A SUICIDE PREVENTION TOOLKIT FOR RURAL PRIMARY CARE

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Toolkit Development

- 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?

- 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

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

Suicide Mortality
Rural vs. Urban by Gender

Suicide, by county

http://www.cdc.gov/ncipc/maps/default.htm

- Red  75th national percentile
- Blue  50th national percentile
- Gray  25th national percentile
- White <25th national percentile

Primary Care Suicide Prevention Model

Prevention
1. Staff vigilance for suicide warning signs & key risk factors
2. Universal depression/SA screening for adults and adolescents
3. Patient education:
   Safe firearm storage
   Suicide warning signs & 1-800-273-TALK (8255)

Intervention

Suicide warning signs, major depression, anxiety, SUD, insomnia, chronic pain, PTSD, TBI

Yes  No

Screen for presence of suicidal thoughts  No

Yes  No

Suicide Risk Assessment

Risk Management: referral, treatment initiation, safety planning, crisis support planning, documentation, tracking and follow up

No screening necessary

Rescreen periodically
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

- 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

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 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
1. Getting Started

Develop a referral network to facilitate the collaborative care of suicidal patients. Use the “Developing Mental Health Partnerships” materials in the Toolkit.

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.

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.

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...

1. Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).
2. Our nearest Emergency Department or psychiatric emergency center is __________________________.
   Phone # ____________________.
3. __________________________ 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 __________________________.
- __________________________ will follow up with ED to determine disposition of patient.
- __________________________ will follow up with patient within ____________________.

Office Protocol Development Guide

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

- 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

- 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

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

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.suicid.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
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

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

- **PHQ - 9**

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

2. Educating Staff

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

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).

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2. Educating Staff

**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.¹

**Key components of a suicide risk assessment**
1. Assess risk factors
2. Suicide Inquiry: thoughts/plans/intent/access to means
3. Assess protective factors
4. Clinical judgment
5. Document
2. Educating Staff

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.** 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

- 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

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](http://www.tmhguide.org)

Resources for
- Clinicians/Administrators
- Consumers
- Policymakers
- Community Members
- Media
3. MH Partners

- 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

**Suicide Risk and Protective Factors**

**RISK FACTORS**
- Current/past psychiatric disorders, especially mood disorders, psychotic disorders, alcohol/substance abuse, PTSD, PD, personality disorders (such as Bipolar PD, Antisocial PD, and Obsessive-Compulsive PD)
- Co-morbidity with other psychiatric or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anxiety, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, delusions, for children and adolescents, data on impulsivity 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.
- Prescriptions/stressors: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial, or health status — real or anticipated).
- Chronic medical illness (e.g., CNS disorders, pain).
- History of 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 support.
4. Patient Management—Pocket Guide

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Screening: uncovering suicidality
- Other people with similar problems sometimes have hopes, 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 intent
- What would it accomplish if you were to end your life?
- Do you feel as if you’re a burden to others?
- How significant are your feelings that your life would be better off without you?
- What have you done to begin to carry out the plan?
- For instance, have you obtained what you need (e.g., pills, a gun, food, the rope?)
- Have you made other preparations (e.g., updated your insurance, made arrangements for pets?)
- What makes you feel better (e.g., contact with family, a sense of usefulness)?
- 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 steps are you taking toward carrying out your plan?

Assess suicide ideation and plans
- Assess suicide ideation:
  - Frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (trauma, 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 the thoughts 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 need? Where is it? Right now?
- Do you have a timeline in mind for ending your life? Is there something (e.g., event) that would trigger the plan?

References:
1. SART: Pocket Card. Suicide Prevention Resource Center. Mental Health Screening. (n.d.)

4. Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

High Risk
- Patient has a serious plan with a preparatory action or threat of self-harm.
- Patient has a suicide plan with preparatory action or threat of self-harm.
- Patient has a suicide plan with preparatory action or threat of self-harm.
- Patient has a suicide plan with preparatory action or threat of self-harm.

Moderate Risk
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.

Low Risk
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.
- Patient has a suicide attempt, but no significant risk factors.

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Encourage social support, involving family members, close friends, and other community resources. If patient has hospital, call his/her in presence of patient.

Record risk assessments, collateral, and treatment plans in patient record. Complete billing forms, and continue to monitor patient status via repeat interviews, follow-up contacts, and community resources. Make continued referrals or managing care.
Exercise 1

- 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

- 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

- 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

- Management/co-management
  - Depression
  - Anxiety
  - Psychosocial-behavioral problems

- Encourage support network

- Safety planning

- Crisis support planning
4. Patient Management

- "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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**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
     - prescription & 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

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4. Patient Management - Tracking Log

- 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
### 5. Patient Education

#### Firearm Locking Devices

**Which one is right for you?**

**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:

- Acting strangely or engaging in risky activities—screaming 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

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

PTSD

- RESPECT-MIL--Re-Engineering Systems of Primary Care Treatment in the Military
- Screening for Depression and PTSD
Substance Abuse

Alcohol Screening and Brief Intervention
URL: http://www.apha.org/NR/rdonlyres/35FBB5EF-B4DE-4701-B528-022E0FC7F967/0/SIBMANUAL.pdf
A printable guide for public health practitioners produced by the American Public Health Association.

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://drugsabuse.gov/nalamed/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

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

Other Risk Factors

- 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
Questions?

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