and open communication and to optimize the evaluation and screening of suicide risk.

4. Inquire about the patient's suicidal ideation and behaviors, including whether the patient has passive SI, active SI, contemplation of suicide method, intent to die by suicide, a plan to commit suicide, and/or suicide attempts.

    A. To assist with evaluating the level of suicide risk, a suicide risk screening tool such as the Columbia Suicide Severity Risk Scale (C-SSRS) can be used to administer standardized screening questions *(MCG 1306.1).*

    B. If using the C-SSRS, questions should be asked verbatim, all instructions should be followed, and attention paid to the specified time frames.

5. Evaluate the reliability of information, especially in situations where a patient may be suspected of minimizing or evading questions about SI or suicidal behaviors.

    A. Obtain information from key third parties when feasible.

    B. Document if the patient lacks capacity or is unwilling to participate in the evaluation.

6. When a patient has been evaluated by an authorized LPS-Evaluator regarding placement of a 5150/5585 hold, that evaluation shall generally take precedence in determining whether a patient can be transported involuntarily.

    A. Exceptions include when the EMS provider determines that the patient has a medical need that requires transport to a medical facility and lacks decision-

making capacity (e.g., need for evaluation for trauma or other emergency physical conditions).

B. If concern for suicidal intent in persons that do not meet criteria for a 5150/5585 hold as determined by an LPS evaluator, and refusing voluntary treatment or transport, EMS should contact base contact to discuss patient disposition.

C. For recommendations regarding patient disposition, refer to *MCG 1306.2*.

7. In situations where there may be disagreement with LE or an LPS-evaluator regarding the placement or non-placement of a 5150/5585 hold, and/or transport that cannot be resolved, the following steps should be taken:

   A. EMS provider shall contact higher authority (e.g., EMS Captain or Battalion Chief) to seek resolution, which may be facilitated by a call with the LE or LPS higher authorities.

   B. LE provider should contact higher authority (e.g., Field supervisor or Watch commander).

   C. LPS evaluators (such as PET, SMART, MET) should contact higher authority.

   D. Base Contact can be initiated to mediate discussion between LE and EMS, including discussion of suicide risk screening outcomes for both parties.

   E. In cases of continued disagreement, LE or LPS evaluator determination takes precedence as they are the legal authority for placement or non-placement of a 5150/5585 hold.

8. EMS clinicians can perform safety planning to help reduce the patient's risk of suicide or self-harm with the following interventions:

   A. **Establish mental health services:** Provide the national suicide lifeline phone number (9-8-8), and recommend the patient call their mental health provider, or take steps to establish mental health care (e.g., LA County Department of Mental Health 800-854-7771, or contact their insurance provider)

   B. **Help the patient identify support contacts:** Identify a family member, friend or other trusted individual who they can reach out to for help and recommend that they be accompanied or supported in the short term.

   C. **Reduce access to suicide means:** Provide direction to the patient or key third parties (e.g., family, friends) to remove or secure any identified or potential means of suicide, especially firearms, knives, pills, or other toxins.

      Firearms can be secured through use of gun locks, storage lockers, or transferred to family or friend for safekeeping. LE personnel can also be contacted to advise about securing firearms.

   D. **Reduce the risk of alcohol or drugs**: Recommend that the patient avoid use of alcohol or any other drugs, and/or take steps to limit their availability.

9. Document decision-making and involved personnel on the ePCR including:

    A. All responding agencies on scene
    B. EMS assessment
    C. Base hospital medical direction, if applicable
    D. Course of escalation and LPS/LE evaluator information including name and badge number, if applicable
    E. Name and assignment of the highest ranking LPS/LE evaluator involved in the decision-making, if applicable
    F. Any follow up plans and resources requested and/or provided to the patient for non-transport decision