PRISM

Primary Care Suicide Prevention Protocol Development Guide

The Importance of Developing a Primary Care Suicide Prevention Protocol

Suicide is a leading cause of death, and roughly 50% of patients who complete suicide have been seen by a health care provider in the 8 weeks prior to their death. This places primary care providers in an important position to identify suicide risk and initiate effective intervention to prevent suicide.

This begins with primary care practices establishing a thoughtful, well-informed, and effective suicide prevention protocol within the primary care practice. To be successful, leadership must prioritize protocol development and roll out, including training providers and staff in suicide prevention, and engaging in process improvement as data becomes available.

This document was developed to assist primary care practices in mindfully developing a suicide prevention protocol.

Guiding Principles

1. ALL clinic staff are made aware of, and trained on, a clinic's suicide prevention protocol and their role in enacting it.
2. Whenever possible, involve the entire team in developing the protocol to ensure foreseeable challenges are addressed, staff are on board, and training needs are identified.
3. "Safety contracts" and "no-suicide contracts" are not effective and generally should not be used.
4. All expressed suicide risk is to be taken seriously, addressed, and assessed at the time of presentation.
5. Protocols effectively identify who will be responsible for each step by role, who the backup is, and how to navigate foreseeable barriers and circumstances.

Primary Care Suicide Prevention Protocol Elements:

1. Identification and Initial Screening
2. Engagement and Evaluation of Identified Risk
3. Determine Appropriate Response and Intervention
4. Follow up and Transition Support

Process Development Components

Identification and Initial Screening

Screening should be conducted routinely and whenever concern arises. For CoCM clinics, the PHQ-9 is administered routinely and question #9 asks about suicidal thoughts. A positive response to this item (anything other than zero) should prompt further assessment. The Columbia Suicide Severity Rating Scale (C-SSRS) can be used as an additional screening tool. Patients who are positive for more than two of the suicide ideation items on the C-SSRS, or who are positive for having made a recent suicide attempt, are considered at particularly increased risk, though any ideation should be assessed and monitored.

Any screening tool which inquires about suicidal ideation, plan, or intent should be reviewed prior to ending contact with the patient (in person or virtual).

Evaluating Identified Risk – Clinical Risk Assessment

If suicidal ideation, intent, or plan are endorsed/reported/suspected, a primary care or behavioral health clinician should initiate or arrange further clinical risk assessment.

Considerations

How quickly does the assessment need to occur?

a. Immediately
b. 24-72 hours
c. Follow up with mental health provider within 1-2 weeks

Who will conduct the clinical risk assessment?

a. PCP
b. Integrated Mental Health Provider or BHCM
c. Independent clinical provider (local ED, CMH, Crisis Center, etc.)

What is required for safety?

a. Does the patient require supervision while assessment arrangements are being made?
b. Does the patient require transport to another site for further assessment?

What is required for access?

a. Will this patient require consent from another person to legally access care?
b. Does this patient have financial and physical access to mental health services? (transportation, insurance, phone, computer access, stable address, etc.)

Patient Risk Assessment Components:

- Intensity/frequency of ideation itself
- Level of intent/planning
- Protective factors
- Hope
- Social support
- Reasons for living/not dying
- Sense of purpose or meaning in life
- Method
- Lethality (actual or believed)
- Method access

Other risk factors that may amplify risk:

- Recent loss
- Hopelessness
- Isolation
- History of family or acquaintance suicide attempt or completion

Appropriate Response and Intervention

Validated screening tools (such as the C-SSRS), when combined with clinical judgment, can help determine levels of risk and aid in making clinical decisions about care.

Risk Levels:

LOW RISK

Current wish to die or passive suicidal ideation without method, intent, or plan and with strong protective factors and no history of suicidal behaviors.

→ **Assist in securing mental health connection and/or provide bridge appointment in the interim if patient agrees.**

Optional Interventions:

- Safety plan with patient
- Notify PCP or specialty clinic referral source

MODERATE RISK

Current suicidal ideation with method, plan, or remote prior attempts but without intent or preparatory behavior.

→ **Consider immediate evaluation for hospitalization if risk factors outweigh protective factors**

→ **Construct a safety plan with patient**

Optional Interventions:

- Notify PCP or specialty clinic referral source

HIGH RISK

Suicidal ideation with intent, preparatory behavior, or recent attempt. **Make every attempt to not leave patient alone and to discourage patient from leaving.**

→ If patient appears to be violent toward self or others, enlist assistance (911, security, etc.)

→ Arrange for patient to be transported (EMS, local police, other responsible/able party) to nearest emergency facility or crisis center. If patient refuses emergent evaluation/care, contact authorities to escort patient to emergency

Follow up and Transition Support

Primary care clinic develops a clear plan on who will follow up on the referral, when the follow up is to occur, and how to communicate the referral status with the patient's primary care team.

For patients not admitted, follow up to ensure treatment recommendations are accessible and sought timely with risk level.

High Risk: urgent follow-up secured within 24 hours

Moderate Risk: appropriate services are secured within 2 weeks and follow-up and subsequent BH providers are aware of concerns

Low Risk: continue/ensure service provision as usual for their mental health concerns

For patients admitted to hospital-based care or day treatment care, the primary care clinic needs a clear plan on who will follow up with the patient upon discharge and how that will occur, be communicated, and documented to ensure access to follow up support and services.

Internal Support and Review

1. The clinic identifies team members to offer support and follow up with staff who may be impacted by a patient treated for suicide risk or one who dies by suicide.
2. Consideration may be given to holding debriefing huddles within 1-3 days post event to check in on how well the protocol worked, troubleshoot any concerns, and provide support as needed.

Resources:

1. The Columbia-Suicide Severity Rating Scale
2. Other Screening Tools
3. Safety Plan
4. AIMS Developing Protocols for Suicide Prevention in Primary Care Guidelines
5. Suicide Prevention Implementation Toolkit
6. Integrated Primary Care Suicide Prevention Resources
7. Suicide Care Implementation Tools (Bree)
8. Suicide Prevention in Healthcare Settings
9. Preventing Suicide: A Technical Package of Policy, Programs, and Practices