

Customized Information: Primary Care Providers

The Role of Primary Care Providers in Preventing Suicide

Recognizing the Warning Signs

Responding to the Warning Signs

Helping Yourself and Your Colleagues

References

Resources

- Primary Care Toolkit
- Resources for Primary Care Providers
- General Resources on Suicide and Suicide Prevention

I was seeing a new patient—a young woman presenting with symptoms of a urinary tract infection. I thought the visit would be fairly routine. But on entering the examination room, I noticed that the patient seemed almost overly alert. As I moved closer, I saw small reddened areas on her arm as though she had been scratched or cut. Her boyfriend sat silently next to her as, in response to my questions, she gave me a list of medications she was taking, both for her chronic back pain and her depression and anxiety.

The patient also detailed a long psychiatric history, as well as multiple hospitalizations for back pain. She could not remember the names of any of her previous doctors or her psychiatrist. Almost as an afterthought, she confided that she had tried to stab herself with a knife earlier in the day. Somehow her boyfriend had gotten the knife away from her. Her boyfriend calmly confirmed her story.

I thought that this situation was beyond my expertise. I suggested that it might be a good idea to call a mental health clinic for an evaluation. The patient immediately became agitated and started loudly accusing me of calling her “crazy.”

I didn't know what to do. I felt as though my suggestion had made things worse. I excused myself from the room to allow her to calm down and to consider my best course of action. Although I didn't have a complete picture of the patient, I thought that she might have some type of personality disorder. I found a chance to question the patient's boyfriend in private. He assured me that he had been through similar episodes with her and would not, under any circumstances, leave her alone that night. I gave him the number of the local suicide crisis line and the number of the closest mental health clinic. But I lost sleep that night. I wished I had been better prepared for this situation.

The Role of Primary Care Providers in Preventing Suicide

Since physical illness itself is a risk factor for suicide (Maris, Berman, & Silverman, 2000), primary care and other health care providers are highly likely to see patients who are depressed and may be at risk of suicide. Most people who take their lives signal their intention to do so before they act, and they often display these distress signals to their doctors. A substantial percentage of people who die by suicide have visited their primary care provider in the month prior to their suicide; this is especially true for of elderly people (Luoma, Martin & Pearson, 2002).

Successful intervention will depend on your ability to recognize the warning signs of suicide and to make sure that your patient receives immediate and appropriate care for what, after all, is a life-threatening condition. This document will provide you with an overview of some of the roles primary care providers can take to prevent suicide attempts. A comprehensive toolkit for primary care practices is available free online at www.sprc.org/pctoolkit/index.asp.

Prevention of Suicide Risk

There are four key roles primary care clinicians can play to lower the risk for suicide in all their patients. The first is to screen for and aggressively treat or refer for treatment major depressive disorders and substance (especially alcohol) abuse and dependence. The second is to assess and treat the health problems commonly seen in primary care practices that are key risk factors for suicide: insomnia, chronic pain, and severe anxiety disorders (including PTSD). The third is to provide education to all patients on the warning signs of suicide and provide them with the number for the National Suicide Prevention Lifeline (800) 273-TALK (8255). Finally, primary care practices should teach patients the benefits of safe firearm and ammunition storage practices. Explanations of these approaches and a list of related resources is provided in the Primary Care Suicide Prevention Toolkit referenced above.

Recognizing the Warning Signs

People who are in danger of harming themselves may try to reach out to their primary care providers—sometimes directly, sometimes indirectly. Rarely will patients immediately volunteer the information that they are thinking of harming themselves. Instead, they display any number of warning signs.

You should be alert for imminent warning signs that a patient may be at risk of suicide:

Strongest Warning Signs – Take Immediate Action to Protect Person: Full Risk Assessment Warranted

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself 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

Other warning signs of suicide (See *Responding to the Warning Signs*, below)

- Anxiety, agitation
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Purposelessness—no reason for living
- Hopelessness
- Withdrawing from friends, family and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes
- Feeling trapped - like there's no way out

These signs are especially critical if the patient has a history or current diagnosis of a psychiatric disorder (e.g., major depression, alcohol or drug abuse, bipolar disorder, or schizophrenia), a severe chronic illness (especially CNS disorders, including traumatic brain injury), and/or has recently experienced a personal event leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—whether real or anticipated).

People of different ages are at different levels of risk and display different types of warning signs.

Research indicates that many older adults who visited a primary care physician within a month of dying by suicide had an undiagnosed mental illness associated with suicide, such as depression or anxiety (Conwell, et al., 2000) or had a common medical condition associated with an increased risk of suicide, such as congestive heart failure, chronic obstructive lung disease, urinary incontinence, and moderate or severe pain (Juurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004). Providers should pay careful attention to elderly patients who are physically ill and socially isolated, particularly in the presence of any of the risk factors just listed.

Adolescents are also at an increased risk of suicidal behaviors, though their key risk factors and warning signs may be different than adults (Screening for Mental Health and Suicide Prevention Resource Center, 2009). Be alert for the following:

- Conduct problems (anti-social, aggression, impulsivity)
- Depression
- ADHD
- Volatile mood swings or sudden changes in their personality
- A sudden deterioration in their personal appearance
- Self-injury
- Increased risk taking behavior
- Eating disorders
- Gender or sexual orientation issues¹
- Family chaos
- History of physical or sexual abuse
- Romantic breakups

Recognizing the signs or risk is the first step in preventing suicide.

Responding to the Warning Signs

There are no hard and fast guidelines for determining a patient's risk of suicide. However, if there's a chance that your patient may be at risk, you can ask the sometimes difficult questions that will provide you with more evidence about his or her state of mind and intentions, for example:

- Do you ever wish you could go to sleep and never wake up?
- Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts?
- Are you thinking about killing yourself?

You should act immediately if you have any reason to believe that the patient is in imminent danger or poses a grave danger to him- or herself. Immediate action should also be taken when warning signs are combined with any of the following risk factors:

- Past incidents of suicidal behavior or self-harm
- A family history of suicide
- The patient's admission that he or she is seriously considering suicide or has a suicide plan

¹ For more information, see Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth.*

You can help protect a patient by doing the following:

- Referring the patient to a mental health professional who may be better able to evaluate the patient's risk and recommend treatment
- Being available to provide medical management of the patient's psychiatric symptoms in collaboration with a non-physician mental health professional
- Helping the patient's family, friends, and caregivers develop a plan so that someone knowledgeable of patient's situation can be with him or her at all times
- Helping the patient's family, friends, and caregivers make sure that lethal means, especially firearms and medications, are not available to the patient
- Hospitalizing the patient, if necessary

The use of medications (especially antidepressants) should always be considered when developing a comprehensive treatment plan for patients with a major depressive disorder, or patients who express suicidal ideation, intent, or plans. Antidepressants are effective in reducing the symptoms of depression, as well as other problems, including obsessive-compulsive disorders and panic disorders. The Food and Drug Administration has determined that there is some evidence for an association between the class of antidepressants known as "selective serotonin reuptake inhibitors" and the emergence of suicidal ideation, particularly in youths and young adults up to age 25².

Although this is a relatively rare occurrence, mental health professionals should carefully monitor the signs and symptoms of depression during the first few months of treatment with any antidepressant medication. Careful monitoring might include frequently contacting the client (in person or by telephone) to ask about suicidal thoughts, teaching the client's family and support network to monitor the emergence of suicidal ideation and behaviors, and providing emergency contact information, including the National Suicide Prevention Lifeline number, 1-800-273-TALK (8255).

If you have any suspicions that a patient is seriously considering harming him- or herself, speak with your patient honestly and non-judgmentally about their suicidal thoughts, let them know you care and that he or she is not alone-- you are there to help. Work to ensure that he or she will be adequately supported until a mental health professional can provide a thorough assessment. In some areas of the country, this can be accomplished by a mobile crisis team. In other areas, a staff person may have to accompany your patient to a nearby emergency room. A call to the National Suicide Prevention Lifeline (800-273-TALK [8255]) is another option, linking the patient with a trained crisis caller at a nearby certified crisis center. If the person is uncooperative, combative, or otherwise unwilling to seek help, and if you sense that the person is in acute danger, call 911. Tell the dispatcher that you are concerned that the person with you "is a danger to [him- or herself]" or "cannot take care of [him- or herself]." These key phrases will alert the dispatcher to locate immediate care for this person with the help of police. Do not hesitate to make such a call if you suspect that someone may be a danger to him- or herself. It could save that person's life.

You may determine that a patient needs an inpatient assessment or treatment. It is always preferable for patients to be active participants in the decision to be hospitalized—to voluntarily agree to be hospitalized and to "sign in" on their own, taking full responsibility for their decision and acknowledging the purpose of the hospitalization. If a patient is incapable of signing in voluntarily or refuses to do so, it will be necessary for you, ideally in collaboration with the patient's family, to initiate an involuntary commitment process. You should familiarize yourself with your state's policies about both voluntary and involuntary admission procedures.

² For more information, see <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273>

Responding to a health crisis in your office is never easy—a mental health crisis is no different. Having a plan already in place to handle mental health problems involving suicide risk before the crisis is the ideal.

You wouldn't wait until a patient presents with a myocardial infarction to develop an office protocol for cardiac emergencies; nor should you wait for a suicidal patient to develop a suicide crisis management plan. This plan may include arrangements for someone to remain at the side of the at-risk patient until family, friends, a mental health professional, a mobile crisis team or an ambulance arrives. It also should define confidentiality guidelines for the at-risk patient and specify local laws and procedures for involuntary commitment. Every primary care office should have a crisis intervention plan and should train its staff on the plan.

Helping Yourself and Your Colleagues

Along with recognizing warning signs in your patients, it is equally important to recognize warning signs among your colleagues and in yourself, and to take protective measures when necessary. Healthcare professionals are not immune to suicide. The culture in which they work and live often prohibits any complaints about the exhaustion and stress associated with long hours of work and minimal sleep. Grueling schedules coupled with the knowledge that a missed “cue” or clinical finding could lead to the illness, injury or death of a patient places a great deal of stress on clinicians. An American Foundation for Suicide Prevention consensus statement on depression and suicide among physicians (Center et al., 2003) cited a lack of attention in this area, and urged more attention be given to the treatment of depression and prevention of suicide among providers. The statement recommends a shift in professional attitudes and institutional policies—one that encourages healthcare professionals to seek help and obtain treatment for mental illnesses whenever they are present.

References

- Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., et al. (2003). Confronting depression and suicide in physicians: A consensus statement. *Journal of the American Medical Association, 289*(23), 3161–3166.
- Hamilton, N. G. (2000). Suicide prevention in primary care. Careful questioning, prompt treatment can save lives. *Postgraduate Medicine, 108*(6), 81–84, 87. Retrieved March 23, 2005, from http://www.postgradmed.com/issues/2000/11_00/hamilton.htm
- Juurlink, D. N., Herrmann, N., Szalai, J. P., Kopp, A., & Redelmeier, D. A. (2004). Medical illness and the risk of suicide in the elderly. *Archives of Internal Medicine, 164*(11), 1179–1184.
- Maris, R. W., Berman, A., & Silverman M. M. (Eds.). (2000). *Comprehensive textbook of suicidology*. New York: Guilford Press.

Resources

Primary Care Toolkit

Western Interstate Commission on Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) *Suicide Prevention Toolkit for Rural Primary Care: A Primer for Primary Care Providers*. Boulder, Colorado: Western Interstate Commission on Higher Education. <http://www.sprc.org/pctoolkit/index.asp>

Other Resources for Primary Care Providers

Online Resources

- American College of Emergency Physicians. (1997, reaffirmed 2001). *Civil commitment: ACEP policy statement*. Retrieved March 23, 2005, from <http://www.acep.org/webportal/PracticeResources/PolicyStatementsByCategory/MentalHealth/default.htm>
- Bronheim, H. E., Fulop, G., Kunkel, E. J., Muskin, P. R., Schindler B. A., Yates W. R., et al. (1998). The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. *Psychosomatics*, 39(4), S8–S30. Retrieved March 23, 2005, from <http://www.apm.org/prac-gui/psy39-s8.shtml>
- Frierson R. L., Melikian M., & Wadman, P. C. (2002). Principles of suicide risk assessment. How to interview depressed patients and tailor treatment. *Postgraduate Medicine*, 112(3), 65–66, 69–71. Retrieved March 23, 2005, from http://www.postgradmed.com/issues/2002/09_02/frierson4.htm
- Gliatto, M. F., & Rai, A. K. (1999). Evaluation and treatment of patients with suicidal ideation. *The American Family Physician*, 59(6), 1500–1506. Retrieved March 23, 2005, from <http://www.aafp.org/afp/990315ap/1500.html>
- Office of Quality and Performance, Veterans Health Administration. (2000). *Major Depressive Disorder (MOD) clinical practice guidelines: Module A. Primary Care*. Retrieved March 23, 2005, from http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm
These guidelines were developed for clinicians by the Department of Veterans Affairs and the Department of Defense. They draw heavily from the American Psychiatric Association and Agency for Health Care Policy and Research Clinical Practice Guideline No. 5: Depression in Primary Care. The guidelines include information on assessment and treatment of potentially suicidal patients, patient handouts on depression, and guidelines for treatment of depression.
- Quinnett, P. (2000) *Counseling suicidal people: A therapy of hope*. Spokane, WA: QPR Institute. Retrieved March 23, 2005, from <http://www.qprinstitute.com/>
This book was written for therapists, mental health workers, physicians, nurses, and others who are not clinical suicide counselors, but who might find themselves counseling people at risk of suicide. It provides tools and strategies for risk assessment and intervention.
- Screening for Mental Health and Suicide Prevention Resource Center. (2009) *SAFE-T Pocket card*. The SAFE-T card guides clinicians through five steps which address the patient's level of suicide risk and suggest appropriate interventions. The card lists key risk and protective factors that should be considered in the course of completing the five steps, and addresses both adult and adolescent populations http://www.sprc.org/library/safe_t_pcktrd_edc.pdf
- Sharp, L. K., & Lipsky, M. S. (2002). Screening for depression across the lifespan: A review of measures for use in primary care settings. *American Family Physician*, 66(6), 1001–1008. Retrieved March 23, 2005, from <http://www.aafp.org/afp/20020915/1001.html>
- Stovall, J., & Domino, F. J. (2003). Approaching the suicidal patient. *American Family Physician*, 68(9), 1814–1818. Retrieved March 23, 2005, from <http://www.aafp.org/afp/20031101/1814.html>

Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth*. Newton, MA: Education Development Center, Inc.
http://www.sprc.org/library/SPRC_LGBT_Youth.pdf

Books

Hawton, K., & Wan Heeringen, K. (Eds.). (2000). *International handbook of suicide and attempted suicide*. Chichester, UK: John Wiley and Sons.

Jacobs, D. (Ed.). (1999). *The Harvard Medical School guide to suicide assessment and intervention*. San Francisco: Jossey-Bass.

Rutz, W. (2001). The role of primary physicians in preventing suicide: Possibilities, short-comings, and the challenges in reaching male suicides. In D. Lester (Ed.), *Suicide prevention: Resources for the millennium* (pp. 173–188). Philadelphia: Brunner-Routledge.

Videos

American Foundation for Suicide Prevention & Kingsley Communications. (1999). *The suicidal patient: Assessment and care*. Available from the American Foundation for Suicide Prevention at <http://www.afsp.org/survivor/doctor.htm>.

General Resources on Suicide and Suicide Prevention

Suicide Prevention Resource Center (<http://www.sprc.org/>). The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and materials to strengthen suicide prevention efforts. Among the resources found on its website is the SPRC Library Catalog (<http://library.sprc.org/>), a searchable database containing a wealth of information on suicide and suicide prevention, including publications, peer-reviewed research studies, curricula, and web-based resources. Many of these items are available online.

American Association of Suicidology (<http://www.suicidology.org/>). The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. It promotes research, public awareness programs, public education, and training for professionals and volunteers and serves as a national clearinghouse for information on suicide.

American Foundation for Suicide Prevention (<http://www.afsp.org>). The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP's activities include supporting research projects; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of the problems of depression and suicide and the need for research, prevention, and treatment; and supporting programs for suicide survivor treatment, research, and education.

National Center for Injury Prevention and Control (<http://www.cdc.gov/ncipc/>). The National Center for Injury Prevention and Control (NCIPC), located at the Centers for Disease Control and Prevention, is a valuable source of information and statistics about suicide, suicide risk, and suicide prevention. To locate information on suicide and suicide prevention, visit <http://www.cdc.gov/ViolencePrevention/suicide/index.html> .

National Suicide Prevention Lifeline (<http://www.suicidepreventionlifeline.org/>). The National Suicide Prevention Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: (800) 273-TALK (8255). Technical assistance, training, and other resources are available to the crisis centers and mental health service providers that participate in the network of services linked to the National Suicide Prevention Lifeline.

Suicide Prevention Action Network USA (<http://www.spanusa.org>). Suicide Prevention Action Network USA (SPAN USA) serves as the public policy and advocacy division of the American Foundation for Suicide Prevention (AFSP). SPAN USA leverages grassroots support to advance public policies that help prevent suicide. The organization was created to raise awareness, build political will, and call for action with regard to creating, advancing, implementing and evaluating a national strategy to address suicide in the nation.