

Educating Clinicians and Office Staff

The educational section of this Toolkit contains a primer presented in five modules. The first two modules are background material that may be of interest to the entire staff. The third module provides an understanding of general prevention practices that should be implemented to benefit the entire patient population and should be read and discussed by the entire primary care staff. Modules 4 and 5 are designed to educate clinicians for the specialized suicide prevention roles they will play. Module 4 provides the information necessary to evaluate patients who may be at heightened risk for suicide and to make a clinical assessment of that risk. Module 5 discusses interventions that may be necessary to protect patients from intentionally harming themselves, up to and including making arrangements for involuntary hospitalization. Additional educational resources can be found in the Patient Education Tools/Other Resources section of this Toolkit.

In This Section

Module 1 – Prevalence and Comorbidity

This two-page learning module summarizes the magnitude of the suicide problem in the U.S. and describes how the vast majority of those cases are associated with one or more mental health or substance abuse problems.

Module 2 – Epidemiology

This three-page learning module summarizes the epidemiology of suicide attempts and suicide deaths in various demographic groups.

Module 3 – Effective Prevention Strategies

This five-page learning module discusses general practices that can be incorporated into primary care settings to lower the risk of suicide across their entire patient population.

Module 4 – Suicide Risk Assessment

This six-page learning module presents a methodology for gathering information about a patient's suicidal thoughts and plans and an approach for assessing the level of suicidal intent. It concludes with pointers for clinical decision making regarding the assessment of risk.

Module 5 – Intervention

This eight-page learning module discusses a range of patient management approaches that can be implemented in the primary care setting according to the level of risk.

A GUIDE FOR PRIMARY CARE PROVIDERS AND MEDICAL PRACTICE MANAGERS



SUICIDE PREVENTION PRIMER



List of Modules

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Module 1 – Prevalence and Comorbidity

Prevalence of Suicide

More than 44,000 U.S. individuals died by suicide in 2015.¹

From 1999 to 2015, the U.S. suicide rate increased by 27%.¹



Suicide impacts people of all ages in the U.S.²:

- Suicide is the tenth leading cause of death in the U.S.
- Suicide is the third leading cause of death for children ages 10-14 and the second leading cause of death for children ages 15-34.

In 2015, 9.8 million U.S. adults (4.0%) considered suicide in the past year, of those approximately, 28% (2.7 million) made a suicide plan, and 14% (1.4 million) attempted suicide.³ Some of these people will seek your care.

Rates of suicidal behaviors and death by suicide are higher in rural areas.⁴

In Primary Care:

Individuals often use health services prior to death by suicide.

83% of individuals who died by suicide had a health care visit in the year prior to their death and contact with a primary care provider (PCP) was the most common visit type (64%).⁵

Comorbidity

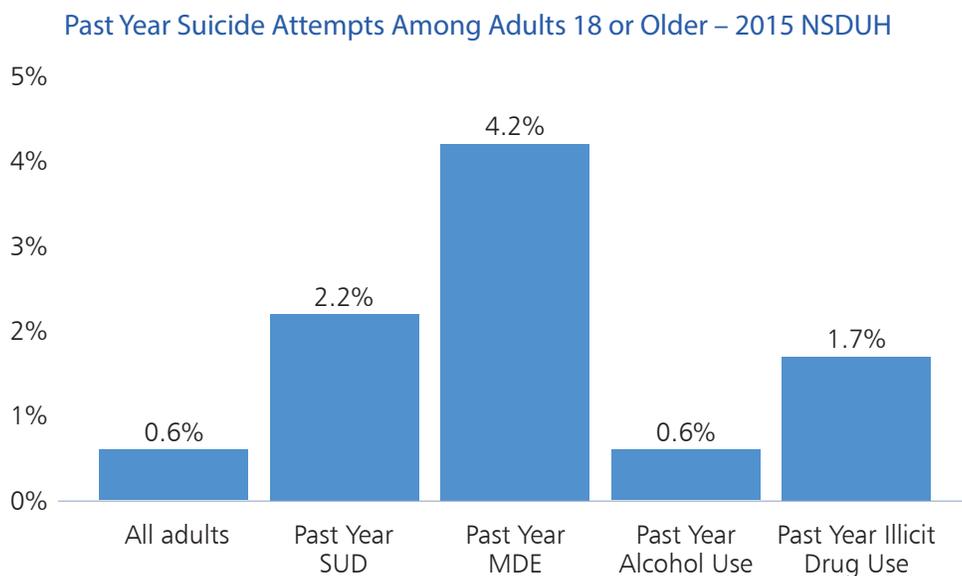
Mental illness is neither a necessary nor sufficient condition for suicide, but is strongly associated with suicide.

Adults with a mental illness are at increased risk for attempting and completing suicide, and those with multiple (comorbid) disorders have at least a two-fold risk of suicide attempts, increasing with the number of comorbid disorders.^{6,7}

- Approximately 66% of adults who consider suicide and nearly 80% of those who attempt suicide had a prior mental health disorder.⁶
- More than 70% of adults who have attempted suicide have an anxiety disorder.⁷
- Adults with mood, anxiety, or substance use disorders have been shown to be at greater risk of contemplating or attempting suicide.^{6,8}

Adults who had a Substance Use Disorder (SUD) or Major Depressive Episode (MDE) within the past year are significantly more likely to have suicidal thoughts, make suicide plans, and attempt suicide.³

Adults who use alcohol or drugs are more likely to have suicidal thoughts, make suicide plans, and attempt suicide.³



Similar patterns have been found for youth, with mood disorders being strongly associated with suicidal thoughts, plans, and attempts. Substance use, anxiety, and disruptive behavior disorders are associated with suicidal thoughts and attempts, and eating disorders are associated with suicide attempts.⁹

Proactive support and treatment of psychiatric and substance use disorders is an important part of a comprehensive, primary-care based approach to suicide prevention.

Module 2 – Epidemiology

High Risk Populations

All demographic groups have some level of risk. It is important not to dismiss any individual as being free of risk because they belong to a particular demographic group. There are some demographic groups, however, that are at relatively greater risk than others.

- See Module Four, Suicide Risk Assessment, for information on individual, social/environmental, and societal risk factors.

Gender

Males are about three times more likely to die by suicide than females.¹ However, the U.S. rates for females have increased by approximately 50% since 1999.¹⁰ Therefore, both should be supported with suicide preventative care.

Age

While adolescents and young adults are more likely to consider suicide, adults have higher rates of death by suicide.^{11,12}

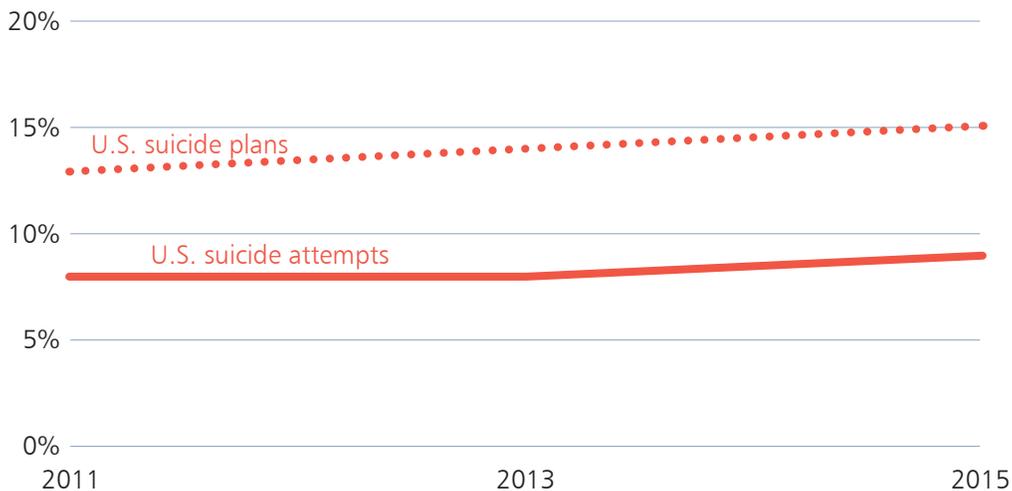
Adults aged 18-25 are more likely to consider suicide, plan for suicide, and attempt suicide than adults aged 26 or older.³ Yet adults 45 years or older, especially men, have the highest suicide rates.¹¹

For children and adolescents, the death rate for suicide doubled from 2007 (0.9) to 2014 (2.1).¹³

From 2011 to 2015, reported rates of considering suicide, planning for suicide, and attempting suicide for high school youth have slightly increased.¹²

High school females have higher reported rates of making a suicide plan and attempting suicide than high school males.¹²

Rates for Planning For and Attempting Suicide for U.S. High School Youth



Race/Ethnicity

Patterns of suicide rates emerge among the various races, with American Indians and Alaska Natives having high suicide rates.

In 2015, the U.S. suicide rate was highest for American Indians and Alaska Natives, followed by White individuals, Asian and Pacific Islander individuals, Black individuals, and Hispanic individuals.¹

For American Indian and Alaska Native adolescents and young adults ages 15-34, the suicide rate is especially high, 1.5 times that of the national average.¹⁴

In 2015 multi-racial high school students had the highest reported rates of planning for and attempting suicide, followed by American Indian or Alaska Native students.¹²

Note: White, Asian and Pacific Islander, and Black individuals' statistics reported are non-Hispanic.

Lesbian, Gay, Bisexual, Transgender, Queer Individuals

These groups have disproportionately high rates of reported suicide attempts.¹⁵

Overall, lesbian, gay, and bisexual (LGB) individuals are more than twice as likely as heterosexual persons to attempt suicide.¹⁵ This community is also more likely to be at risk for depression, anxiety disorders, and substance dependence.^{15,16} Potential reasons for these elevated rates include the prejudice, discrimination, and social stigma faced by these groups.¹⁷

Rates of reported attempted suicide for LGB youth have been shown to range from 20% to 53%, and in one small focused study, transgender youth had a 25% lifetime rate of attempted suicide.^{18,19} Parental support or rejection also appears to play a significant role, as LGB young adults who reported high levels of rejection by their families were 8.4 times more likely to report having attempted suicide.¹⁶



Veterans

Veterans of the armed forces carry an alarmingly and disproportionately higher risk for suicide than the civilian population, and are often not utilizing the Veterans Health Administration (VHA) for their healthcare.

It is always helpful for practices to ascertain Veteran status, as they are likely to see Veterans who may not know that they are entitled to services from the VHA, and knowing Veteran status provides indications of the need for other screenings, such as trauma and traumatic brain injury.



On average, 20 U.S. Veterans die by suicide each day.²⁰ Veterans' risk of suicide is 21% higher than that of U.S. adult civilians and, while Veterans made up 8.5% of the U.S. adult population in 2014, they accounted for 18% of suicide deaths.²⁰ Male Veterans have an 18% higher suicide risk than U.S. civilians and female Veterans' risk is twice as high as U.S. civilians. More than half of all Veterans who die by suicide are age 50 or older.²⁰

Only 28% of Veterans receive at least one healthcare service or benefit from the VHA.²¹ From 2001 to 2014, the suicide rate for Veterans has increased at a much greater rate than U.S. civilians, and Veterans who did not receive services from the VHA had a greater increase than Veterans who used VHA services; however, the difference between suicide rates for Veterans who did not receive VHA services and those who did has decreased since 2001.²⁰

Veterans who die by suicide are more likely to use a firearm. Approximately two-thirds of Veterans that died by suicide used a firearm, while about half of U.S. adults aged 17 and older used a firearm in their suicide.^{20,1}

About 24% of all U.S. Veterans reside in rural communities, which may be far from military or Veterans services.²²

Module 3 – Effective Prevention Strategies

Primary care providers can implement some of the most effective strategies for suicide prevention. Ideally, a primary care clinic would plan a comprehensive suicide prevention approach such as the Zero Suicide framework (see information on Zero Suicide in Section 6: Patients Education Tools/Other Resources of this Toolkit) that includes all the strategies in the box below. We will discuss the strategies in five sections: staff training, screening and management of depression, screening for suicide risk, patient education, and restricting means for lethal self-harm. Assessing and managing patients at risk for suicide are discussed in Modules 4 and 5 of this Primer.

Suicide Prevention Strategies in Primary Care

1. Train staff to recognize and respond to warning signs of suicide
2. Screen for and manage depression
3. Screen all patients for suicide risk
4. Educate patients about warning signs for suicide
5. Safety Plan/Temporarily restrict means for lethal self-harm

1. Train Staff to Recognize Warning Signs of Suicide

As workers in primary care settings interact with their patients, they may be able to observe and respond to many of the common warning signs for suicide, but only if they know what to look for.

All staff should be trained in suicide prevention, relative to their role in the clinic. In addition to the information provided below, suicide prevention trainings or individual online learning can teach recognition and response to suicide warning signs. Trainers are available in most areas to teach these important skills. Training is also available online. See the Resource List for some of the national vendors of these programs; contact the authors or the Suicide Prevention Resource Center (www.sprc.org/states) for your state's suicide prevention coordinator. After even minimal training, staff can observe and respond to warning signs of suicide in patients while talking with them on the phone or in the office. When they detect a warning sign, staff can immediately alert office clinicians who are prepared to ask the patient about suicidal ideation. Though these trainings require a modest investment of time and money, they may save lives.

Identify Warning Signs

People who are in danger of harming themselves may reach out to their primary care providers – sometimes directly, sometimes indirectly. **Rarely will patients immediately volunteer the information that they are thinking of harming themselves or ending their lives.** Be alert for warning signs that a patient may be at risk of imminent suicide. Warning signs include:²³

Strongest Warning Signs – Take Immediate Action to Protect Person – Full Risk Assessment Warranted

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking about feeling hopeless or having no reason to live

Other warning signs of suicide

- Anxiety
- Agitation, aggression
- Acting reckless
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Withdrawing or feeling isolated
- Talking about being a burden to others
- Rage or seeking revenge
- Dramatic mood swings
- Feeling trapped – like there’s no way out
- Talking about being in unbearable pain



2. Screen For and Manage Depression

Training providers to recognize and treat depression increases prescription rates for antidepressants and decreases suicidal ideation and completed suicides in their patients.²⁴

A key factor in reducing suicides and suicidal behaviors is the effective diagnosis and management of major depression. Tools for screening and managing depression within a primary care setting have been developed by The MacArthur Initiative on Depression and Primary Care and are available free of charge online. A downloadable toolkit can be found at: <http://otgateway.com/articles/13macarthurtoolkit.pdf>

Keep in mind that the best approach to treating major depressive disorder (as well as many other mental illnesses) uses a combination of medication and psychotherapy whenever possible.^{25,26,27} This is why it is so important to have reliable and trusted mental health treatment partners to refer to.

3. Screen all patients for Suicide Risk

Screening all patients for suicidal thinking is an important part of suicide prevention and is recommended by The Joint Commission.²⁸ Patients with warning signs or other risk factors should routinely be asked about suicidal thoughts as well. It is also helpful for practices to ascertain Veteran status, as they are likely to see Veterans who may not know that they are entitled to services from the VHA, and knowing Veteran status provides indications of the need for other screenings, such as trauma and traumatic brain injury.

Using simple screening tools such as the 9-item Depression Scale of the Patient Health Questionnaire (PHQ-9) can be an effective, matter-of-fact, and time-efficient way to screen patients. PHQ-9 is included as part of the MacArthur Initiative Toolkit discussed above and English and Spanish versions, as well as a modified version for adolescents are available at: <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

The Columbia Suicide Severity Rating Scale (C-SSRS) is another, more specialized tool for assessing suicidality. If screening tools such as the PHQ-9 are used, providers must be diligent about reviewing patient responses and specifically monitoring whether patients endorse items related to suicidality. The C-SSRS is available at: <http://cssrs.columbia.edu/>

Suicidal ideation can vary greatly. Some experience chronic suicidal ideation over the course of their lifetime, some have thoughts of suicide in situations of acute stress, trauma, or loss. It is important to fully understand the context of someone's thoughts of suicide and how it may impact their safety in the immediate future by doing a complete assessment as laid out in Module 4 of this Primer.

The Joint Commission Sentinel Event Alert (SEA) Number 56, Detecting and Treating Suicide Ideation in All Settings, outlines 8 guidelines for effectively addressing suicidal ideation in all care settings, including the recommendation that providers "Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool." All SEA 56 recommendations can be found at: https://www.jointcommission.org/sea_issue_56/

Some or all of the Sample Questions in Module 4 for inquiring about thoughts of suicide can be used for informal screening of patients. The key is to ask directly about thoughts of suicide or ending one's life as part of the screening. Practice asking the question(s) several times before trying it in a clinical situation.

Never ask leading questions such as "You're not thinking of hurting or killing yourself, are you?"

Sample screening question:

"We ask every one of our patients about whether they have felt suicidal or have been considering hurting themselves. Have you had thoughts of hurting yourself or killing yourself?"

"Sometimes people with your condition (or in your situation) feel like they don't want to live anymore, or sometimes they think about killing themselves. Have you been having any thoughts like these?"

A positive response to this screening question requires additional assessment (assessments can be found in Module 4). These instruments should always be used as an augment to a thorough clinical interview.

In addition to routine screening for all patients, certain conditions, situations or life events may warrant inquiry into whether the patient is experiencing suicidal thoughts, these RISK FACTORS include:

Key Risk Factors²⁹

- Prior suicide attempt(s)
- History of depression or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Exposure to suicide in community, social circles, or the media
- Physical illness or recent serious diagnosis



- Feeling alone
- Irritability, agitation, aggression

Other Risk Factors

- Other mental health or emotional problems
- Chronic pain
- Insomnia
- Post-Traumatic Stress Disorder (PTSD)
- Traumatic Brain Injury (TBI)
- Events or recent losses leading to humiliation, shame or despair

This Decision Support Tool, from the Suicide Prevention Resource Center’s Caring for Patients with Suicide Risk: A Consensus Guide for Emergency Departments, may be a helpful tool to screen for suicide risk:³⁰

TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (NOTE: the transitional question above is not part of scoring.)

- 1. THOUGHTS OF CARRYING OUT A PLAN** Recently, have you been thinking about how you might kill yourself? If yes, consider the immediate safety needs of the patient.
- 2. SUICIDE INTENT** Do you have any intention of killing yourself?
- 3. PAST SUICIDE ATTEMPT** Have you ever tried to kill yourself?
- 4. SIGNIFICANT MENTAL HEALTH CONDITION** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?
- 5. SUBSTANCE USE DISORDER** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
- 6. IRRITABILITY/AGITATION/AGGRESSION** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the answer to the Transition Question and any of the other six items is “Yes,” further intervention, including assessment by a mental health professional, is needed.

4. Educate patients and their loved ones about Suicide Warning Signs

Just as we educate the public on the warning signs of strokes and heart attacks, we should provide basic information to the public on the warning signs of suicide. For severe suicide warning signs, the appropriate response may be to call 911 or help the patient get to the nearest hospital emergency department or acute crisis unit.

For less emergent situations, it may be appropriate to call the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). Calls to this number are routed to a nearby certified crisis center with trained counselors. Counselors are available 24/7 and provide services in English, Spanish and many other languages. Veterans calling the National Lifeline may press “1” to be directed to a crisis center run by the Department of Veterans Affairs. The service is free anywhere in the United States. The most effective and expedient response will depend on the resources in your area.

This Toolkit contains a wallet card (pg 66) for everyone that list the most recognizable warning signs and the number of the national crisis line. These cards are available free and can be provided to all primary care patients and their loved ones through the office. For information on ordering the wallet cards, see the SAMHSA Store or the “National Suicide Prevention Lifeline Resources” web address in the Resource List of the Toolkit.

5. Safety Plan and Temporarily Restrict Means of Lethal Self-Harm

As primary care providers, you and your staff can and should work with suicidal or potentially suicidal patients and their loved ones to temporarily restrict means of lethal self-harm in their homes. Involuntary commitment and hospitalization should be utilized only as last resorts, when safety planning has been unsuccessful and the patient is assessed to be at imminent risk of harming themselves.

Safety Planning: A safety plan (also referred to as a “crisis response plan”) is developed *collaboratively* with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. A simple and structured safety planning process is reviewed in detail in Primer Module 5: Intervention.³¹

Temporarily Restricting Means of Lethal Self Harm: This step can be the hardest step for many patients, and perhaps the most critical. The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will agree to solutions to temporarily restrict his or her access to lethal means. Lethal means restriction for patients of all ages is reviewed in detail in Primer Module 5: Intervention.

Module 4 – Suicide Risk Assessment

While there is no way to predict with complete certainty who will attempt suicide, understanding certain imminent warning signs as well as statistically related risk factors will help providers know when to actively intervene and further assess for imminent suicide risk.

Key components of a suicide risk assessment^{32,33}

1. Assess warning signs and risk factors
2. Assess protective factors
3. Suicide Inquiry: thoughts/plan/intent/access to means
4. Clinical judgment

1. Warning Signs and Risk Factors

Warning signs are changes in behavior or new behaviors that may indicate that a person is suicidal, while risk factors are characteristics or conditions that increase the chance that a person may try to take their life.

Identify Warning Signs

People who are in danger of harming themselves may reach out to their primary care providers—sometimes directly, sometimes indirectly. Rarely will patients immediately volunteer the information that they are thinking of harming themselves or ending their lives. Be alert for warning signs that a patient may be at risk of imminent suicide. Warning signs include:²³

Strongest Warning Signs – Take Immediate Action to Protect Person – Full Risk Assessment Warranted

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
 - This includes statements such as: “My family would be better off without me”; “I won’t be around for xxx”
 - Among the elderly, these statements may sound more like “I don’t want to be a burden” or “I don’t belong anywhere anymore”
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person

Other warning signs of suicide

- Anxiety, agitation, irritability
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Purposelessness – no reason for living
- Hopelessness

- Withdrawing from friends, family and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes
- Feeling trapped – like there's no way out

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.³⁴

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt. A prior suicide attempt does not always mean that a person will go on to complete suicide; over 90% of individuals who have survived an attempt will not go on to later die by suicide. It is important to take all attempts seriously, however, and not interpret a patient who has had multiple attempts as solely "attention seeking." Help, hope, and recovery are possible.³⁵

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.³⁶

Individual Risk Factors

- Previous suicide attempt, especially within the past year
- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including TBI
- Mental illnesses, particularly:
 - Mood disorders
 - Schizophrenia
 - Anxiety disorders (including, PTSD)
 - Certain alcohol and other substance use disorders
 - Personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD)
 - In youths: Attention-deficit/hyperactivity disorder (ADHD) and conduct disorders (antisocial behavior, aggression, impulsivity)
- Psychiatric symptoms/states of mind: anhedonia (diminished or inability to gain pleasure from normally pleasurable experiences or activities), severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
- Impulsive and/or aggressive behavior
- History of trauma or abuse
- Family history of suicide or exposure to suicide in social network, community, media
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated)

Social/Environmental Risk Factors

- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- Lack of social support and increasing sense of isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Local clusters of suicide that can have a contagious influence

- Legal difficulties/contact with law enforcement/incarceration
- Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)³⁶
- Exposure to, including through the media, and influence of others who have died by suicide

2. Protective Factors

While protective factors provide only a limited counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment) and vary greatly from one individual to another, **protective factors may mitigate risk in a person with moderate to low suicide risk.** Strengthening protective factors can be a part of safety planning, which will be discussed in Module 5.



Some important protective factors are:³⁷

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness
- Coping skills
- Problem-solving skills
- Strong therapeutic relationship with a trusted provider
- Reality testing ability
- Religious faith

3. Suicide Inquiry

If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted. Patients will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. **Ask patients directly about suicide and seek collateral information** from other clinicians, family members, friends, EMS personnel, police, and others.³⁸

Asking about suicide and suicidal thoughts can be very uncomfortable for some providers – it is important for providers to assess their own level of comfort with suicide inquiry and rehearse or role-play to increase their level of comfort. Read on for a variety of tools and sample questions that you can use to assess suicide risk. How you ask the questions affects the likelihood of getting a truthful response. Use a **non-judgmental, non-condescending, matter-of-fact approach.**

NEVER ask leading questions like:

"You're not thinking of suicide, are you?"

"I hope that you aren't thinking about hurting yourself."

PRACTICE the questions below several times prior to a clinical encounter; again, asking about suicide for the first time may be harder than you think!

Thoughts of Suicide

Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Questions to uncover suicidal thinking:³⁹

"Sometimes, people in your situation (describe the situation) lose hope; I'm wondering if you may have lost hope, too?"

"Have you ever thought things would be better if you were dead?"

"With this much stress (or hopelessness) in your life, have you thought of hurting yourself?"

"Have you ever thought about killing yourself?"

Prior Attempts

A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Questions to assess prior attempt:

"Have you ever tried to kill yourself or attempt suicide?"

"Have things ever been so bad for you in the past that you thought about killing yourself or actually tried to hurt yourself or kill yourself?"

If your questioning reveals no evidence of suicidal ideation AND you do not otherwise suspect that the patient is minimizing or being less than truthful about their suicidal ideation, you may end the inquiry here and document the finding.

If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you are seeing and what the patient is saying.

"You seem very upset to me, and I'm still concerned about you, are you sure that you haven't been thinking about hurting yourself or thinking that your loved ones would be better off without you?"

You can also ask to speak with a family member or friend if you remain concerned.

If your patient is having suicidal thoughts, ask specifically about frequency, duration, and intensity.

Questions to assess suicidal ideation:

"When did you begin having suicidal thoughts?"

"Did any event (stressor) precipitate the suicidal thoughts?"

"How often do you have thoughts of suicide? How long do they last? How strong are they?"

"What is the worst they have ever been?"

"What do you do when you have suicidal thoughts? Do you find that you have them more frequently or more intensely at different times of the day or of the week?"

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.³⁸ Ask whether the patient has a plan and, if so, get the specifics.

Questions to assess suicidal planning:

"Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?"

"Do you have the (drugs, gun, rope) that you would use? Where is it right now?"

"Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?"

Intent

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient's reasons to die vs. reasons to live. Many patients are very ambivalent about suicide – see Module 5: Intervention – of this Primer to learn more about ways to capitalize on this ambivalence and get them focused on reasons for living. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan.³⁸

Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Questions to assess intent:

"What would it accomplish if you were to end your life?"

"Do you feel as if you're a burden to others?"

"How confident are you that this plan would actually end your life?"

"What have you done to begin to carry out the plan?"

"For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?"

"Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?"

"What makes you feel better (e.g., contact with family, use of substances)?"

"What makes you feel worse (e.g., being alone, thinking about a situation)?"

"How likely do you think you are to carry out your plan?"

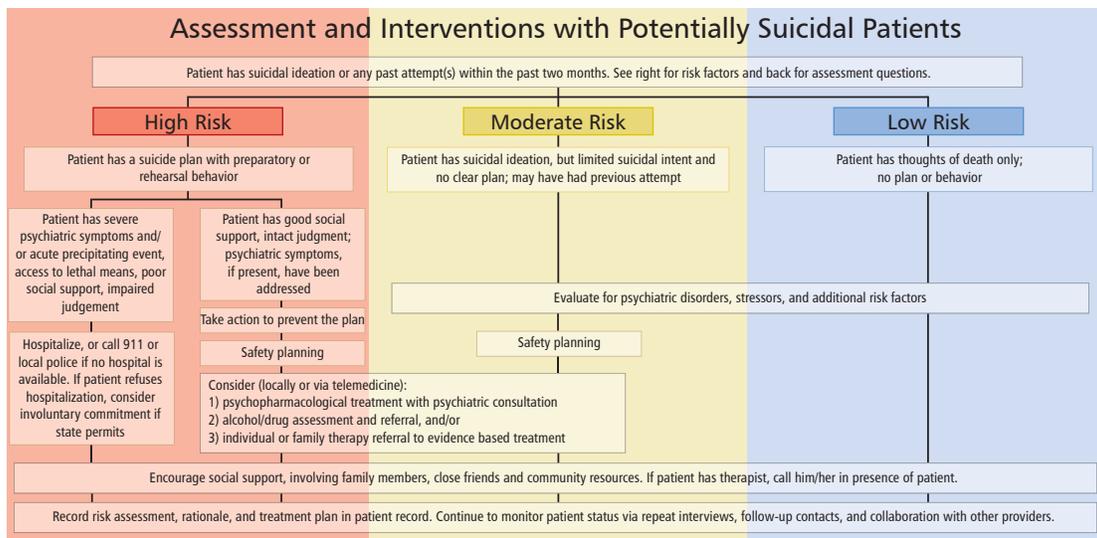
"What stops you from killing yourself?"

Look for any disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with youth, seek to confirm the patient's reports with information from a family member, spouse, or close friend. Patients are more likely to tell a family member than a PCP that they are suicidal.⁴⁰

It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.³³

4. Clinical Judgment of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients without thoughts of death or wanting to die, and without intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end of the risk spectrum. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can predict with complete accuracy which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for use by primary care professionals in assessing suicide risk and determining appropriate interventions (covered in Module 5). The copy of the pocket guide is also available as a separate document/tool for reference .



Suicide Risk and Protective Factors¹

RISK FACTORS

- ▶ Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- ▶ Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- ▶ Current/past psychiatric disorders: especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- ▶ Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: oppositionality and conduct problems.
- ▶ Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- ▶ Chronic medical illness (esp. CNS disorders, pain).
- ▶ History of or current abuse or neglect.

PROTECTIVE FACTORS

- Protective factors, even if present, may not counteract significant acute risk.
- ▶ Internal: ability to cope with stress, religious beliefs, frustration tolerance.
 - ▶ External: responsibility to children or pets, positive therapeutic relationships, social supports.

Module 5 – Intervention

Taking appropriate action following a suicide risk assessment is critical and may save lives. The decision tree presented in the previous module will help determine appropriate interventions with potentially suicidal patients. You can make a difference in your patients' lives by addressing suicidality with the following steps:

1. PCP Treatment
2. Collaborative Safety Planning
3. Referral to Evidence Based Treatment
4. Documentation and Follow-up Care

1. PCP Treatment

Primary care providers are invaluable in the treatment and support of potentially suicidal patients. Important interventions that can be carried out in a primary care office include treatment of psychiatric symptoms, including depression and severe anxiety.

Depression treatment- medication

Most antidepressant prescriptions in the United States are written by primary care providers. Prescribing providers should monitor patients to ensure their symptoms are responding to treatment as expected. Medication adherence may be improved by addressing concerns regarding medication side effects when they are initially prescribed and as needed thereafter. Patients should also be informed that many antidepressant medications take 4-6 weeks before their onset of action; this information will help patients manage expectations and to continue taking the medication even if they do not initially notice any benefit. If the patient has been referred to a mental health provider, obtain a release of information from the patient and seek ongoing collaboration with that provider to coordinate care and to share information about the patient's mental health status. Follow-up care should be documented carefully to ensure that the patient continues to receive recommended services.

Always monitor frequently for efficacy and side effects.

Encourage a support network

Encouraging depressed, anxious, or otherwise at-risk patients to identify and utilize a support network is a key component of suicide prevention. Patients may need assistance with identifying the supportive individuals in their lives. Having a predetermined list of supportive individuals and their contact information will increase the likelihood that the patient will seek help before or during a crisis. This information should always be included in the patient's safety plan.

The support network may include:

- friends
- family members
- a therapist
- co-workers
- a suicide prevention hotline
- clergy/minister
- peer support

Encouraging the patient to utilize their support network even when they are not feeling suicidal can help reduce the number of suicidal crises they experience.

2. Safety Planning

A safety plan (also referred to as a “crisis response plan”) is developed collaboratively with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The plan is developed in six steps,³¹ and providers can help patients fill out the simple safety plan template included in Section 4: Patient Management Tools, section of this Toolkit.

The plan is to be provided to the patient to serve as a reference and support if thoughts of suicide occur.



1. Recognizing warning signs that a suicide crisis may be approaching
2. Identifying internal coping strategies that can be used by the patient to soothe emotions and avert the crisis
3. Utilizing friends and family members that can be contacted in order to distract from suicidal thoughts and urges without discussing suicidal thoughts
4. Contacting friends and family members who may help to resolve a crisis and with whom suicidal thoughts can be discussed directly
5. Contacting health professionals or agencies, including dialing the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to a local hospital emergency room
6. Making the environment safe—reducing access to lethal means

Step 1. Warning signs and triggers

The first step in safety planning is to help patients become aware of their own triggers and the cues that signal that a suicidal crisis may be developing for them. For example, a patient might start to feel very angry, anxious, or alienated before a suicidal crisis. Patients who are familiar with their own personal triggers and cues can utilize coping strategies and may be able to prevent themselves from reaching a point where they feel out of control.

To help patients determine their own unique triggers and cues you can ask patients such questions as:

“How do you feel in the hours or days before you first notice that you are feeling suicidal?”

“What do you notice in your thoughts and feelings, or in your body?”

“What are your triggers? What happens just before you start feeling or thinking this way?”

If the patient is unable to answer these questions, family members and friends have likely noticed changes that occur before the patient enters into a crisis. With permission from the patient, you may be able to involve people close to the patient (their support network) in answering these questions.

Step 2. Coping Strategies

The second step in safety planning is to help patients identify and practice coping strategies to help prevent or avert the development of a suicidal crisis. Coping techniques have different effects on different people; therefore, the provider should help the patient think through what really helps him or her feel better. Some examples of coping techniques are relaxation techniques, physical activity, moving away from a stressor or stressful person, and distraction techniques.

Some sample questions to get patients thinking about effective coping techniques are:

"What relaxes you?"

"When was the last time you felt relaxed or peaceful? What were you doing?"

"Are there any things that you do that help you take your mind off thinking about death and dying?"

"Who do you spend time with that makes you feel good?"

Once coping strategies are identified, encourage patients to practice them before a crisis arises. Practicing these strategies when the patient is calm helps make them more automatic for the patient and thus easier to employ when the patient is distressed. Refer at-risk patients to the website resource below for help to identify techniques for self-soothing: <http://www.nowmattersnow.org/skill/mindfulness>

Step 3. Distracting from the crisis

Ask your patient about reaching out to family or friends, or going to specific social settings, such as a park or a coffee shop, or activities to distract them from their feelings or thoughts.

Ask:

"Where could you go or who could you call to take your mind off the crisis or off of how you are feeling?"

"Who helps you feel better when you socialize with them?"

"Is there anything you do that helps you feel better?"

Assess how likely it is that the patients will actually take these steps, if you suspect resistance, ask about it.

Ask:

"You've come up with some good options, but I'm worried that you might not follow through when you are in crisis – what steps could we take now to help make sure that you will be able to follow through?"

Step 4. Family, friends, and other supports who can help

While similar to Step 3, this step involves working with the patient to identify individuals in her/his life that s/he can turn to in a crisis who will be able to help resolve a crisis.

Ask:

“Among your family or friends, who do you think you could contact for help during a crisis?” or

“Who is supportive of you and who do you feel that you can talk with when you’re under stress?”

“Who do you feel comfortable with discussing your thoughts of suicide?”

Encourage the use of peer supports if the patient experiences chronic struggles with any mental illness and/or suicidal thoughts. Individuals with lived experience can help patients in ways that health care providers can’t. To find peer support specialists near you, contact your local Community Mental Health Center.

Ask the patient to list more than one person, in case one contact is unreachable. They can then prioritize their list, realizing that they may be more comfortable with different people at various times.

As in Step 3, assess how well you think the patient will follow through with this in a crisis and discuss barriers that might come up.

Step 5. Professionals to contact for help

Add any mental health, substance abuse, health care or other types of counselors and providers such as clergy or specialty providers that may be of support or assistance to the patient. If the client has no current connections to a professional they could ask for help, see Item 3: Referral, above.

Step 6. Temporarily restricting access to lethal means of self harm

The last step in safety planning addresses the issue of access to lethal means. This step may be the most delicate step for many patients, and perhaps the most critical. The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will relinquish his or her access to lethal means. **If the patient has expressed any suicidal ideation, described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting, loading a gun) it is essential to inquire about whether those specific means are available and to eliminate access to them while they are at risk.** Lethal means may include guns (ask about all guns in the home or that a patient may have access to elsewhere), ammunition, medications (prescription as well as over-the-counter), knives, razors, etc. It is important to help the patient identify whom they will entrust with these items until they can be safely returned. **With the patient’s permission, contact family members or other persons within the patient’s support system in order to assist with temporarily limiting access.**⁴⁰ Discussing lethal means with your patient is not a time for debating social issues around firearm ownership. Counseling on access to lethal means is a time to work with the patient to identify strategies to temporarily make their environment safe during periods of crisis.

The Harvard Means Matter Campaign and website asserts: “Means reduction” (reducing a suicidal person’s access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. It is based on the following understandings:

- Many suicide attempts occur with little planning during a short-term crisis.
- Intent isn’t all that determines whether someone who attempts suicide lives or dies; means also matter.
- 90% of attempters who survive do NOT go on to die by suicide later.
- Access to firearms is a risk factor for suicide.
- Firearms used in youth suicide usually belong to a parent.
- Reducing access to lethal means saves lives.

Learn more about lethal means safety for patients of all ages: <https://www.hsph.harvard.edu/means-matter/> or <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0>

You can alert all your patients that gun locks can be obtained free of charge at: <http://www.projectchildsafe.org/safety/get-a-safety-kit>

Direct patients, parents and other concerned family members to the website below for tips on temporarily removing lethal means from the home: www.suicideproof.org

As the plan is developed write each step on a paper the patient can take home. Use the handy form included on Section 4: Patient Management Tools of this Toolkit, or create one of your own. When it is clear the patient understands the plan, the patient should be able to commit to their clinician they will follow the plan, in sequence.

Rehearse with the patient how he/she will use the plan:

Where will the plan be kept?

How will he/she know when to take the first step?

What comes next?

When implementing the plan, the patient builds coping skills and develops confidence that they can manage future crises when they occur. Both the patient and their support person(s) should know the number for the National Suicide Prevention Lifeline 1-800-273-TALK (8255) and any crisis lines in your state.

Lethal Means Planning Among Specific Patient Groups:

Youth. Firearms remain the number one way by which young people die by suicide, although intentional deaths by prescription pain killers are on the rise among youth.⁴¹ It is important to find out about a youth’s specific plan for suicide, if it exists, and work with family members or guardians to restrict access to means of any kind, including access to firearms, potentially lethal prescription and over the counter (OTC) medications (including containers of more than 25 acetaminophen tablets), alcohol, and even rope. Anecdotal evidence suggests young people frequently know where guns and keys to gun cabinets are kept, even though parents may think that they do not. Primary care providers should counsel parents or guardians of children



and adolescents to either temporarily remove firearms from the home entirely or securely lock guns and ammunition – in separate locations. When primary care providers recommend that parents restrict access of their children to guns and medications in the home, most of them do.²² The websites listed above, for the Means Matter and Suicideproof.org programs, provide valuable insight on restricting and temporarily removing access to lethal means around the home.

Elderly. Along with assessing for access to firearms, providers should pay close attention to the number and nature of medication prescriptions written for older adult patients from all of their providers, and assess for any possible stockpiling. If elderly patients are not able or willing to return or destroy excess medication, family members or other friends or loved ones can hold on to excess medication until such time that the patient is not at risk of harming themselves. Providers should also be aware that smaller doses of medications can have a higher lethality when mixed with alcohol, so access to alcohol should be discussed and potentially restricted as well. Providers can look for and access the Prescription Drug Monitoring Program in their state to get information on patients' prescriptions from other providers.

Veterans. Lethal means restriction is often more complex with patients who are Veterans, service members, National Guardsmen members, and other Reservists. Veteran patients are more likely to have firearms in their possession, more comfortable with firearms, and more likely to use a firearm in a suicide attempt, thus making the lethality of their attempts very high. Veterans are also typically more likely to resist relinquishing their firearms. It is crucial, therefore, when a Veteran patient is expressing or exhibiting any level of suicidality, to:

1. Discuss gun storage safety with Veterans per the gun storage laws in your state – ask your Veteran patients to commit to one or all of the following temporary measures until such time as they are no longer at risk of harming themselves (important to stress this last part to Veteran patients):
 - Storing guns away from their homes temporarily, potentially with a friend, family member or trusted battle buddy
 - Storing guns and ammunition separately, both under lock and key
 - Storing guns with a gun lock
2. Discuss whether the patient has a trusted friend or family member that would be willing to store the patient's firearm(s), lock box keys, or gun lock key(s) until such time as the patient no longer is at risk of harming themselves.
 - Have the patient commit to a plan of action for safe gun storage and follow-up with the patient or a friend or family member to ensure that they have followed through.
3. Assess the number and nature of medication prescriptions written for the patient from all of their providers, and assess for any possible stockpiling

Find a pocket card developed by the Veterans Administration to guide the development of a safety plan provided with this Toolkit and downloadable from the Department of Veterans Affairs:

<http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf>

Additionally, find an excellent free video training for safety planning at:

<http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm>

NOTE: “No-suicide contracts” have been found to be ineffective in preventing suicidal behavior and are often done solely to alleviate anxiety on the part of the provider. It is more effective to make a plan with your suicidal patients concerning what they will do in the event that they feel suicidal and are worried about their safety, rather than what they won't do.

3. Referral to Evidence-Based Treatment

For patients in the moderate and high risk categories and who have symptoms of a psychiatric disorder, consider a referral to a **psychiatrist for a medication evaluation** and to a mental health professional for evidence-based psychotherapy. (Telemedicine is increasingly becoming an option for accessing psychiatric services in rural locations. See the Resource List in the Patient Education Tools section of this Toolkit for more information about establishing telemedicine services in your area.) For patients with alcohol or substance use issues, consider a referral for alcohol/drug assessment and treatment.

For patients in any risk category who are having significant thoughts of death or suicide, consider a referral for evidence-based individual or family therapy. When in doubt about whether a behavioral healthcare provider provides evidence-based treatment, ask! For all patients at increased risk, be sure to provide information about state crisis hotlines. Patients can also access the **National Suicide Prevention Lifeline, 1-800-273-TALK (8255)**. By calling the Lifeline, patients are connected to the nearest certified crisis center, usually within the state. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 rescue when indicated.



For patients who are an imminent danger to themselves despite intervention efforts and attempts at safety planning, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily.

Locate specific information about your state's involuntary treatment laws and have this in the office as well as contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area.

Developing an office protocol for hospitalization

Having a pre-established office protocol to follow once you have determined that a patient is high risk for suicide can ease the process of hospitalization. Some important additional questions to answer in developing your office protocol are:

- What emergency department or crisis stabilization unit is nearest to your clinic/facility?
- What transportation options are available for transporting suicidal patients to the nearest emergency department?
- Is there a mental health provider in your area who can assist in an involuntary psychiatric admission? How can you contact him/her?

Use the "Protocol for Suicidal Patients: Office Template" worksheet in this Toolkit for more information to quickly and easily establish a protocol for your clinic.

4. Documentation and Follow-up Care

Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist). In the case of hospitalization, it will be necessary to provide this information to the admitting facility. Thorough documentation will help ensure that the patient receives appropriate referrals and follow-up care. Copying and storing the Safety Plan template included in Section 4: Patient Management Tools is a good form of documentation and will help with follow-up as well.

Close follow-up with a potentially suicidal patient is critical. Studies show that even very simple follow-up contacts with suicidal patients reduce their risk of repeat attempts and death. Every follow-up contact is an opportunity to assess for recurrent or increased suicidality. Flagging the records of patients at risk for suicide with color coded labels, as is frequently done for allergies or certain chronic diseases, may help insure suicide risk is reassessed on follow-up visits.

- Providers should ensure that the patient attends their next appointment(s), follows through on clinical recommendations, and discusses potential obstacles to following through on recommendations. Whenever possible, enlist the participation and support of the patient's loved ones to achieve this.

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