Suicide Prevention Resource Center

Suicide Safer Care: **Suicide Prevention in Primary Care**

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@SPRCTweets

SAMHSA

Funding and Disclaimer

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Disclosures

No financial relationships or conflicts of interest to report.

About SPRC

The Suicide Prevention Resource Center (SPRC) is the only federally funded resource center devoted to advancing the implementation of the *National Strategy for Suicide Prevention*. SPRC is supported through a grant from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

SPRC builds capacity and infrastructure for effective suicide prevention through consultation, training, and resources for state, tribal, health/behavioral health, and community systems; professionals and professional education programs; and national public and private partners and stakeholders.

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body.

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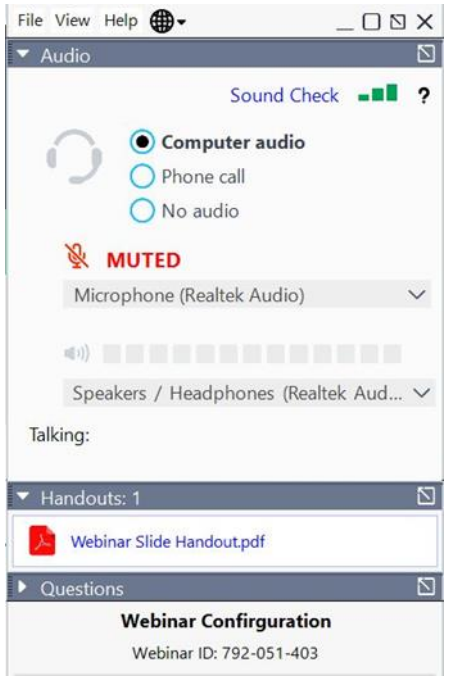
How To Download Handouts

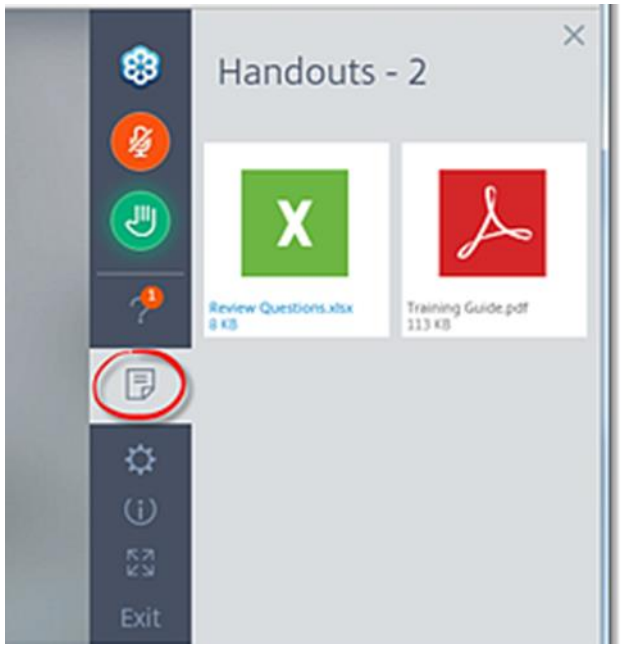
Desktop

Use the “Handouts” area of the attendee control panel.



Instant Join Viewer

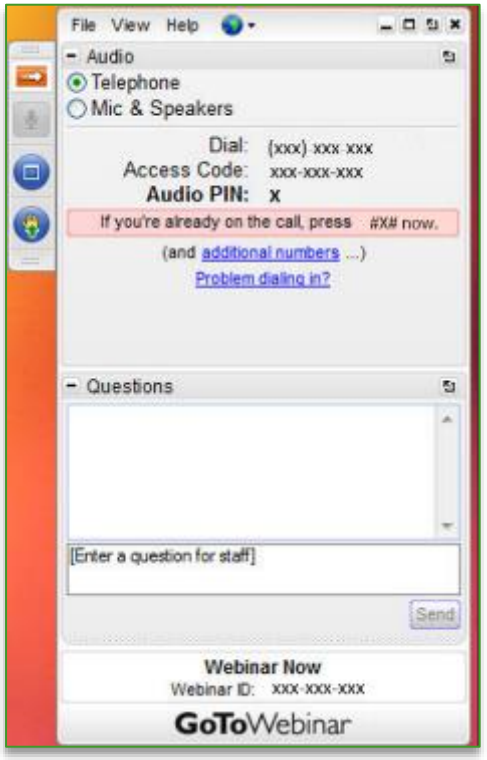
Click the “Page” symbol to display the “Handouts” area.



How To Participate in Q&A

Desktop

Use the “Questions” area of the attendee control panel.



Instant Join Viewer

Click the “?” symbol to display the “Questions” area.

Language Matters

Choosing Compassionate & Accurate Language

• • •

Died of/by Suicide *vs* ~~Committed Suicide~~

Suicide *vs* ~~Successful Attempt~~

Suicide Attempt *vs* ~~Unsuccessful Attempt~~

Describe Behavior *vs* ~~Manipulative/Attention Seeking~~

Describe Behavior *vs* ~~Suicidal Gesture/Cry for Help~~

Diagnosed with *vs* ~~they're Borderline/Schizophrenic~~

Working with *vs* ~~Dealing with~~ Suicidal Patients

now matters now

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Overview

- Role of the primary care provider (PCP) in suicide safe care
- Identification of patients at risk for suicide
- Assessment of patients at risk for suicide
- Safety planning
- Office-based interventions for PCPs

Why Focus on Health Care Settings?

- 84% of those who die by suicide have a health care visit in the year before their death.
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.
- Almost 40% of individuals who died by suicide had an emergency department (ED) visit, but not a mental health diagnosis.

Source: Ahmedahni, 2014; Ahmedahni, 2015

Joint Commission Sentinel Event Alert 56

Sentinel Event Alert

EMBARGOED UNTIL FEB. 24

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

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

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

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

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

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

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Baerum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[5] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

The suggested actions in this alert cover detection of suicidal ideation, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of individuals at risk. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk of suicide, and documenting their care.

National Patient Safety Goal (NPSG) 15.01.01

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018
UPDATED Nov. 20, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R³ Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R³ Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R³ Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) were applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. Effective July 1, 2020, these requirements also will be applicable to Joint Commission-accredited critical access hospitals. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission held five technical expert panel meetings between June 2017 and March 2018. The results of the first four meetings were published in the November 2017, January 2018, and February 2018 editions of *The Joint Commission Perspectives*.

The revisions for the critical access hospital (CAH) accreditation program only have been posted on the Prepublication Standards page of The Joint Commission website and will be available online until the end of June 2020. The new and revised EPs also will be published online in the spring 2020 E-dition update of the CAH accreditation program, and in print in the 2020 Update 1 to the *Comprehensive Accreditation Manual* for the CAH accreditation program. After July 1, 2020, please access the new requirement in the E-dition or standards manual.

National Patient Safety Goal

NPSG.15.01.01: Reduce the risk for suicide.

HAP Note: EPs 2-7 apply to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3-7 apply to all patients who express suicidal ideation during the course of care.

CAH Note: EPs 2-7 apply to patients in psychiatric distinct part units in critical access hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care in critical access hospitals. In addition, EPs 3-7 apply to all patients who express suicidal ideation during the course of care.

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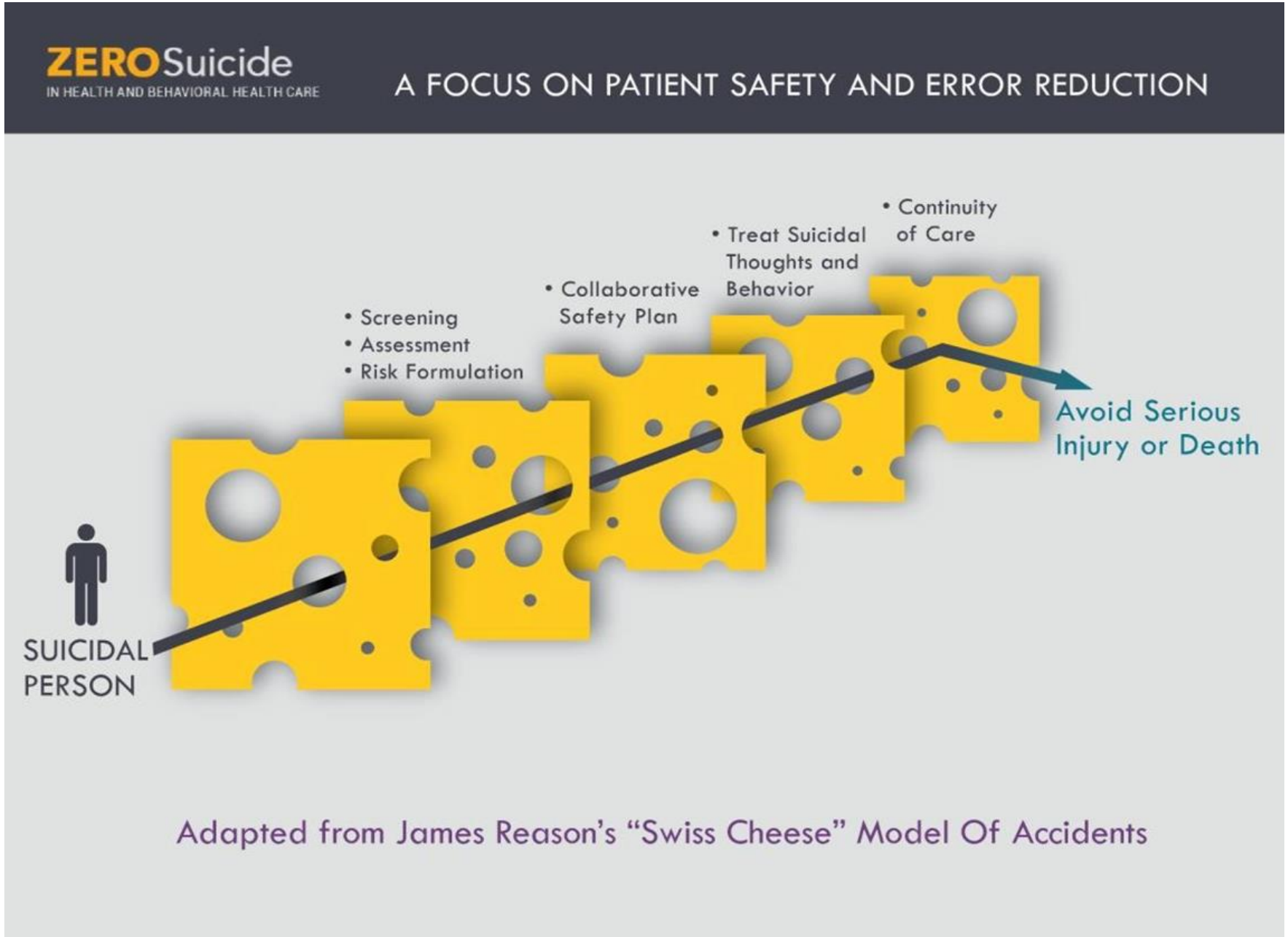
The Joint Commission

- SEA 56 was retired in February 2019.
- NPSG 15.01.01 covers the topics in SEA 56 and includes new and revised performance elements effective July 2019.
- The Joint Commission website includes a Suicide Prevention Portal with resources and guidance.

National Patient Safety Goal 15.01.01



7 Elements of ZEROSuicide

Zero Suicide

Access at:

www.zerosuicide.com

What We Hear Sometimes…

"I don't have the knowledge to assess or intervene."

"With such a short amount of time, I don't have time to ask or address suicide risk."

In the Office:
Three Things that People at Risk of Suicide Want from You

- Do not panic.
- Be present, listen carefully, and reflect.
- Provide some hope, e.g., “You have been through a lot, I see that strength.”

LANGUAGE MATTERS!

Identification

- Many offices are screening for depression.
- Ask patients directly (ask what you want to know).
- Social determinants play a role.
- Many patients don’t have depression.
- Substance and alcohol use play a role.
- Transitions are a time of risk.

Population of Patients at Risk for Suicide

- Do you know how many are on your panel, in your practice, or organization?
- Are you adding ICD-10 codes to your problem list?
- Do you have expectations/standards for BOTH newly identified patients and patients following up for routine primary care?
- What does excellent care for patients at risk of suicide in your organization look like?

The Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
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 asleep, 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're 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
Column Totals	_____ +	_____ +	_____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those 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 ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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 ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

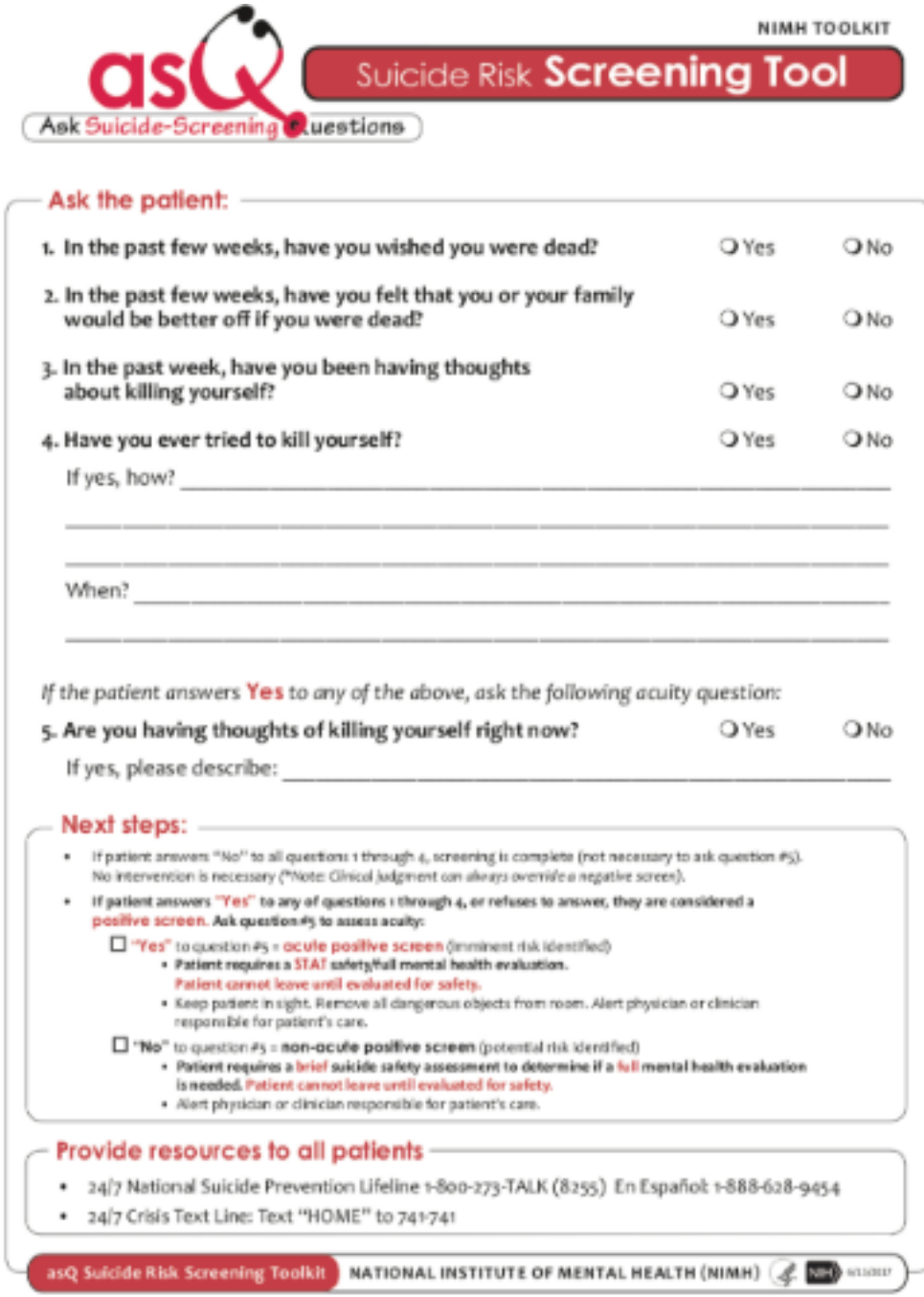
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can *always* override a negative screen).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.**
      Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

NIMH TOOLKIT: EMERGENCY DEPARTMENT

Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"I'm so glad you spoke up about this. I'm going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you."

If patient screens positive, say to parent/guardian:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child."

asQ
Ask Suicide-Screening Questions

NIMH TOOLKIT: EMERGENCY DEPARTMENT

Parent/guardian flyer

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

I just always run into the issue where as soon as things start becoming difficult, they just immediately suggest that I go to the mental hospital and I just cannot stress enough that it was not a good environment for me. And, they still suggest that I go back, when it'll just make things worse . . . It just seems like that's one of their first options when it should be a last resort.

Source: Richards, 2019

Appropriate Levels of Care

- Not everyone needs an alternate level of care.
- There is no “emergency room” magic.

Assessing Risk

- Can and does happen in primary care settings; appropriate level of care
- Helpful to speak the same language and understand the assessment process
- The suicide risk becomes the focus of the primary care visit

Response Protocol

Ask questions that are in bold.

Ask Questions 1 and 2	Past Month: YES	Past Month: NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual thoughts of killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Schedule Follow-Up

Address Lethal Means, Safety Planning, Schedule Follow-Up

Evaluate Hospitalization, Address Lethal Means, Safety Planning, Schedule Follow-Up

Suicidal Ideation

Method

- "Have you been thinking about **how** you may do this?"

Intent

- Have you had these thoughts and had some **intention** of acting on them?"

Plan

- Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this **plan**?

Protective Factors

What are reasons you would not die by suicide today?

Some common protective factors:

- Kids
- Family/spouse/parents
- Pets
- Religion
- Job

What is Safety Planning?

The Safety Planning Intervention consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.

The Minimum: What to Do

- Before the patient leaves your office, add the National Suicide Prevention Lifeline or Crisis Text Line in their phone.
- Call 1-800-273-8255.
- Text the word “hello” to 741741.
- Address guns in the home and the patient’s preferred method of suicide.

NowMattersNow.org Works

Website visits are associated with decreased intensity of suicidal thoughts and negative emotions.

This includes people who rated their thoughts as “completely overwhelming.”

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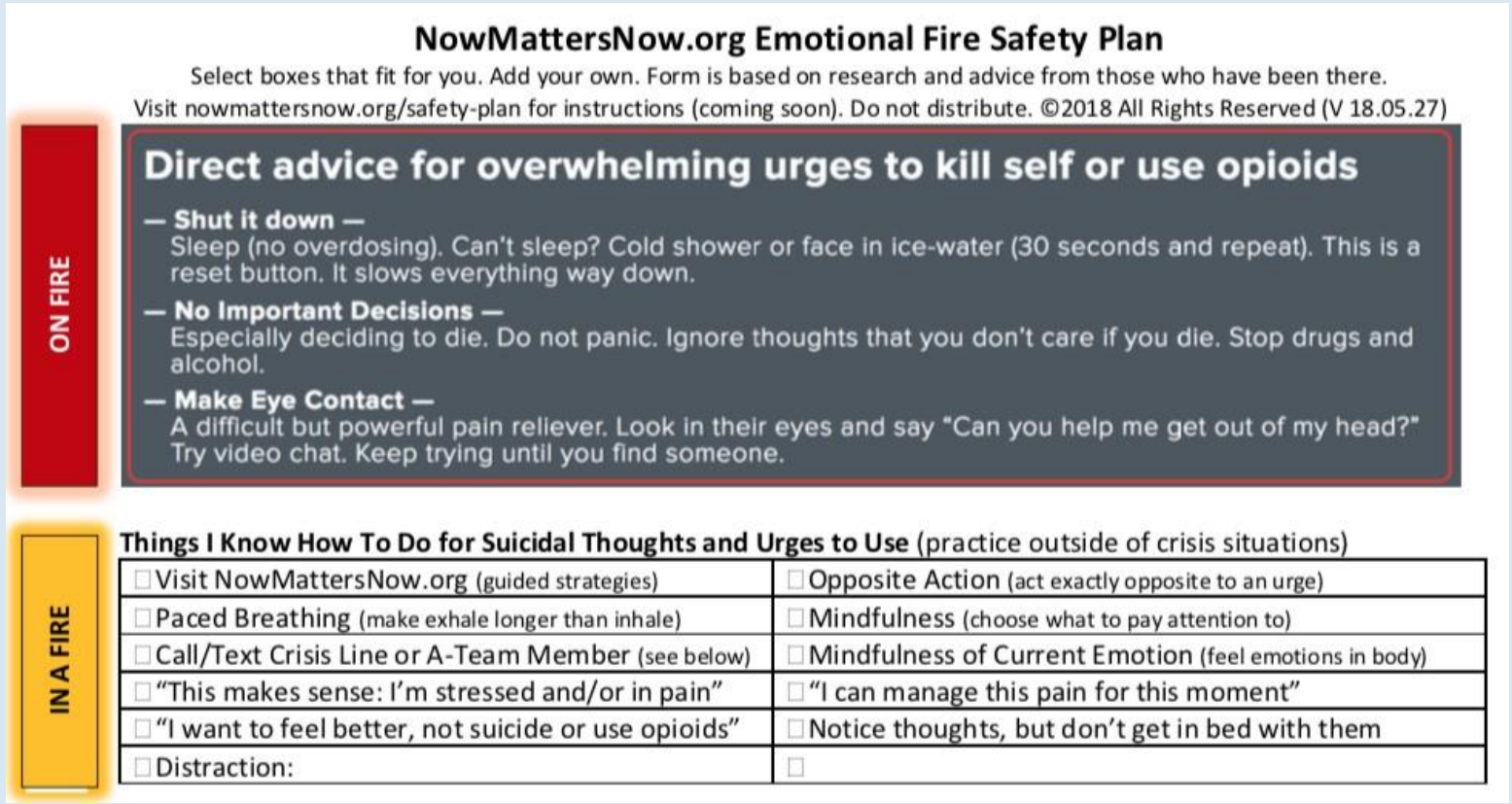
SuicideIsDifferent.org provides suicide caregivers with interactive tools and support to:

Learn About Suicide | Process Your Feelings | Adapt to Change | Set Safe Boundaries | Talk About Suicide

"I'm a suicide caregiver and this is exactly what I didn't know I needed! Thanks for reminding me to take care of myself." – Suicide Is Different User

SUICIDEISDIFFERENT.ORG

Safety Plan



NowMattersNow.org Emotional Fire Safety Plan

Select boxes that fit for you. Add your own. Form is based on research and advice from those who have been there.
Visit nowmattersnow.org/safety-plan for instructions (coming soon). Do not distribute. ©2018 All Rights Reserved (V 18.05.27)

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— Shut it down —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— No Important Decisions —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— Make Eye Contact —
A difficult but powerful pain reliever. Look in their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

☐ Visit NowMattersNow.org (guided strategies)	☐ Opposite Action (act exactly opposite to an urge)
☐ Paced Breathing (make exhale longer than inhale)	☐ Mindfulness (choose what to pay attention to)
☐ Call/Text Crisis Line or A-Team Member (see below)	☐ Mindfulness of Current Emotion (feel emotions in body)
☐ "This makes sense: I'm stressed and/or in pain"	☐ "I can manage this pain for this moment"
☐ "I want to feel better, not suicide or use opioids"	☐ Notice thoughts, but don't get in bed with them
☐ Distraction:	☐

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Patient Safety Plan

Patient Safety Plan Template

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. Place_____ 4. Place_____

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_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:

_____

Safety Planning

- Can the activity happen all times of the day and all times of the year?
- Call someone from the patient's team. "Sarah and I would like to speak with you; she has listed you on her suicide safety plan."
- Be creative – Walmart!
- How can we keep you safe today?

Lethal Means Reduction

- Temporary
- Matter of Fact
- Standard Practice
- Safety Approach (Public Health!)
- Preferred method is important to know and note

Lethal Means

- How much medication is in your home? (neighbors, family)
- Medication boxes, family, individual wrapping, “pill packs”
- Gun locks, boxes, family or surrender for holding
- The time to talk to the pharmacy is now

Caring Contact

Henry,

I don't know you well, yet I am glad that you told me a little more about your life. I have lots of hope for you–you've been through a lot. I hope you'll remember that and come back to see us.

With care,
Nurse Matt

Caring Messages

Caring Messages

Ursula Whiteside	Kristine Laaninen	Daniel DeBrule	Breanna Laughlin	Debbie Reisert
Dear you. Yes, you! Remember that one time you felt connected to the universe. No one can take that away from you. It's yours	You may feel like you don't matter, but you do and see no future. Yet it is there – please let it evolve because the world needs you and your contribution.	When things have been rough, I think of things or touch items that give me a sense of pride, joy, encouragement, or hope. Sometimes memories that remind me I'm okay and things often change quickly. I don't know if that would help you.	Please don't stop fighting. You are being prepared for something far greater than this moment.	Just like winter, the long dark days slowly get shorter until there is more light than dark. Please believe this while you wait to see the light.

Questions?

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Thank you!

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