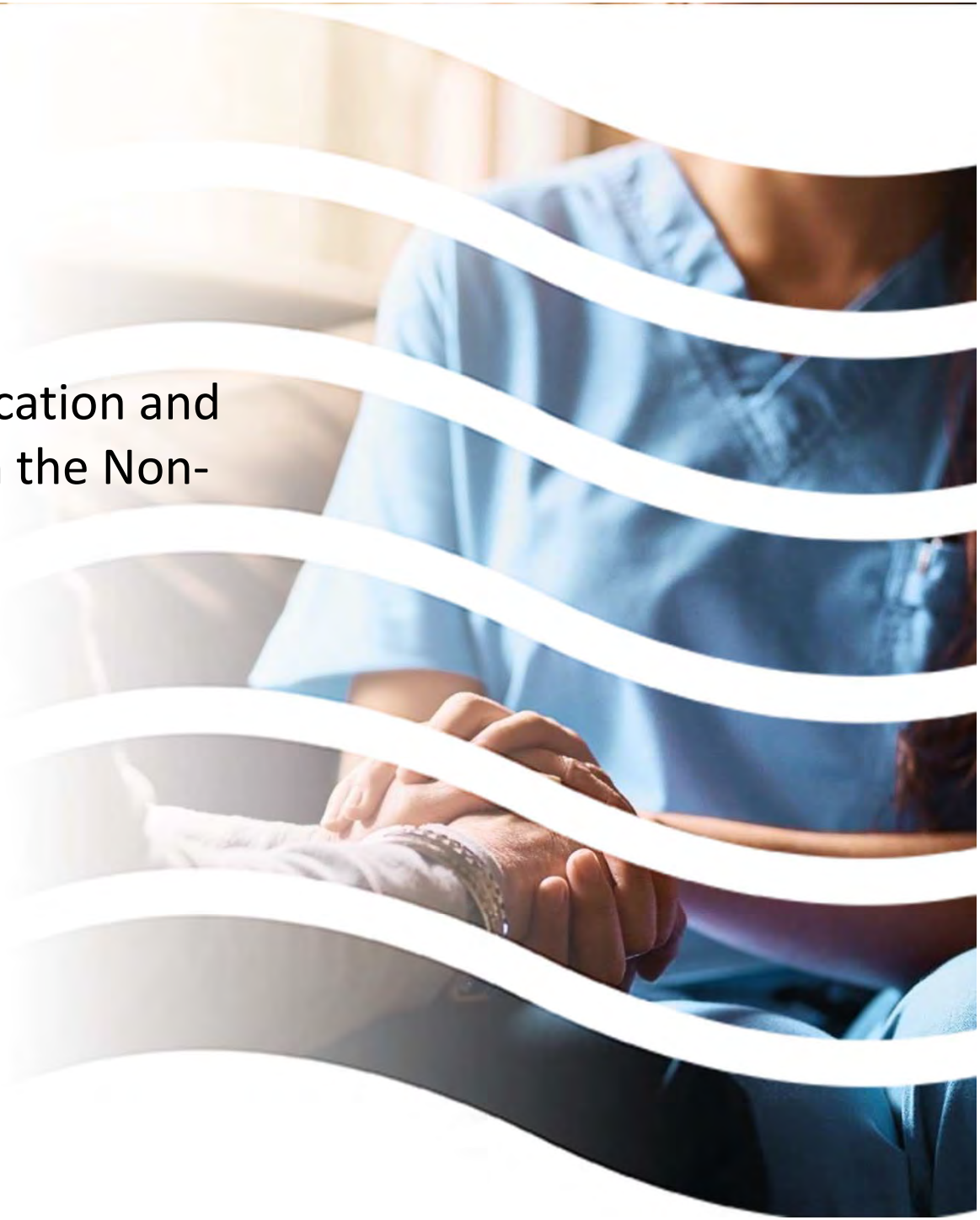
NorthShore University HealthSystem

Guidelines for the Identification and Management of Suicide in the Non-Psychiatric Office Setting



Frederick E. Miller MD, PhD

Healthcare for what's ❯ next.

Case Vignette

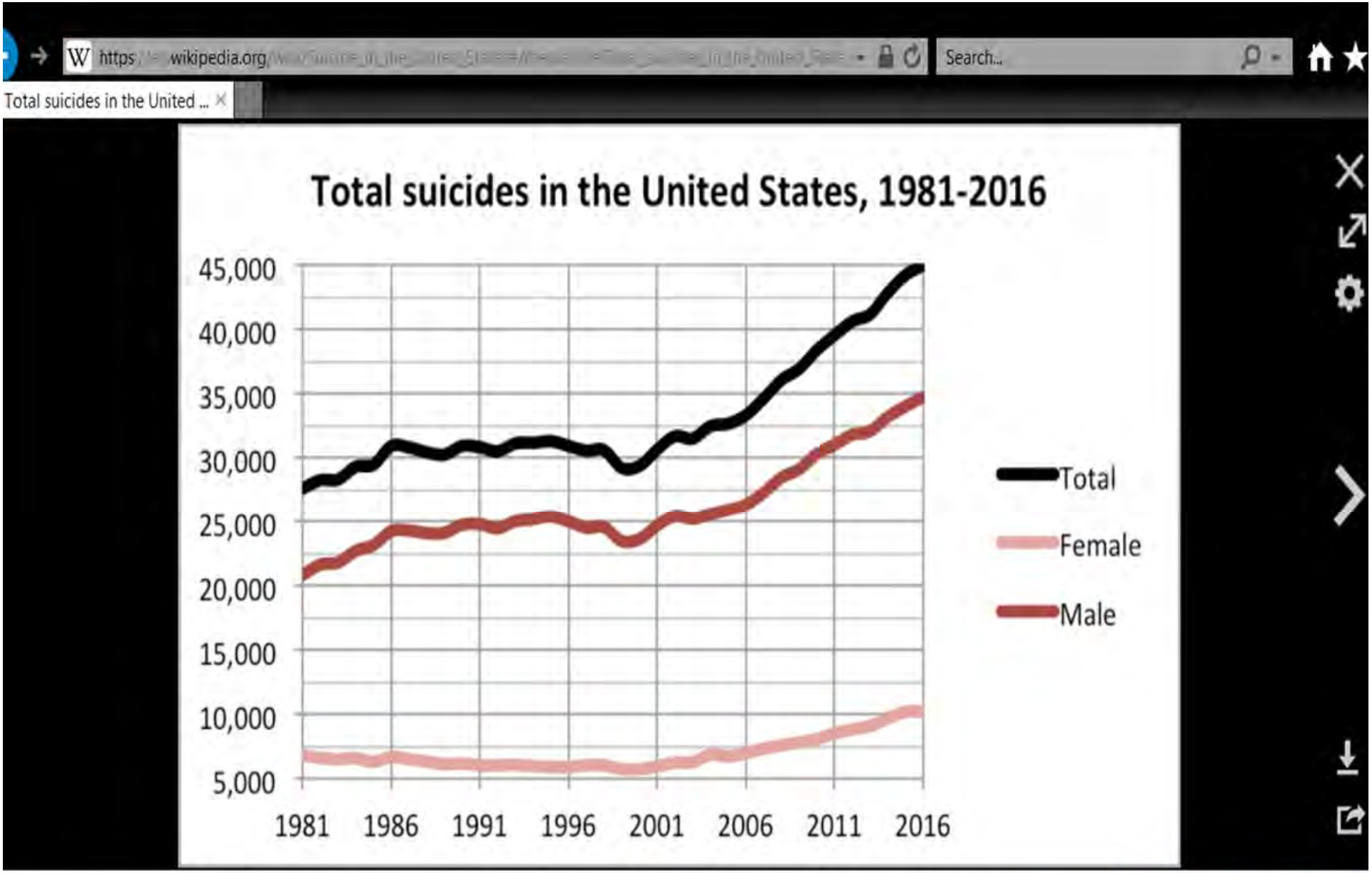
A middle aged man presents to his primary care physician with complaints of anxiety and insomnia. He describes being in the midst of a bitter divorce and, at the same time, being hounded at work by a supervisor who is threatening to fire him. He has withdrawn from his friends out of embarrassment over his situation. When asked about feelings of depression he focuses on being extremely anxious and unable to think as he is consumed by negative thoughts about his future. The PCP then asks the patient if he has been having thoughts of suicide. The patient denies having such thoughts and again reiterates that he is anxious and feeling trapped.

The PCP gives the patient a prescription for escitalopram and zolpidem for sleep. The PCP also provides the patient with a referral to be seen by a psychiatrist.

One week later, on his usual way home from work, he is stopped by a railroad crossing gate. At the last second he steps in front of the train and is killed.

Prevalence

- Rates of suicide reached a 50 year peak in 2017
- Over 30% increase since 1999
- One person dies by suicide in US every 12 minutes



Total Suicides in the United States, 1981–2016. Data from CDC WISQARS Fatal Injury Reports.[1]

More details

Jajhill - Own work

2nd leading cause of death age 15-34

10th leading cause of death overall

- Up to 45% of patients who die by suicide visited their primary care physician within a month of their death

- 81% of people who die by suicide did not seek psychiatric help

- 67% of patients who have attempted suicide receive medical care as a result of their attempt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We all have a role to play.
Together, we can save lives.
Effective prevention starts with you.
Make a plan to prevent suicide
Find a suicide prevention program
Measure your program's success
Improve suicide care for your patients
Take action after a suicide

MF1
MF2

Screening for Suicide a Requirement?

The Joint Commission in February 2016 released Sentinel Event Alert 56, which recommended that primary, emergency, and behavioral health clinicians look for suicidal ideation in all patients in both non-acute and acute care settings. The Joint Commission advised 1) reviewing each patient's personal and family history for suicide risk factors, 2) screening all patients for suicide risk factors using a brief, standardized, evidence-based screening tool, and 3) reviewing screening questionnaires before the patient leaves the appointment or is discharged.

Slide 8

MF1	Miller, Frederick, 10/29/2019
MF2	Miller, Frederick, 10/29/2019

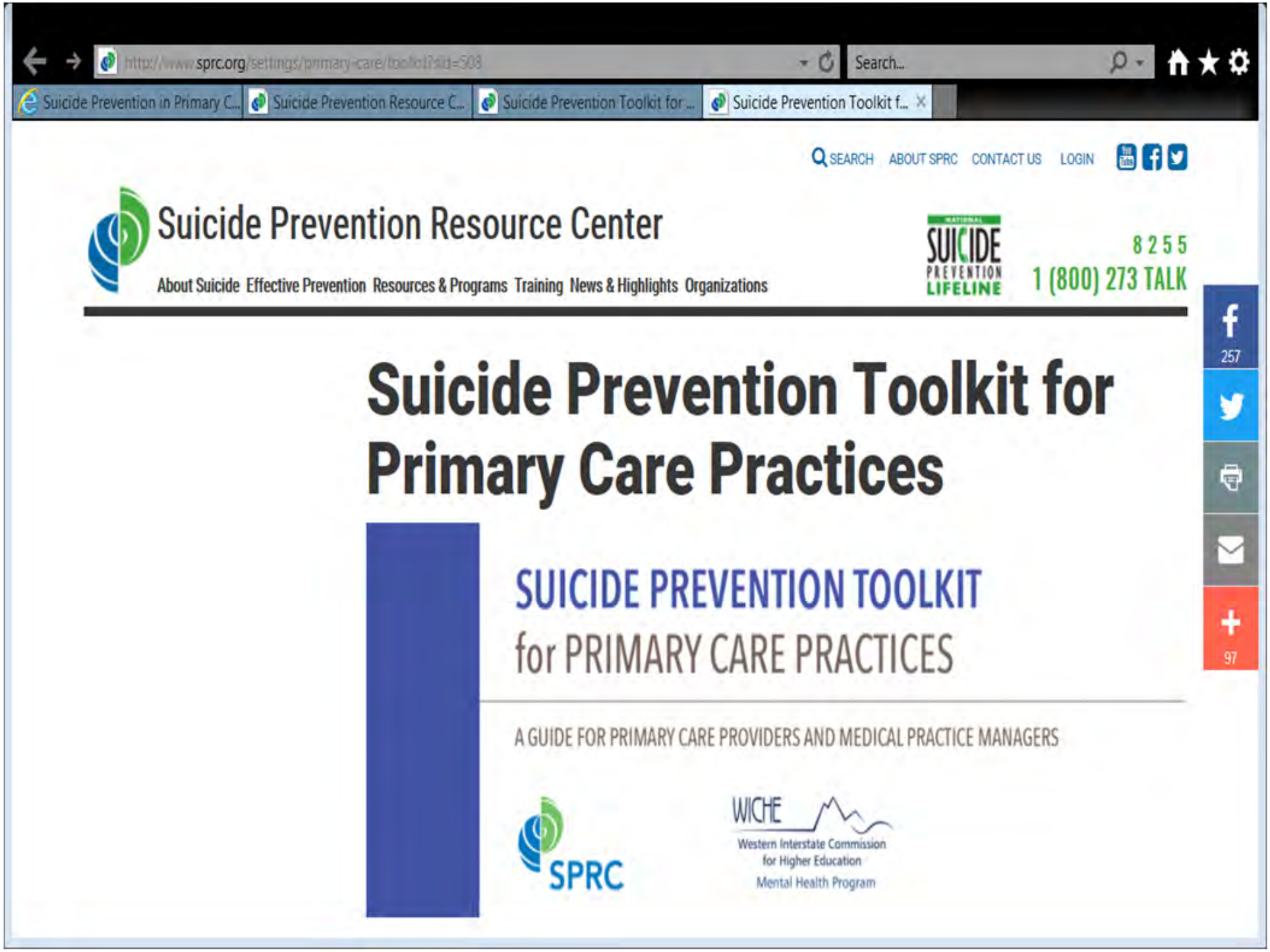
National Action Alliance for Suicide Prevention

Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE SUICIDE SAFE

Summary of Recommended Standard Care Elements – National Action Alliance

Primary Care:

1. Identify Suicide Risk for patients with MI / SUD
2. Complete the brief Safety Planning Intervention during the visit where the patient is identified and discuss with family
3. Discuss any lethal means considered by, and available to the patient and arrange for and confirm removal
4. Make appointments with mental health professional and complete one “caring contact” within 48 hours or next business day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A GUIDE FOR PRIMARY CARE PROVIDERS AND MEDICAL PRACTICE MANAGERS
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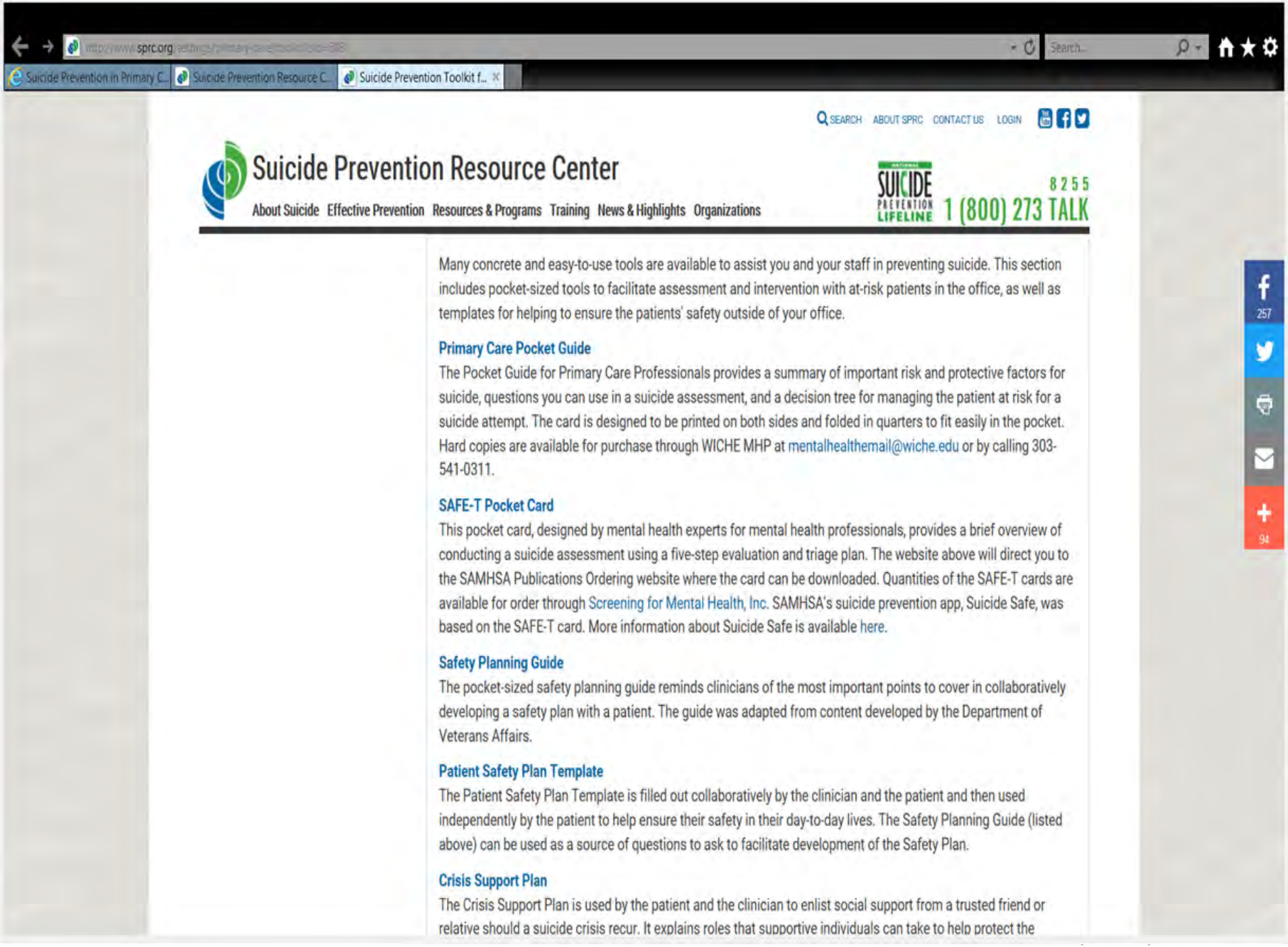
Mental Health Program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Many concrete and easy-to-use tools are available to assist you and your staff in preventing suicide. This section includes pocket-sized tools to facilitate assessment and intervention with at-risk patients in the office, as well as templates for helping to ensure the patients' safety outside of your office.
Primary Care Pocket Guide
The Pocket Guide for Primary Care Professionals provides a summary of important risk and protective factors for suicide, questions you can use in a suicide assessment, and a decision tree for managing the patient at risk for a suicide attempt. The card is designed to be printed on both sides and folded in quarters to fit easily in the pocket. Hard copies are available for purchase through WICHE MHP at mentalhealthemail@wiche.edu or by calling 303-541-0311.
SAFE-T Pocket Card
This pocket card, designed by mental health experts for mental health professionals, provides a brief overview of conducting a suicide assessment using a five-step evaluation and triage plan. The website above will direct you to the SAMHSA Publications Ordering website where the card can be downloaded. Quantities of the SAFE-T cards are available for order through Screening for Mental Health, Inc. SAMHSA's suicide prevention app, Suicide Safe, was based on the SAFE-T card. More information about Suicide Safe is available here.
Safety Planning Guide
The pocket-sized safety planning guide reminds clinicians of the most important points to cover in collaboratively developing a safety plan with a patient. The guide was adapted from content developed by the Department of Veterans Affairs.
Patient Safety Plan Template
The Patient Safety Plan Template is filled out collaboratively by the clinician and the patient and then used independently by the patient to help ensure their safety in their day-to-day lives. The Safety Planning Guide (listed above) can be used as a source of questions to ask to facilitate development of the Safety Plan.
Crisis Support Plan
The Crisis Support Plan is used by the patient and the clinician to enlist social support from a trusted friend or relative should a suicide crisis recur. It explains roles that supportive individuals can take to help protect the
257
94

Problem #1

Your suicidal patients won't tell you that they are thinking of killing themselves unless you ask (occult suicide risk)

Traditional Method Of Assessing Risk

Columbia Suicide Severity Rating Scale

1. Suicidal Ideation
2. Suicidal Behavior

Protective Factors

Protective factors are personal or environmental characteristics that help protect people from suicide.

Major protective factors for suicide include:
Effective behavioral health care
Connectedness to individuals, family, community, and social institutions
Life skills (including problem solving skills and coping skills, ability to adapt to change)
Self-esteem and a sense of purpose or meaning in life
Cultural, religious, or personal beliefs that discourage suicide

Problem #2:

Patients that are at imminent risk for suicide often do not think of themselves as suicidal

These people have “implicit risk”

Predictive Validity of the Suicide Trigger Scale (STS-3) for Post-Discharge Suicide Attempt in High-Risk Psychiatric Inpatients

Igor I. Galynker

Suicide Crisis State

1. Frantic hopelessness
2. Ruminative Flooding

What Can You Do quick summary

- **More formal screening and assessment**
- **Look for the anxious, “trapped”, hopeless patient**
- **Have a picture in mind of the vulnerable patient**
- **Removal of lethal means**
- **Safety planning**
- **Caring contacts**