



SUICIDE PREVENTION PRIMER



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Module 5 – Intervention

Taking appropriate action following a suicide risk assessment is critical and may save lives. The decision tree presented in the previous module will help determine appropriate interventions with potentially suicidal patients.

1. Referral

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

For patients in any risk category who are having significant thoughts of death or suicide, consider a referral for **individual or family therapy**. For all patients at increased risk, be sure to provide information about the **National Suicide Prevention Lifeline**, 1-800-273-TALK (8255). By calling the Lifeline, patients are connected to the nearest certified crisis center, usually within the state. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 rescue when indicated. The Lifeline offers free materials, including posters and pocket cards with the Lifeline number (www.suicidepreventionlifeline.org).

For patients in the high risk group who are an imminent danger to themselves, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily. **Locate specific information about your state's involuntary treatment laws** and have this in the office as well as contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area.

Criteria for involuntary commitment for 48-120 hours (depending on the state):

- ▶ Imminent danger to self or others
- ▶ Grave disability - Inability to provide for his/her own basic needs
- ▶ A psychiatric diagnosis (in most states)

Developing an office protocol for hospitalization

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

- ▶ What are the laws in your state regarding involuntary psychiatric admission?
- ▶ Where will all necessary forms for hospitalizing suicidal patients be kept? (It is assumed that the patient's provider will fill out all necessary papers for hospitalization.)
- ▶ What emergency department is nearest to your clinic/facility?
- ▶ What transportation options are available for transporting suicidal patients to the nearest emergency department?
- ▶ Is there a mental health provider in your area who can assist in an involuntary psychiatric admission? How can you contact him/her?

See the full "Office Protocol" worksheet in this toolkit for more information about developing a protocol for your clinic.

2. PCP Intervention

Primary care providers, especially in rural areas, are invaluable in the treatment of potentially suicidal patients. Important interventions that can be carried out in a primary care office include treatment of psychiatric symptoms, including depression and severe anxiety, strengthening the support network, developing a safety plan, and helping the patient practice coping strategies in the plan.

Depression treatment

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

Studies indicate that a small portion of children, adolescents, and young adults may experience an increase in suicidal thoughts upon introduction of an antidepressant medication (SSRIs); therefore, close monitoring of suicide risk during the first months of antidepressant treatment is essential. The United States Food and Drug Administration (FDA) requires that manufacturers of antidepressant medications include a Black Box Warning on prescription labels warning consumers that the use of antidepressant medications may increase the risk of suicidal thoughts and behaviors in individuals ages 24 years and younger. The FDA's labeling recommends that providers balance these risks against clinical need when considering the use of antidepressants in children.³⁵ **The general consensus of experts has been that the benefits of prescribing antidepressants to adolescents and young adults for treatment of depression far outweighs the risk of inducing suicidal thoughts.** Studies have found no evidence that antidepressants increase the risk of suicidal thinking in adults over age 24.³⁶

Encourage a support network

Helping patients to identify and utilize a support network is a key component of suicide prevention. Patients may need assistance with identifying the supportive individuals in their lives. Having a predetermined list of supportive individuals and their contact information will increase the likelihood that the patient will seek help before or during a crisis. The support network may include friends, family members, clergy/minister, co-workers, a therapist, primary care doctor, or a suicide prevention hotline. Encouraging the patient to utilize their support network even when they are not feeling suicidal can help reduce the number of suicidal crises they experience.



Safety Planning

A safety plan (also referred to as a “crisis response plan”) is developed *collaboratively* with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The plan is developed in six steps: ³⁷

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

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

- ▶ How do you feel in the hours or days before you first notice that you are feeling suicidal?
- ▶ What do you notice in your thoughts and feelings, or in your body?
- ▶ What are your triggers? What happens just before you start feeling or thinking this way?

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

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

activity, moving away from a stressor or stressful person, and distraction techniques. Some sample questions to get patients thinking about effective coping techniques are:

- ▶ What relaxes you?
- ▶ When was the last time you felt relaxed or peaceful? What were you doing?
- ▶ Are there any things that you do that help you take your mind off thinking about death and dying?
- ▶ Who do you spend time with that makes you feel good?

Once coping strategies are identified, they must be practiced. Practicing these strategies when the patient is calm helps make them more automatic for the patient and thus easier to employ when the patient is distressed.

The last step in safety planning addresses the issue of access to lethal means. This step is left for last because it is the hardest step for many patients, and perhaps the most critical. **The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will relinquish his or her access to lethal means.** If the patient has described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting) it is essential to inquire about whether those specific means are available and to eliminate access to them. Lethal means may include guns, ammunition, medications (prescription as well as over-the-counter), knives, razors, etc. It is important to help the patient identify whom they will entrust with these items until they can be safely returned. With the patient's permission, contact family members or other persons within the patient's support system in order to assist with limiting access.³⁸

As the plan is developed write each step on a paper the patient can take home. When it is clear the patient understands the plan, the patient should be able to commit to their clinician they will follow the plan, in sequence. **Rehearse with the patient how he/she will use the plan.** Where will the plan be kept? How will he/she know when to take the first step? What comes next? When implementing the plan, the patient builds coping skills and develops confidence that they can manage future crises when they occur. Patients should also have a supportive friend or family member who is aware that the patient is at risk for suicide and who is willing to help him or her follow the crisis plan. Both the patient and the support person should know the number for the Suicide Prevention Lifeline – 1-800-273-TALK (8255).

A **pocket card** developed by the Veterans Administration to guide the development of a safety plan is provided with this Toolkit and can be downloaded from the Department of Veterans Affairs at:

<http://www.mentalhealth.va.gov/College/suicide.asp>.

NOTE: No-suicide contracts have been found to be ineffective in preventing suicidal behavior.³⁹ It is more important to make a plan with your suicidal patients concerning what they *will* do in the event that they feel suicidal and are worried about their safety, rather than what they *won't* do.

3. Documentation and Follow-up Care

Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist). In the case of hospitalization, it will be necessary to provide this information to the admitting facility. Thorough documentation will help ensure that the patient receives appropriate referrals and follow up.

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

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