

Suicidal Ideation in the Family Medicine Clinic

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Case Objectives

- Recognize suicide as a major public health problem and the critical role of primary care in preventing suicide.
- Describe risk factors associated with increased risk of suicide.
- Be familiar with The Joint Commission recommendations regarding the management of suicide risk across health care settings.
- Understand how to assess suicide risk in the primary care setting and how to triage high-risk patients.
- Recognize the importance of a systems approach to suicide prevention.

The Case

A 20-year-old woman with bipolar disorder, borderline personality disorder, and a history of multiple inpatient psychiatric hospitalizations for prior suicide attempts called her primary care doctor's office at 10:30 AM stating that she had been "cutting her wrists" and had taken "extra doses of medication."

A front office staff member who did not have any clinical training answered the patient's phone call. He informed the patient that the next available appointment was at 3:00 PM that afternoon. The primary care doctor was not notified of the patient's behavior at the time of the phone call.

During the patient's office visit that afternoon, she was noted to have multiple cuts on both her wrists and stated that she "did not care" if she harmed herself. She stated that in addition to cutting herself, she had ingested several lithium pills. Recognizing that the patient was at high risk for suicide based on her behavior and medical history, the evaluating physician called security to escort the patient to the emergency department for a formal psychiatric assessment and inpatient admission. However, the patient was unintentionally left unattended for a brief period and eloped before providers could evaluate her.

The emergency department physician notified the local police who found the patient at her apartment later that evening. Luckily, she had not engaged in additional self-destructive behavior. She was brought back to

the emergency department and ultimately admitted to an inpatient psychiatry unit for further treatment.

The Commentary

by Christine Moutier, MD

Suicide is one of the world's leading preventable causes of death. In 1999, United States Surgeon General David Satcher drew attention to suicide as national public health crisis and called upon policy and community leaders, researchers, and health care systems to act to reduce the national suicide rates.⁽¹⁾ In 2002, the Institute of Medicine issued a similar call to action.⁽²⁾

Suicide prevention has traditionally been viewed as the primary responsibility of mental health providers. Unfortunately, many who might benefit from dedicated mental health treatment are unable to access it for at least two reasons. First, there remains a significant shortage of psychiatrists and other mental health professionals. Second, there continues to be significant stigma associated with seeking care from such providers, although thankfully this is diminishing. In fact, the majority of those who die by suicide have never seen a mental health professional (62%), but they do visit primary care, often in the weeks before death.⁽³⁾

Although the US Preventive Services Task Force deemed the evidence supporting screening for suicide risk insufficient in 2014 ⁽⁴⁾, 2 years later The Joint Commission issued Sentinel Event Alert 56 regarding the detection and care of suicide risk.⁽⁵⁾ In it, they recommend formal screening for suicide risk as well as a series of action steps for all health care settings ([Table 1](#)).⁽⁵⁾ This has prompted a newfound interest in suicide prevention and highlighted the need for training and implementation of care protocols in ambulatory settings.

This case presents a patient who is clearly at very high risk for suicide based on the presence of multiple risk factors, including self-harm behavior, history of suicide attempts, history of psychiatric hospitalizations, and concurrent diagnoses of bipolar disorder and borderline personality disorder. Primary care providers need to be able to quickly recognize the presence of suicide risk factors, including those that may be less readily apparent, such as a family history of psychiatric illness ([Table 2](#)). A rich body of research demonstrates that a diagnosable psychiatric condition contributes to death in more than 90% of suicide cases ⁽⁶⁾, but the condition had been untreated in about half of those cases. Thus, it is critical to routinely screen for mental health problems in the primary care setting. This can be accomplished by using validated instruments (such as the PHQ-9, a publicly available depression screening tool) ⁽⁷⁾ and by asking patients about changes in behavior, mood, and physical symptoms of depression.

This case represents a missed opportunity to provide high quality care to a patient at high risk for suicide. When the patient called the office and stated that she had cut her wrists and taken some pills, the staff member treated the call as routine and scheduled an appointment without recognizing the urgency of the situation. The reaction highlights the importance of training all staff, even nonclinical staff members, on the basics of suicide prevention, including the recognition of risk factors. Such brief education for nonclinical staff can be provided during a short training session and includes teaching on suicide risk factors, warning signs to watch for, and how to converse with suicidal individuals in a supportive manner.⁽⁸⁾ Longer

trainings, such as Mental Health First Aid, are also available and teach lay individuals how to recognize mental health issues and what to do to help.(9) In this case, the staff member should have had a clinician speak with the patient by phone immediately. If that was not possible, the staff member taking the call should have triaged the patient to the emergency department (ED) for emergent evaluation.

When the primary care physician eventually evaluated the patient, her decision to have the patient escorted to the ED by security was appropriate. However, the fact that the patient eloped reveals a major gap in care, in that this patient who warranted urgent psychiatric and medical evaluation lacked a failsafe plan for 1:1 observation until evaluation by an ED provider was possible. This highlights the critical need for protocols to safely transition high-risk patients between care settings and involves careful coordination among all providers to ensure safe handoffs. The details vary, but states have developed processes for holding patients involuntarily pending formal psychiatric evaluation if there is concern for "dangerousness to self."(10)

Determining a patient's current level of suicide risk and triaging the patient appropriately are two of the most challenging aspects of mental health care in any setting, but this can be particularly difficult in the ambulatory setting. The two levels of risk to be considered in outpatients are (i) acute risk and (ii) all other nonacute, lower levels of risk. An algorithm that is sometimes helpful in making this assessment is available: <https://www.sprc.org/settings/primary-care/toolkit>.(11,12) Importantly, suicidal ideation (defined as thinking about or considering suicide) by itself does not amount to acute risk. In fact, among primary care patients, 2%–3% report experiencing suicidal ideation in the preceding month. Although suicidal ideation indicates possible psychopathology and need for mental health treatment, its presence does not predict progression to suicide.(13)

However, suicidal ideation can evolve into a higher risk scenario. When a patient expresses intent and articulates a viable plan for lethal self-harm, that patient should be considered at acute and high risk for suicide. However, outside of this clearly defined scenario, there are many factors to consider in determining risk level. The most important thing to keep in mind is that suicide risk is highest when multiple risk factors coexist in one patient, such as the patient in this case. If a patient expresses suicidal thoughts but the nature of the intent and plan is not clear, asking about several other risk factors can be very helpful to appropriately determine risk and triage the patient accordingly. Key risk factors to be considered include: prior history of suicide attempt; family history of suicide or mental illness; the presence of agitation, anxiety, or insomnia; sense of being a burden; and the escalating use of alcohol or other substances. If the patient's suicidal ideation has been coming and going for some time with no prior history of attempt and no other risk factors, and protective factors such as a strong sense of connection to others are present, the patient is not likely to be at imminent risk of suicide. Because suicide risk is dynamic and may change over time, providers should document these findings in detail along with their rationale for risk determination at the time they assess the patient. In addition, documentation is closely examined if litigation ensues. Courts will usually respect a medical decision if a rationale that falls within a reasonable range of standard practice is documented, even if a bad outcome occurs.(14,15)

Sometimes providers "contract" with patients to ensure their safety by asking patients to promise that they won't self-harm and will follow up as planned at the next scheduled visit. There is no empirical evidence to support this practice of "contracting for safety." Moreover, it does not afford medicolegal protection in the

case of an adverse outcome.⁽¹⁶⁾ The current recommendation is to use a simple process referred to as *safety planning* (Table 3). Safety planning empowers patients to recognize their own triggers and warning signs. It involves developing a step-wise plan to remain safe and can be kept in writing or via mobile application.⁽¹⁷⁾ Safety planning can be facilitated by trained clinic staff in 10–20 minutes. It has been adopted in a wide variety of settings such as the Veterans Affairs, military bases, college campuses, and high schools.

Another best practice is counseling patients specifically on *lethal means*, methods for suicide with high fatality rates such as firearms, toxic chemicals, and medications.^(18,19) Providers should ask patients and involved family members if there are guns, weapons, dangerous medications, or other potential sources of lethal harm in the home environment. If the answer is yes, the provider should strongly advise the patient and family when possible that they be stored securely to further mitigate the risk of harm.

The electronic health record can play a key role in flagging patients who are at high suicide risk and facilitates tracking of missed appointments, unfilled medications, and dispensing of potentially lethal or harmful medications. A framework called Zero Suicide is one example of a comprehensive systems approach to mitigating suicide risk and involves implementing policies, training, and better care for patients at risk for suicide.⁽²⁰⁾ It was launched in 2012 by the Suicide Prevention Resource Center following the US Surgeon General's 2012 National Strategy for Suicide Prevention. It focuses on training, practice, and policy in order to better identify patients at risk for suicide, provide suicide-specific care, ensure closer follow-up, and track patient outcomes. It leverages the electronic health record by including suicide risk as part of the patient dashboard so that patients with particular levels of risk don't get lost to follow-up. This allows concerning events, such as missed appointments or refills, to be noted and communicated to the primary provider.

Many of the strategies described above are consistent with recommendations from The Joint Commission, the American Academy of Family Physicians, and the American Academy of Pediatrics.^(5,21,22) Mitigating suicide risk in ambulatory care is challenging. However, keeping patients safe is possible if ambulatory practices put systems in place to identify high-risk patients and triage them safely to the appropriate site of care.

Take-Home Points

- Triageing suicide risk is a common problem in primary care settings.
- All clinic staff should be trained to identify suicide risk factors and to appropriately triage high-risk patients.
- Determination of suicide risk involves assessing suicidal ideation, intent, planning, and access to lethal means, such as weapons and medications.
- Acutely high-risk patients warrant emergent psychiatric evaluation and possible hospitalization.
- The electronic health record can be leveraged to identify and monitor patients at risk for suicide.

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Faculty Disclosure: *Dr. Moutier has declared that neither she, nor any immediate members of her family, have a financial arrangement or other relationship with the manufacturers of any commercial products discussed in this continuing medical education activity. In addition, the commentary does not include information regarding investigational or off-label use of pharmaceutical products or medical devices.*

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Tables

Table 1. Joint Commission SEA 56 Recommendations for All Health Care Settings.(5)

1. Review each patient's history and family history for suicide risk factors
2. Use a standardized tool to screen all patients for deterioration in mental health and suicidal ideation (e.g., PHQ-9, ED-SAFE Screen)
3. Review these screening tool results before patient leaves appointment
4. For suicidal crisis, keep patient safe via 1:1 observation and emergent evaluation in ED or psychiatric unit

5. For lower risk states and for all patients with suicidal ideation:
 - a. Provide patient and family the National Suicide Prevention Lifeline: 1-800-273-TALK
 - b. Conduct safety planning
 - c. Restrict access to lethal means
 - d. Remember at subsequent visits to reevaluate suicide risk in an ongoing manner
 - e. Consider suicide-specific treatment interventions/referrals
 - f. Follow up closely
6. Educate all staff in patient care settings how to identify and respond to patients with suicidal ideation
7. Document decisions regarding detection, care and referral

Table 2. Risk Factors for Suicide.

Psychiatric condition (major depressive disorder, bipolar disorder, substance use disorder, borderline personality disorder, schizophrenia, posttraumatic stress disorder, anxiety disorder)

Prior suicide attempt

Family history of suicide

Family history of psychiatric condition

Chronic medical conditions/chronic pain

Childhood abuse

Recent stressful event, loss, shaming rejection, humiliating event

Suicide exposure (peer or celebrity)

Access to lethal means

Cognitive rigidity (perfectionistic, black or white thinking)

Feeling like a burden

Symptoms including agitation, hopelessness, insomnia, anxiety, command hallucinations

For youth: neglect, parental discord, rejection, LGBT, bullying

Table 3. Safety Planning Intervention.(23)

Patients (with doctor/staff/therapist/peer specialist) develop and document a stepped series of actions to prevent or abort crisis. Available as a printable plan or mobile application.

- Warning signs (thoughts, behaviors, situations)
- Internal coping mechanisms
- People/social settings that provide good distraction

- People whom I can ask for help
- Professionals/agencies I can contact during a crisis
- Making the environment safe

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