

The title slide features a dark brown background with white text. At the top, there are logos for WICHE (Western Interstate Commission for Higher Education) and SPRC (Suicide Prevention Resource Center). The title 'A SUICIDE PREVENTION TOOLKIT FOR RURAL PRIMARY CARE' is centered in a large, bold, white font. Below the title, the names and titles of the authors are listed: David A. Litts O.D., Peggy West, Ph.D. MSW, Mimi McFaul, PhD, and Tamara DeHay, PhD. The slide is framed by a thin black border and has a decorative bar at the bottom with orange and blue segments.

WICHE Access Innovation Collaboration
Western Interstate Commission for Higher Education

SPRC SUICIDE PREVENTION RESOURCE CENTER

A SUICIDE PREVENTION TOOLKIT FOR RURAL PRIMARY CARE

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Toolkit Development

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- WICHE/Mental Health Program – HRSA
- SPRC—SAMHSA
- Formative evaluation
 - Reviewers (AHEC provider and community committees)
 - Pilot webinar – U CO – interdisciplinary health professions students in rural track
 - American Association of Suicidology Conference—panel presentation
- Launch June 2009

Why Rural?

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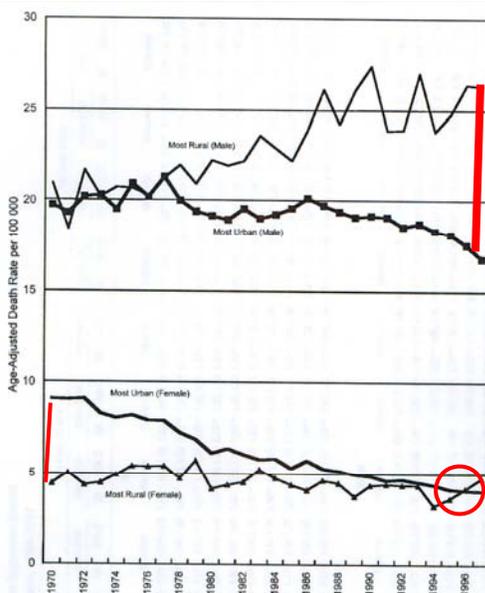
- Suicide rates are higher for nearly every demographic group in rural vs non-rural*
- The gap between rural and urban suicide rates is widening*
- Access to mental health services is less in rural vs. non-rural
 - One-third of the most rural counties (population < 2,500) have no mental health professional**

* Singh GK, Siahpush M. The increasing rural urban gradient in US suicide mortality, 1970,-1997 Am J Public Health. 2003 July 2003;93(5):1161-1167

** Advancing Suicide Prevention, Fall/Winter 2004-5



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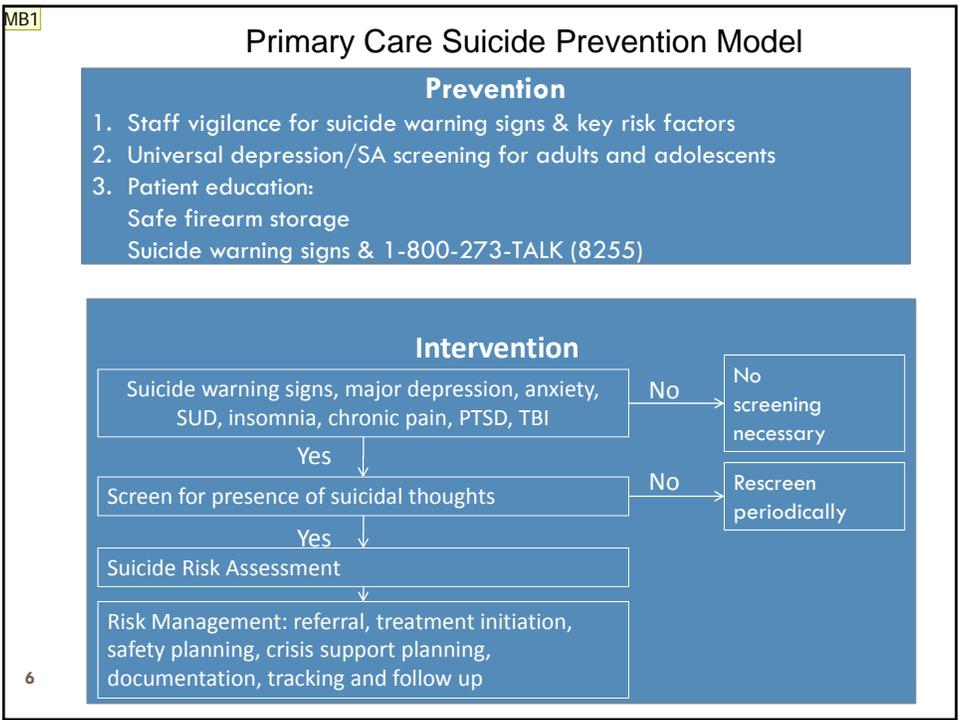
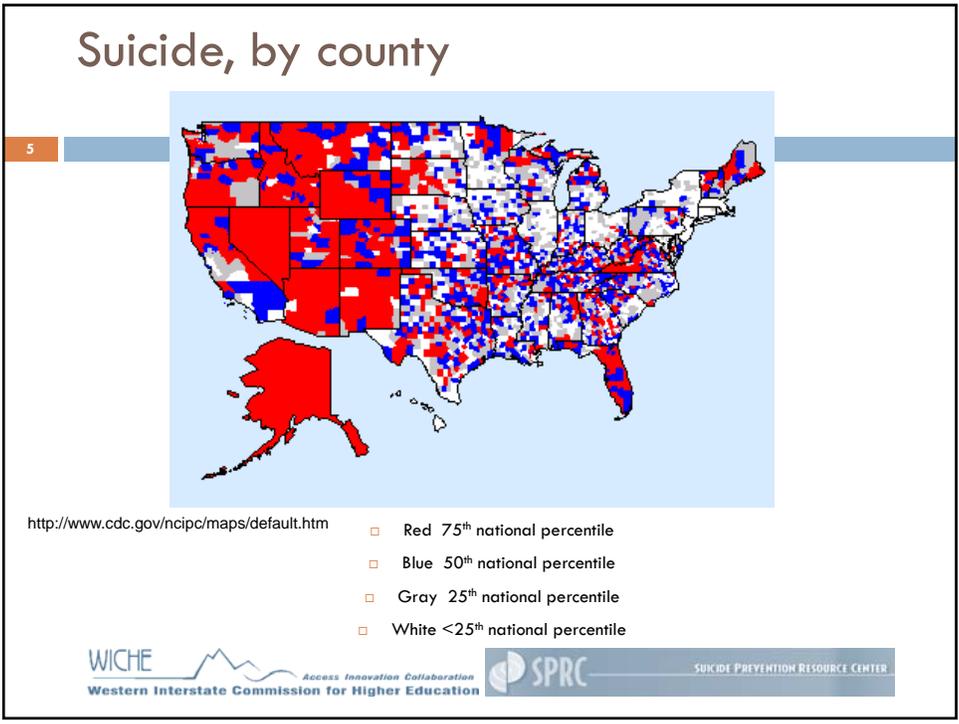


Suicide Mortality Rural vs. Urban by Gender

Singh GK, Siahpush M. The increasing rural urban gradient in US suicide mortality, 1970,-1997 Am J Public Health. 2003 July 2003;93(5):1161-1167

FIGURE 1—Age-adjusted US suicide mortality rates for the most urban counties (metropolitan, 1 million people or more) and the most rural counties (fewer than 2500 people): 1970 to 1997.





Slide 6

MB1 I would add "staff" after all just to make it more clear.

Do docs use "tx" like we do? Maybe they do. Otherwise, let's spell it out.

One little extra space in (Prevention) #3 before "suicide warning signs"

First box - Put colon after Warning signs:

Mimi Bradley, 5/14/2009

Toolkit: Overall Layout

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- Six sections
 - Getting started
 - Educating clinicians and office staff
 - Developing mental health partnerships
 - Patient management tools
 - Patient education tools
 - Resources
- The Toolkit is available in 2 forms
 - Hard copy, spiral bound ordered through WICHE
 - Electronic copy (www.sprc.org)

1. Getting Started

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QUICK START GUIDE

How to use the Suicide Prevention Toolkit



- | | |
|---------------|---|
| STEP 1 | Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit. |
| STEP 2 | Meet to develop the "Office Protocol" for potentially suicidal patients. See the "Office Protocol Development Guide" instruction sheet in the Toolkit. |
| STEP 3 | Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2. |
| STEP 4 | Develop a referral network to facilitate the collaborative care of suicidal patients. See the "Developing a Referral Network" instruction sheet in the Toolkit. |

1. Getting Started

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- STEP 4** Develop a referral network to facilitate the collaborative care of suicidal patients. Use the "Developing Mental Health Partnerships" materials in the Toolkit.
- STEP 5** Read the Toolkit's "Primer". Providers may wish to study the last two sections on Suicide Risk Assessment and Intervention first. The first three sections may then be reviewed in order to gain knowledge about Prevalence, Comorbidity, Epidemiology, and Prevention.
- STEP 6** Order community and patient education tools, such as suicide prevention posters and brochures, for your office. See the "Patient Education Tools" section of the Toolkit.



1. Getting Started

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To be used with instruction sheet to create an office protocol that may be referred to when a potentially suicidal patient presents

Office Protocol Development Guide

Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected...

- ✓ _____ should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).
- ✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization...

- ✓ Our nearest Emergency Department or psychiatric emergency center is _____ Phone # _____
- ✓ _____ will call _____ to arrange transport.
(Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)
- Backup transportation plan: Call _____
- ✓ _____ will wait with patient for transport.

Documentation and Follow-Up...

- _____ will call ED to provide patient information.
- ✓ _____ will document incident in _____
(Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- ✓ Necessary forms are located _____
- ✓ _____ will follow-up with ED to determine disposition of patient.
(Name of individual or job title)
- ✓ _____ will follow up with patient within _____
(Name of individual or job title) (Time frame)

1. Getting Started

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- Who conducts initial assessment when S is detected?
- Who can be called for consultation?
- What are procedures/forms for hospitalizing?
- To what emergency service are S pts referred?
- How will you arrange pt transport?
- Who notifies ED? What information is transmitted? How?
- How attends pt?
- How will patient be managed after d/c
- How are charts of S patients flagged?

2. Educating Clinicians and Office Staff

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- **Primer with 5 brief learning modules**
 - ▣ Module 1- Prevalence & Comorbidity
 - ▣ Module 2- Epidemiology
 - ▣ Module 3- Effective Prevention Strategies
 - ▣ Module 4- Suicide Risk Assessment
 - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
 - ▣ Module 5- Intervention
 - Referral, PCP Intervention, Documentation & Follow-up

Primer



SPRC
Suicide Prevention Resource Center

Suicide Prevention Toolkit for Rural Primary Care

A Primer for Primary Care Providers

Western Interstate Commission for Higher Education (WICHE) Mental Health Program
and
Suicide Prevention Resource Center (SPRC)

Module 1: Prevalence and Comorbidity

Prevalence of Suicide

More than 32,000 deaths by suicide occur each year in the U.S.

Suicide rates across demographic groups are higher in rural counties than in urban counties.

Suicide is the second leading cause of death in persons 25-54 years old in the U.S.

Suicide is the third leading cause of death in persons 15-24 years old in the U.S.

Suicide was the eleventh leading cause of death (by age) in U.S.

In Primary Care:

Up to 80% of people who die by suicide had contact with their primary or physician PCP in the year prior to their death.

Up to 60% had contact with their PCP in the month prior to their suicide.

These rates indicate a high need for suicide risk care to reach and treat high risk mental health professionals in the year and month prior to their suicide.

Comorbidity

Mental illness is neither a necessary nor sufficient condition for suicide, but it is a strong associated condition.

More than 80% of people who die by suicide have a mental health disorder, substance abuse disorder, or both. (For youths under 18, that percentage is 74, but still significant.)

More than 50% of suicides are associated with a major depressive episode as well as 20% of suicides are associated with a substance abuse disorder, episode with mental illness or substance.

Two percent of suicides are associated with a psychotic disorder such as schizophrenia.

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

Patients in whom warning signs or other risk factors are detected should be asked about suicide thoughts as well as other topics. It is common to assess for suicidality if there is any suspicion that a patient might be suicidal.

Key Risk Factors

- 1. Prior Suicide attempt
- 2. Family History
- 3. Substance Use Disorders

Other Risk Factors

- 1. Other mental health or emotional problems
- 2. Ongoing pain
- 3. Loneliness
- 4. PTSD
- 5. Thoughts of harm (e.g. CTS)
- 6. Events or stressors causing feeling of humiliation, shame or guilt?

Some or all of the Sample Questions in Module 4 for Inquiring about Thoughts of Suicide can be used for interim screening of patients. The key is to ask directly about thoughts of suicide or harming self, as part of the screening. It is not asking the questions) unless there is some reason to do so in a specific situation.

Sample screening question:

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

• positive response to this screening requires additional assessment. (Module 4) More formal suicide screening instruments, such as paper and pencil questionnaires, are also available for use in primary settings or can be derived using the questions above or questions in Module 4. These instruments should always be used as an adjunct to the clinical interview.

4. Educating Patients about Suicide Warning Signs

Just as we educate the public on the warning signs of stroke and heart disease, we should provide basic information to the public on the warning signs of suicide. For some warning signs, the appropriate response may be to call 911 or the National Emergency Department. For other situations, it may be appropriate to call the National Suicide Prevention Helpline, 1-800-273-8255. Call to the number can be made by a nearby, unlisted and/or other unlisted numbers. Questions are

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

2. Educating Staff

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1. Training Staff to Recognize Warning Signs of Suicide

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

Suicide prevention trainings that teach recognition and response to suicide warning signs can be provided to clinic staff as an in-service. In most areas trainers are available to teach these important skills. Training is also available online. (See the Resource List for some of the national vendors of these programs or www.sprc.org for the suicide prevention coordinator in your state.) After even minimal training, staff can observe 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**

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Discussion

What behaviors might ancillary staff notice that could tip them off to suicide risk that could go un-noticed by clinical staff?

2. Educating Staff

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2. Screening for and Managing Depression

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

A key factor in reducing 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://www.depression-primarycare.org/clinicians/toolkits/>

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.^{iv v vi}

2. Educating Staff

PATIENT HEALTH QUESTIONNAIRE

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Patient Health Questionnaire (PHQ-9)

< Previous | Next >

PHQ - 9

NAME John Q. Sample

DATE _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Somewhat difficult	Very difficult	Extremely difficult
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns

TOTAL

10 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	<input type="checkbox"/>
	Somewhat difficult	<input checked="" type="checkbox"/>
	Very difficult	<input type="checkbox"/>
	Extremely difficult	<input type="checkbox"/>

PHQ-9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD ® is a trademark of Pfizer

PHQ-2

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- First two questions of the PHQ-9
- PHQ-2 score >3 had a sensitivity of 83% and a specificity of 92% for major depression.

Kroenke K, et al. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care. Vol 41. No 11. 1284-1291.

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2. Educating Staff

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THE MACARTHUR INITIATIVE ON
depression & Primary
Care



About the Initiative
Resources for Clinicians
Resources for Organizations

Home > Resources for Clinicians > Re-Engineering Practices
2 April, 2010

RESOURCES FOR CLINICIANS

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RE-ENGINEERING PRACTICES

The **Three Component Model (3CM)** is a specific clinical model for depression. The 3CM is a systematic approach that includes tools, routines, and a team approach to patient care. The three components include the prepared primary care clinician and practice, care management, and a collaborating mental health specialist.

The Prepared Practice refers to education for both the primary care clinician (PCC) and the office staff about skills needed for use of a depression diagnosis and response measure and the use of communication forms and routines. To download a training manual for clinicians, [please click here](#). Overall educational plan for the prepared practice includes predisposing, enabling, and reinforcing activities. The effectiveness of the initial predisposing program is increased by [DVD/videos](#) (a primary care physician and care manager role modeling the major process tasks).

[Care manager training](#) covers skills necessary to help patients follow through with the depression management plans developed by their PCC. In addition, patient treatment responses are reviewed by the care manager with the supervising psychiatrist during care manager supervision calls. The care manager has frequent and sustained contacts with the patient, providing the opportunity to bring information from the patient to the PCC via the Care Manager Report, Agendas and forms are covered as a major mechanism to support communication and coordination of information, which may be enhanced by personal contact or by telephone contact. As with clinician education, the effectiveness of the initial care manager predisposing program is increased by [DVD/videos](#).

The [Supervising Psychiatrist Training Manual](#) is specifically to help a psychiatrist learn how to serve as the key mental health component in a Three Component Model of depression

2. Educating Staff

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3. Screening for Suicide Risk

Screening for suicidal thinking appears to be an effective and efficient means of identifying individuals at risk when conducted on people who have key risk factors.

Key Risk Factors

- Prior suicide attempt
- Major depression
- Substance use disorders

Other Risk Factors

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

2. Educating Staff

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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.**

Sample screening question:

- 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 requires additional assessment (Module 4).

2. Educating Staff

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Module 4: Suicide Risk Assessment

About 3% of adults (and a much higher percentage of youths) are entertaining thoughts of suicide at any given time; however, there is no certain way to predict who will go on to attempt suicide.^{i ii}

Key components of a suicide risk assessment

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

2. Educating Staff

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2. 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.^{vi} How you ask the question 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?”
- **Practice questions several times prior to a clinical encounter;** asking about suicide for the first time may be harder than you think.

3. Developing Mental Health Partners

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- Letter of introduction to potential referral resources-
-template
 - Increasing vigilance for patients at risk for suicide
 - Referring more patients
 - SAFE-T card for Mental Health Providers
 - Invitation to meet to discuss collaborative management of patients
 - NSSP recommends training for health care professionals
 - Nationally disseminated trainings for MHPs

3. MH Partners

SAFE-T

Suicide Assessment Five-step
Evaluation and Triage

for Mental Health Professionals

- 1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk
- 2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced
- 3
CONDUCT SUICIDE INQUIRY
suicidal thoughts, plans, behavior and intent
- 4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk
- 5
DOCUMENT
Assessment of risk, rationale, interventions and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical changes for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). Co-morbidity and recent onset of illness increase risk
- ✓ Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- ✓ Family history: of suicide, attempts or Axis I psychiatric disorders requiring hospitalization
- ✓ Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated), Ongoing medical illness (esp. CHS disorders, pain), Intoxication, Family turmoil/chaos, History of physical or sexual abuse, Social isolation.
- ✓ Change in treatment: discharge from psychiatric hospital, provider or treatment change
- ✓ Access to firearms

2. 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 beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ Ideation: frequency, intensity, duration—in last 48 hours, past month and worst ever
- ✓ Plans: timing, location, lethality, availability, preparatory acts
- ✓ Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self-injurious actions
- ✓ Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

* For youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition
* Homicide inquiry: when indicated, esp. in character disordered or paranoid states dealing with loss or humiliation, inquire in four areas listed above.

4. RISK LEVEL/INTERVENTION

- ✓ Assessment of risk level is based on clinical judgment, after completing steps 1-3
- ✓ Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

3. MH Partners – Telemental Health

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- Web-based guide for developing a telemental health capacity (created by the U CO Denver as part of SAMHSA's Eliminating Health Disparities Initiative) www.tmhguide.org
- Resources for
 - Clinicians/Administrators
 - Consumers
 - Policymakers
 - Community Members
 - Media

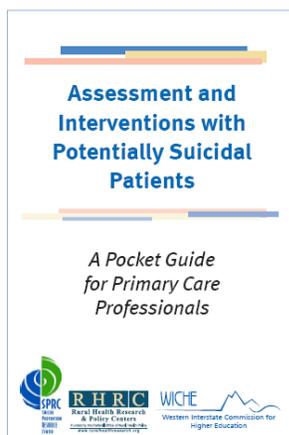
3. MH Partners

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- SAMHSA mental health and substance abuse treatment locator guides (www.samhsa.gov)
- Veterans resource locator (<http://www.suicidepreventionlifeline.org/Veterans/ResourceLocator.aspx>)

4. Patient Management—Pocket Guide

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Suicide Risk and Protective Factors¹

RISK FACTORS

- ▶ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive 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: also oppositionality and conduct problems.
- ▶ **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.
- ▶ **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 beloved pets, positive therapeutic relationships, social supports.

4. Patient Management—Pocket Guide

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals



Screening: uncovering suicidality¹

- ▶ Other people with similar problems sometimes lose hope; have you?
- ▶ With this much stress, have you thought of hurting yourself?
- ▶ Have you ever thought about killing yourself?
- ▶ Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans²

- ▶ Assess suicidal ideation – frequency, duration, and intensity
 - 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 the thoughts of suicide?
 - What is the worst they have ever been?
 - What do you do when you have suicidal thoughts?
 - What did you do when they were the strongest ever?
- ▶ Assess suicide plans
 - 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?

Assess suicide 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 your 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 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?

Endnotes:

¹ SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).

² Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

³ Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.

4. Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients



Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

High Risk	Moderate Risk	Low Risk
<p style="text-align: center; color: red;">Patient has a suicide plan with preparatory or rehearsal behavior</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%; padding: 2px;"> <p style="font-size: 8px;">Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement</p> <p style="font-size: 8px;">Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits</p> </div> <div style="width: 45%; padding: 2px;"> <p style="font-size: 8px;">Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed</p> <p style="font-size: 8px;">Take action to thwart the plan</p> <p style="font-size: 8px;">Consider (locally or via telemedicine): 1) psychopharmacological treatment with psychiatric consultation 2) alcohol/drug assessment and referral, and/or 3) individual or family therapy referral</p> </div> </div>	<p style="text-align: center; color: yellow;">Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt</p> <p style="text-align: center; color: yellow; font-size: 8px;">Evaluate for psychiatric disorders, stressors, and additional risk factors</p>	<p style="text-align: center; color: blue;">Patient has thoughts of death only; no plan or behavior</p>
<p style="font-size: 8px;">Encourage social support, involving family members, close friends and other community resources. If patient has therapist, call him/her in presence of patient.</p>		
<p style="font-size: 8px;">Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and community resources. Make continued entries in tracking log.</p>		

Exercise 1

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- 74 y/o male; wife (who was also your patient) died ~ a year ago
- Back pain from degenerative disease has increasingly gotten worse; not a candidate for surgery; hurts all the time....a lot
- Routine screening for depression (PHQ-9) = 18; endorsed "1" on question 9
- A combination of the pain and loneliness has caused him to give up just about everything he once enjoyed
- Further questioning about suicidal ideation revealed the thoughts are brief only. Denies ever having attempted suicide.
 - ▣ Plan: hasn't really thought about it. Doesn't own a gun.
 - ▣ Intent: Doesn't think he would ever kill himself; he hopes to help his grandson through college and see him graduate.

Exercise 2

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- 24 y/o male; served 4 years in the Army; combat deployments.
- CC: Insomnia—has not slept for "5 days straight"
- Intrusive thoughts occur several times a day; take him back to the firefight when his buddy was killed in Iraq
- When asked by the office nurse about thoughts of suicide using a normalizing technique, he revealed he had strong urges to kill himself at least every day. He has several guns and has at times sat contemplating suicide with a loaded gun in his hands.
- He hasn't been able to keep a job; his wife left him when he was in Iraq; his disability pension has been inadequate to make mortgage payments; he was just served notice the bank was taking his house.

Exercise 3

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- 52 y/o female has been your patient for 25 years. She has been in and out of marriages and relationships over that time and had several children by various fathers. She has been treated unsuccessfully several times for alcohol dependence; you suspect she's drinking again.
- You asked her about suicidal thoughts using the normalizing technique and discovered she has been contemplating wanting to find a way to die or even kill herself. Further questioning indicated she had occasionally thought about drinking herself to death, but didn't know if that would work, since she had tried it one time. She has no plans other than that.

4. Patient Management

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- Management/co-management
 - Depression
 - Anxiety
 - Psychosocial-behavioral problems
- Encourage support network
- Safety planning
- Crisis support planning

4. Patient Management

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- “Safety Plan” (Brown and Stanley, 2008)
 - Collaboratively developed with patient
 - Template that is filled out and posted
 - Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers
- “Crisis Support Plan” (Rudd, 2006)
 - Provider collaborates with Pt and support person
 - Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed

4. Patient Management

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Safety Planning Guide

*A Quick Guide for Clinicians
may be used in conjunction with the "Safety Plan Template"*

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

SAMPLE SAFETY PLAN	
Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1. Name _____	Phone _____
2. Name _____	Phone _____
3. Name _____	Phone _____
Step 4: People whom I can ask for help:	
1. Name _____	Phone _____
2. Name _____	Phone _____
3. Name _____	Phone _____
Step 5: Professionals or agencies I can contact during a crisis:	
1. Clinician Name _____	Phone _____
2. Clinician Pager or Emergency Contact # _____	Phone _____
3. Local Urgent Care Services _____	Urgent Care Services Address _____
	Urgent Care Services Phone _____
4. Suicide Prevention Hotline Phone: 1-800-273-TALK (2283)	
Step 6: Making the environment safe:	
1.	_____
2.	_____
<small>Adapted from: Trueman, Harold W. <i>Reducing Suicide Risk: A Manual</i>. (Berkley & Bohn, 2004)</small>	
The one thing that is most important to me and worth living for is:	

4. Patient Management

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CRISIS SUPPORT PLAN

FOR: _____ DATE: _____

I understand that suicidal risk is to be taken very seriously. I want to help _____ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
 - _____
 - _____
- Help _____ follow his/her Crisis Action Plan
- Ensure a safe environment:
 1. Remove all firearms & ammunition
 2. Remove or lock up:
 - knives, razors, & other sharp objects
 - prescriptions & over-the-counter drugs (including vitamins & aspirin)
 - alcohol, illegal drugs & related paraphernalia
 3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
 4. Pay attention to his/her stated method of suicide/self-injury and restrict

Suicide Prevention Resource Center Training Institute. (2008) Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. Newton, MA: Education Development Center, Inc.

4. Patient Management - Tracking Log

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- Log & Instruction sheet
- Provider uses:
 - Update PCP on suicide status of a patient
 - Remind provider of recent interventions or problems with regard to the patient's treatment

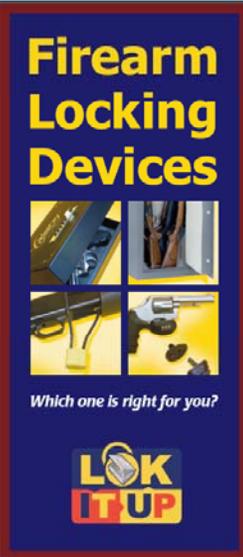
Suicidality Treatment Tracking Log (for Patient Chart)

Patient Name _____ Medical Record # _____ Primary Care Provider _____

Session Date								
V = Visit P = Phone C = Cancellation NS = No Show	V P C NS							
Suicidal thoughts?	Yes No							
Suicidal Behaviors?	Yes No							
Risk: H = High M = Moderate L = Low	H M L							
Medication Prescribed?	Yes No Meds							
Medication Dosage/Start Date								
Medication Adherence	Yes No							
Medication Side Effects								
Other Interventions								
Mental Health Provider	Yes No							

Suicide Status Tracking discontinued (date ____ / ____ / ____) because: Suicidality Resolved _____ Dropped out _____ Other _____

5. Patient Education



Firearm Locking Devices

Which one is right for you?

LOK IT UP

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself 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
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

6. Resources

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- Resource list for providers
 - Associations & Organizations
 - Other resources with links for downloading or ordering
- Posters and brochures for clinics

PTSD

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- RESPECT-MIL--Re-Engineering Systems of Primary Care Treatment in the Military
- Screening for Depression and PTSD
 - <http://www.pdhealth.mil/respect-mil/index1.asp>

DEPRESSION AND PTSD

WEB-BASED TRAINING

- Login Here

QUICK LINKS

- PCC Manual
- CF Manual
- BH Manual
- Newsletter



INFORMATION ON PTSD IN PRIMARY CARE

PTSD is a consequence of extreme psychological trauma including assault, rape, abuse, motor vehicle accidents, natural and human-caused disasters, and combat. Most people exposed to an extreme traumatic event do not develop PTSD, but the condition has been observed in military populations from most countries and after every major conflict since it was first officially defined in 1980. In the U.S., some veterans of Vietnam, the Gulf, Bosnia/Kosovo, Afghanistan, and Iraq Wars have developed PTSD. Prior to that, PTSD-like syndromes have been recognized since the US Civil War and gone by names like Soldier's Heart, Shell Shock, Hysteria, and Effort Syndrome. In addition to war veterans, PTSD is relatively common among occupations at high risk of encountering destruction and violence, including fire fighters, police, and other community crisis responders. US peacekeeping forces deployed to international war zones have also developed PTSD.

Substance Abuse

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Substance Abuse

Alcohol Screening and Brief Intervention

URL: <http://www.apha.org/NR/rdonlyres/39FB5EAB-E4DE-4701-B598-022E9FC7F9BF/0/SBIMANUAL.pdf>

A printable guide for public health practitioners produced by the American Public Health Association.

Helping Patients Who Drink Too Much: A Clinician's Guide and Related Professional Support Resources

URL: <http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm>

A guide for clinicians produced by the National Institute on Alcohol Abuse and Alcoholism. Includes the downloadable guide, a medications update, a PowerPoint presentation, and a 10 minute interactive video course. The downloadable and video courses include free CME/CE credits.

Screening for Tobacco, Alcohol and Other Drug Use

URL: <http://drugabuse.gov/nidamed/screening/>

A Web-based interactive tool produced by the National Institute on Drug Abuse to guide clinicians through a short series of screening questions and, based on the patient's responses, generate a substance involvement score that suggests the level of intervention needed. Also provides links to resources for conducting a brief intervention and treatment referral, if warranted.

AUDIT: Alcohol Use Disorders Identification Test

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- 8-15 = Advise on reduction of drinking
- 16-19 = Brief counseling and monitoring
- >20 = Further diagnostic testing

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.
For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:
12 oz. of beer (about 5% alcohol) = 8.9 oz. of wine (about 12% alcohol) = 5 oz. of spirits (about 20% alcohol) = 1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 5 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
Total					

800-458-5231
National Institute on Alcohol and Alcoholism www.niaaa.nih.gov/audit

AUDIT: Guidelines for use in PC--http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Other Risk Factors

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- ADD/ADHD
- Eating disorders
- Discipline problems/juvenile justice
- Hx of Abuse
- Domestic violence

LESSONS LEARNED FROM EARLY IMPLEMENTATION

Importance of state specific information

- Local hotline numbers
- State mental health laws regarding commitment and local MPH's
- State hospital locations and admission procedures
- Local and state mental health resources
- State Medicaid rules for presumptive eligibility and payment for mental health services

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Questions?

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