WELCOME TO THE 2ND ANNUAL
IDAHO INTEGRATED BEHAVIORAL HEALTH NETWORK
CONFERENCE
Team and Evidence-Based Strategies to Assess Suicide Risk with Opioid Use Disorders, SUDs, MH and Chronic Disease in Primary Care: Session I

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April 25, 2019
Faculty Disclosure

The presenter of this session has received consulting and training fees during the past 12 months.
Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Describe how to efficiently and accurately screen for and assess suicide risk and determine an appropriate disposition within a brief 20-minute primary care appointment.

2. Demonstrate your understanding and skill with suicidal patients in discussing ambivalence about living.

3. Assess the relevance of drug overdose (accidental and intentional) as it pertains to the suicidal patient’s clinical presentation.


5. Explain the roles of all primary care team members who can collaborate to address suicide in PCMH and reverse integration settings.
Bibliography / Reference


Bibliography / Reference


Brief Overview

- Important Concepts in Contemporary Suicidology
- Collaborative and Team-Based Approaches
- Assessment
- Interventions

Why spend so much time discussing assessment?
Basic Suicide Risk Assessment: Part One
The Bad News About Risk Prediction

According to a recent meta-analysis, considering the last 50 years of research, our ability to predict suicide is generally poor (Franklin et al., 2017).
Take Your Best Shot

So, what do we do?
Predispositions
- Prior suicide attempts
- Abuse history
- Impulsivity
- Genetic vulnerabilities

Behavior
- Substance abuse
- Social withdrawal
- Non-suicidal self-injury
- Rehearsal behaviors

Trigger
- Job loss
- Relationship problem
- Financial stress
- Life transitions

Cognition
- “I’m a terrible person.”
- “I’m a burden on others.”
- “I can never be forgiven.”
- “I can’t take this anymore.”
- “Things will never get better.”

Emotion
- Shame
- Guilt
- Anger
- Anxiety
- Depression

Physiology
- Agitation
- Sleep disturbance
- Concentration problems
- Physical pain
Video: Lifelong Struggle

https://www.youtube.com/watch?v=yg5Z-8FWEYE
Observations

1. How did her affect change overtime?

2. What did you observe of her (apparent) cognitive process and speech/language as the video played on?

3. What increased or decreased as the video progressed?
Barriers to Accessing MH Care

#1 reported reason patients do not access specialty MH treatment:

“I don’t need it”

Of those patients who **do** believe they need treatment, 72.1% would prefer to do it on their own

(Keesler et al., 2001)
Barriers to Accessing MH Care

Additional barriers to accessing specialty MH treatment:

Uncertainty about how to access services

Time constraints

Inability to afford services

Not enough MH providers

Economic limitations

(transportation, unemployment, housing instability, etc)
Typical Primary Care Appointment

Patient presentation
(Symptoms, signs)

PCP exam

PCP orders tests, labs, etc.

PCP refers to specialist when needed

PCP provides intervention

Follow-up plan
Typical PC Appt for Suicide Risk

Patient presentation (Suicidal)

Follow-up plan
PCP provides intervention
PCP refers to specialist when needed
PCP exam
PCP orders tests, labs, etc.
PCP provides intervention
How Does this Change in the Presence of the Following?

Opioid Use Disorders
Substance Use Disorders (SUDs)
Mental Health (MH)
Chronic Disease
Challenges in Managing Suicide

- PCP seeks to turn over complete responsibility for managing high-risk patients to BH provider
  - In some cases, this could violate practice standards

- Over-responding to suicidal patients
  - Mistaken assumption that hospitalization is “gold standard” treatment for suicide risk
Limitations of Psychiatric Hospitalization

Psychiatric Hospitalization is not the “Gold Standard” for treatment

➔ Many clinicians assume that hospitalizing suicidal clients actually treats the suicidal symptoms. In most cases it doesn’t, it simply removes the clients’ opportunities and means to attempt suicide.

➔ This may be why the postdischarge suicide rate is approximately 100 times the global suicide rate during the first 3 months after discharge and patients admitted with suicidal thoughts or behaviors have rates near 200 times the global rate upon discharge (Chung et al., 2017)

➔ Therefore, it is incumbent on us - the outpatient medical community to more fully and accurately address the suicide
Some Benefits of Hospitalization

https://www.youtube.com/watch?v=NHHPNMIK-fY
Flappy Feet 3 years ago
being in a mental hospital seems easier to me right now because it means I no longer have to disappoint.

Nirali Tanna 2 years ago
Life is beautiful, life is brutal.
If you are alive, you are still invited.
By far the best I ever heard.

Monique Meneses 2 years ago
simply one of the best ted talks

MandiMal Games 2 years ago
I've been out of the hospital for a month and a half now and I miss it because just like she said, in there, there is no more hiding, I could just be my broken self and it was okay. Every one else was broken too so we all understood each other. Out here I just feel too overwhelmed to carry on.

Paula Nowak 4 years ago
A lovely delivery of her talk. She's real. Really grabbed my attention from the moment she started.

Bruce Finnie 4 years ago
OMG This woman really knows what she's talking about. Brilliant video.
Cool Cat 2 years ago
I've been to a mental hospital myself. There's a lot of mixed feelings but I can say the patients there were I only knew for 5 days were the best people I had ever met. We were a family I would only greet and say goodbye forever.

View 2 replies ▼

Nadine Sara 2 years ago
This is one of the most wonderful talks I've heard in a while.

View 7 replies ▼

Mark Forquer 5 years ago
Spoke right to my own heart.

View reply ▼

Andromeda Lasso 4 years ago
Haven't said this to anyone in about 7 years but- you go girl.

Akhya Sinha 3 years ago
I'm tired of showing up.

View reply ▼

Joseph Sanchez 4 years ago
If any of haters you had an ounce of the courage this women has shown in revealing herself to us your friends and relatives would suddenly balk in confusion of who you are. To the haters ... you should be ashamed of yourselves. How dare you. How dare you.

Insensitive people who don't have an intimate relationship with pain have no place speaking here. Yes. We hurt. We hurt so bad, and we learn to survive. If Read more
Should We Screen for Suicide Screening in Primary Care?

▪ Only 17% of pts endorsing SI on paper-and-pencil screeners disclosed SI to PCPs during medical appt (Bryan et al, 2008)

▪ 6.6% of depressed pts endorsed SI/DI on PHQ-9 (Corson et al., 2004)
  ▪ 35% of positive screens had SI
  ▪ 20% of positive screens had plan

▪ USPSTF found inadequate evidence about the costs and the benefits of routine screening in primary care (O’Connor, Gaynes, Burda, Williams C, Whitlock, 2013)
Prevalence Rates

- Prevalence rate for suicidal ideation and suicidal behaviors in general medical settings = 2 to 5% (Cooper-Patrick, Crum, & Ford, 1994; Olfson et al, 1996; Pfaff & Almeida, 2005; Zimmerman, et al., 1995)

- It remains one of the top ten causes of death in America among adults. (31K per year; Hoyert, Heron, Murphy, & Kung, 2006)

- Among children and adolescents ages 10-18, it remains the #2 cause of death (Centers for Disease Control, 2016)

- For PC patients referred to integrated BH provider, prevalence = 12.4% (Bryan et al, 2008)
Suicide in Primary Care

- Suicidal patients report poorer health and visit medical providers more often (Goldney et al, 2001)
  - Greater levels of bodily pain
  - Lower energy
  - More physical limitations

- Medical visits increase in frequency in weeks preceding death by suicide (Juurink et al, 2004)
  - Up to 3 visits per month for suicidal patients
Suicide in Primary Care

- Estimated 1-10% of PC patients experience suicidal symptoms at any given time

- Of individuals who die by suicide:
  - 45% visit PCP within one month (Luoma, Martin, & Pearson, 2002)
  - 20% visit PCP within 24 hrs (Pirkis & Burgess, 1998)
  - 73% of the elderly visit w/in 1 month (Juurlink et al., 2004)
Primary Care is a Critical Window of Opportunity

Top 5 chief complaints by patients during the visits immediately preceding their suicides:

- Anxiety
- Unspecified gastrointestinal symptoms
- Unexplained cardiac symptoms
- Depression
- Hypertension
Other Problems

- GPs noted suicide risk in only 3% of patients who died by suicide (Appleby et al, 1996)

- Nonpsychiatric providers less likely to ask about suicide, and pts are less likely to endorse SI (Coombs et al, 1992)

- Suicidal pts much less likely to communicate suicide risk to nonpsychiatric providers than MH providers (Isometsa et al, 1994)
Why Do We Choose to Address Suicide in Primary Care?

1. Suicidal patients simply “go to the doctor” when they’re not feeling well
2. The first stop is almost always primary care
3. Suicidal patients continue to access PC services for health-related problems
4. The investment is worthwhile considering the cost…what other fatal condition can be mitigated so inexpensively?
Why Do We Choose to Address Suicide in Primary Care?

“But I am too busy managing the other hundred problems my patients have.”
Suicide?

...in Idaho?
Individuals often address multiple issues during their ‘contacts’ (calls, texts or chats) with the hotline. The following reports the number of individuals who reported these categories of issues during their contacts with ISPH:

**4th Quarter 2018 - Identified Issues for Contacts**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide*</td>
<td>1,730</td>
</tr>
<tr>
<td>Self Reported Mental Health Issues</td>
<td>991</td>
</tr>
<tr>
<td>Interpersonal Conflicts</td>
<td>799</td>
</tr>
<tr>
<td>Self Reported Addiction</td>
<td>256</td>
</tr>
<tr>
<td>Financial</td>
<td>240</td>
</tr>
<tr>
<td>Physical Health</td>
<td>175</td>
</tr>
<tr>
<td>Crime Victim Issues</td>
<td>125</td>
</tr>
<tr>
<td>Criminal Justice System Concerns</td>
<td>75</td>
</tr>
</tbody>
</table>

*As part of our commitment to preventing suicide, and per Lifeline network protocols, we endeavor to ask every caller about suicide. The actual number of contacts where suicide was asked or addressed during Q4 2018 was 2,851. Those individuals assessed to be “Not Suicidal” or for whom we could not determine a connection to suicide, were removed from this total.
<table>
<thead>
<tr>
<th>Disposition *</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>911 Dispatched - Rescue / Welfare Check at caller’s request and/or with consent</td>
<td>18</td>
<td>16</td>
<td>20</td>
<td>28</td>
<td>82</td>
</tr>
<tr>
<td>911 Dispatched - Rescue/Welfare Check without caller’s knowledge and/or consent</td>
<td>28</td>
<td>20</td>
<td>36</td>
<td>36</td>
<td>120</td>
</tr>
<tr>
<td>Caller agreed to go to the hospital</td>
<td>14</td>
<td>20</td>
<td>16</td>
<td>19</td>
<td>69</td>
</tr>
<tr>
<td>Caller agreed to go to or accepted referral to local Crisis Center</td>
<td>124</td>
<td>152</td>
<td>212</td>
<td>428</td>
<td>916</td>
</tr>
<tr>
<td>Created Safety Plan with Caller</td>
<td>728</td>
<td>761</td>
<td>791</td>
<td>868</td>
<td>3,148</td>
</tr>
<tr>
<td>Created Safety Plan with 3rd Party Caller</td>
<td>177</td>
<td>211</td>
<td>230</td>
<td>256</td>
<td>874</td>
</tr>
<tr>
<td>Made Contact with Person at Risk</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>Information / Referral</td>
<td>98</td>
<td>148</td>
<td>173</td>
<td>105</td>
<td>524</td>
</tr>
<tr>
<td>Support + Referral</td>
<td>206</td>
<td>348</td>
<td>354</td>
<td>309</td>
<td>1,217</td>
</tr>
<tr>
<td>Support Only</td>
<td>988</td>
<td>1,043</td>
<td>1,353</td>
<td>1,292</td>
<td>4,676</td>
</tr>
</tbody>
</table>

*Based on available data gathered by Responders; not all contacts require that a disposition be entered, and not all outcomes are always entered.

Community Partnerships Contacts for October-December 2018
Any Benefits to Improving this Continuum of Care?

How many psychiatric hospitalizations/year occur from:
- From your Emergency Department/s?
- From the community, delivered to the ED by your First Responders?

How much time, manpower and money does this cost?

**KNOWN COSTS:** $950/call and $17 per mile
- 20 miles per call x $17 = $340 per call
- $950 + $340 = $1,290 per call
- $1,290 x 202 calls = $260,580/yr...just for transportation from hotline to ED

How effectively (including cost effectiveness) do outpatient community mental health providers manage suicidal patients?
Studies have found that less than half of behavioral health professionals receive formal training in suicide risk management in graduate school and the average total duration of formal suicide management training is under 2 hours in duration (Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Guy, Brown & Poelstra, 1990).

Even worse, 90% of people who die by suicide had a psychiatric condition at the time of their death (Maris, Berman, & Silverman, 2000). This means 90% are likely to be under our care.


A Common Miscalculation Systems Make

“We just need to pay for more inpatient beds to handle the volume of at-risk patients.”

(“at risk” includes SPMI, SUDs, OUDs and suicidal patients)

How many patients did the crisis line help and then refer to IBH in a local primary care clinic?
How many patients in Idaho reported SI in primary care in 2018?
Measurement/Surveillance is critical to accurate calculation...and solution development.
Start more conversations locally by asking the “hard questions.”

kentcorso@gmail.com
Sound Bytes

“If you’re still alive, you’re still invited.”

“Show up”

“Do the next right thing”

“...even when you’re scared/shaking.”

“Getting sober...it gets a helluva lot worse before it gets better...”

“What I learned is that sitting with the pain and the joy of being a human being, while refusing to run for any exits is the ONLY way to become a human being”
Knowledge Probe #1

Skills she learned?

Location in which she learned them?

Has she developed any new meaning or purpose in life?
The Importance of Fluid Vulnerability Theory

Suicide risk is actually comprised of two dimensions:

1. **Baseline**: Individual’s “set point” for suicide risk, comprised of static risk factors and predispositions

2. **Acute**: Individual’s short-term or current risk, based on presence of aggravating variables and protective factors
Implications for Care

Suicide risk fluctuates over time from moment to moment, & can re-emerge after resolution

In PC, there is no such thing as a “closed case”

Multiple attempters especially will require ongoing monitoring, preventive interventions
Video: Losing Loved Ones

https://www.youtube.com/watch?v=Jjh1W_TbUNY
Fluid Vulnerability? Risk Type?

jammal akhtar 3 hours ago
Funny in my family they would not care and if they did it would to make themselves feel better the fact they care

anna m 8 hours ago
My grandmother killed herself when I was 12. It really feels like a lot of things ended there. My relationships with other family members, my confidence, my mental health, my childhood. Suicide hurts, it really really hurts.

MSM The Instrumenteuse 13 hours ago
I'm fighting it all, not myself, but my rain clouds, but not not physically, I'm fighting it with comfort, soon it will be a rainbow...

White Dreamer 13 hours ago (edited)
As strange as it looks like I felt deeply sorry for the woman who attacked YouTube's office and subsequently killed herself. Obviously I don't approve of her violence but I saw hundreds of people who were bullying her on Instagram. People told her to kill herself everyday. I knew her tbh and although she was mentally sick I do miss her weird posts! She was kind but her lack of social skills made her look like a weirdo. Ironically she got millions of views after attacking Read more

Lalania Hernandez 16 hours ago
Just lost someone from suicide December 2017 so many questions

Kater Potater 1 day ago
Listening to these stories still doesn't convince me that things would be any worse if I left.
Everyone’s Shared Role in Managing Suicide Risk

Understanding suicide risk from a chronic disease management model

- Suicide risk can be chronic, with periods of acute worsening/exacerbation
- Suicide risk tends to be progressive over time
- Role of primary care is to maintain improvement between acute episodes and prevent relapse
Don’t JUST Screen

Screening alone will not significantly lower suicide rates until it occurs within a well-integrated system that facilitates timely referral to more intensive mental health services for those patients who need them (Bostwick & Rackley, 2012)
Everyone’s Shared Role in Managing Suicide Risk

Patient-level (direct) impact on suicide risk
- Direct patient care with patients, especially those at elevated risk for suicide

Population-level (indirect) impact on suicide risk
- Reducing risk factors and enhancing protective factors through high volume, low intensity strategies
- Regular consultation and feedback to PCPs that alters their practice patterns in desired ways
Rolls
## Roles

<table>
<thead>
<tr>
<th>Staff Member</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>Identify, refer, warm handoff, manage medication</td>
</tr>
<tr>
<td>Nurse</td>
<td>Identify, refer, coordinate care, communicate</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>Identify, refer, coordinate care, communicate</td>
</tr>
<tr>
<td>BH Provider</td>
<td>Identify, assess and reduce risk, determine disposition, make recommendations to staff, <em>provide treatment</em></td>
</tr>
</tbody>
</table>

*The type of treatment delivered depends on the setting and integration model.*
What is the Specialty MH Provider’s Role?

Identify, assess and reduce risk, determine disposition, make recommendations to staff, provide treatment

...does this sound familiar?
Role of Nurses and Medical Assistants

- Screening for suicidal symptoms
- Care coordination and facilitation of disposition

(Bryan & Corso, 2014)
Role of PCP

- Follow-up assessment and risk determination
- Warm hand-off
- Medication management

(Bryan & Corso, 2014)
Role of BHC

- Integration of MH into primary care is practical and effective approach
- Risk assessment primarily
- Additional management interventions if needed
- Transition/bridge to specialty MH services

(Bryan & Corso, 2014)
Take a Break

Stretch!
Video: Social Media

https://www.youtube.com/watch?v=S8bJ3YIgL1Q&t=181s

Stop around 5:00
“But when my student got the letter, it wasn’t the reaction I expected. She cried...she didn’t think someone would say such nice things about her...and that no one would miss her when she was gone...”
Sarah Bobs 6 months ago
If we teens actually were listened to maybe it would change. When we tell you I’m stressed out I’m not coping’ the words ‘ooh wait until you get to my age’ won’t help. When we say ‘I’m sad’ we don’t want ‘ahh cheer up your only young’. We tell you this, we try and try to tell you but adults sometimes just can’t and won’t listen. No one understands

Arianna Heart 6 months ago
My science teacher recently said “Nothing is more important than your grades.”

Not long after that, my woodshop teacher said “Your wellbeing and your safety will never be worth any kind of grade, I’m not just talking about this class, and I want you to remember that you’re more important.”

Marina Mansfield 2 months ago
Can we just agree that our school system is set up in a way that mental health isn’t even really considered as a factor

spidermanfan 1 year ago
In 7th grade I once wrote a suicide note in class and tore it up by the end of class only to have someone find it and give it to the teacher who gave it to the principal, so I had to sit in the principals office with him and my teacher and my abusive mother all demanding to know why on earth I would want to kill myself.

Jane Wyatt 1 year ago
It pisses me off that there’s usually no signs and all my signs were completely ignored until I almost died. It just makes me think how many people are going through it all alone
Knowledge Probe #

Skills children tell us they need to learn?

Location/s where they can best learn them?

How do children without a sense of meaning or purpose in life fair?
Reactions and Conclusions?

The Most Critical Roles Needed?

The Appropriate Role for Outpatient MH (including IBH)?

The Appropriate Role for Inpatient MH (Psychiatric hospitalization)?

The Appropriate Patients for Inpatient MH (Psychiatric hospitalization)?
What do We Know about Idaho Culture?

How does this inform us of the potential REASONS for higher suicide rates in Idaho?

What does this suggest are the most helpful solutions for Idahoans?
Relationships Between Suicide and Overdose
Prevalence

- In 2016, there were 42,000 opioid overdose fatalities, including an unknown number of suicides (CDC, 2017).
- There were 44,965 suicides in the United States in 2016 – 15% by drug overdose (CDC, 2017).
Prevalence

- The proportion of suicides by opioid overdose increased from 2.2% to 4.3% between 1999 and 2014, with the highest change occurring among people 45 to 64 years of age (Braden et al., 2017).

- Among those who died from an overdose of an illicit drug (including opioids), the rate of intentional overdose (suicide) increased by 61% in urban areas and 84% in nonurban areas between 1999 and 2015 (Mack et al., 2017).
Comorbidity between SUDs and Suicide

- Substances as a *means* of ending one’s life is different than comorbid substance use disorders and suicide.

How?
A Mindful Approach to Practice

- We can’t assume suicide *means* = SUDs
- Not all suicide occurs in the context of depression
- We must be careful concluding that an overdose is a suicide attempt
  - How can we distinguish between the two?
Why is the Overdose Prevalence So High?

- Is it just like the risk associated with using other substances?
- Is there a dose-response relationship between opioid dose and increased risk of overdose?
- Is there a relationship between pain severity and suicide risk that is related to the dose relationship?
- What do we know about lethality of “means” and likelihood of suicide?

(Ilgen et al., 2016)
Why is the Overdose Prevalence so High?

BOTTOM LINE
It’s complicated and not simply as straightforward as increased access to opioids = increased access to a highly lethal means of suicide.

(Ilgen et al., 2016)
Why Does it Happen at All?

- Pain variables
- Medical System factors
- Macro Economics
- Intent
- Shared Risk Factors
Pain Variables

- Pain causes alterations in the neurocircuitry related to reward, which result in vulnerability to suicide (Elman et al., 2013).

- The link between pain and suicide is only partially explained by mental health comorbidity (Ilgen et al., 2013).

- Pain is associated with overdose risk, and mediated by quantity prescribed (but no relationship between quantity and suicide risk; Bohnert et al., 2011).
Medical System Factors

- Pain as “The 5th Vital Sign” (Trescot et al., 2008)
  - What is the effect of increased screening...and reporting?

- Average opioid dose in the United States increased from ~ 100 to ~ 700 morphine mg equivalent pppy between 1997 and 2007 (Paulozzi et al., 2011)

- Only recently was the link between overdose and suicide identified (Oquendo & Volkow, 2018)
Macro Economics

- Like other drug epidemics, increased availability of opioids (i.e., supply) have driven and increase in use (i.e., demand)

- Opioid use within and outside of pain treatment is one method people cope with hardship or adversity; social determinants of health and economic struggles are related.
  - Using substances to cope may lead to other mental health problems
  - Hardship may lead to depression, when coping with substances coincides, risk for suicide increases...a cycle is created (Ilgen et al., 2019)
Intent

- Intentional overdose is just one type of suicide (Oquendo & Volkow, 2018)
  - But only 1/3 of intentional overdoses include a suicide note (Rockett et al., 2018)
  - And, there are unintentional overdoses (Ilgen et al., 2019)
- There are also unintentional suicides...making it tricky to understand intent - even patients sometimes don’t clearly understand it (Bohnert et al., 2018)
Shared Risk Factors

- Demographics (age, gender, race)
- Mental Health history
- SUDs
- Medications

...knowing these have not yet helped us interrupt or sustain a decreased suicide rate at a population level
What Percentage of MH Patients Experience Suicidal Symptoms?

Prevalence rate for suicidal ideation and suicidal behaviors in general medical settings = 2 to 5%

(Cooper-Patrick, Crum, & Ford, 1994; Olfson et al, 1996; Pfaff & Almeida, 2005; Zimmerman, et al., 1995)

For PC patients prescribed psychotropic medication, prevalence = 22%

(Verger et al., 2007)
What Can We Do?

- Increase research, policy and program development

- Address shared risk factors and interventions
  - Use motivational interviewing, SBIRT and substance treatment for SUDs
  - Use cognitive behavioral therapy and medications per the literature for mental health conditions
  - Use evidence based assessment (including risk assessment) strategies (Ilgen et al., 2019)
<table>
<thead>
<tr>
<th>Goal and Intervention</th>
<th>Population, Defined According to Level of Opioid Exposure and Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-Risk Regimen of Prescription Opioids</td>
</tr>
<tr>
<td><strong>Identifying who is at risk for suicide and overdose</strong></td>
<td></td>
</tr>
<tr>
<td>Determination of risk score on basis of medical record</td>
<td>+</td>
</tr>
<tr>
<td>Assumption that high level of opioid exposure and misuse puts the patient at risk</td>
<td>+</td>
</tr>
<tr>
<td><strong>Preventing suicide or overdose among those identified as being at risk</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment for mental health conditions, when present</td>
<td>+</td>
</tr>
<tr>
<td>Cognitive behavioral therapy for suicide risk and motivational interviewing for overdose risk*</td>
<td></td>
</tr>
<tr>
<td>Patient-centered taper of opioid dosage†</td>
<td>+</td>
</tr>
<tr>
<td>Overdose education and naloxone distribution*</td>
<td>+</td>
</tr>
<tr>
<td>Medication-assisted treatment‡</td>
<td></td>
</tr>
</tbody>
</table>

* Although these interventions would ideally be available to all persons identified as having any risk of suicide or unintentional overdose, resource constraints are likely to preclude this approach. Given that these approaches can address risks specifically related to opioid use, they should be prioritized for those with riskier levels of use.

† Patient-centered tapering is based on an evaluation of the risks and benefits for a specific patient, at a reasonably slow pace of dosage reduction and with the patient’s engagement in the treatment decision making.

‡ Treatments include methadone, buprenorphine–naloxone, and naltrexone.
Knowledge Probe #3

How Do our Roles Change in the Presence of the Following?

- Opioid Use Disorders (OUDs)
- Substance Use Disorders (SUDs)
- Mental Health (MH)
- Chronic Disease
For BHCs...

- Triage
- Risk assessment
- Identify acute “flare-ups” and refer to specialty MH, SUDs treatment (e.g., use SBIRT)
- Manage baseline risk between flare-ups
- Collaborate with PC team members
For Specialty MH Providers...

- Risk assessment
- Treat suicidal symptoms (e.g., the “Suicide Mode”)
- Manage and treat acute “flare-ups” and refer for SUDs treatment as needed
- Collaborate with PC team members and psychotropic prescriber (e.g., suboxone)
Talking the Talk and Walking the Walk

"Do you give only 'lip service' when you commit?"

I really don't care what you say. I just want to see you drink that.

I'm young.

hyp. o. crite (hip/ə krit)

Function: noun

Meaning:
1. a person who puts on a false appearance of virtue or religion
2. a person who acts in contradiction to his or her stated beliefs or feelings

If you don't walk the walk, it's probably best not to talk the talk.
"I got very angry when they kept asking me if I would do it again. They were not interested in my feelings. Life is not such a matter-of-fact thing and, if I was honest, I could not say if I would do it again or not. What was clear to me was that I could not trust any of these doctors enough to really talk openly about myself."
A Collaborative Approach

Traditional approach to mental illness & suicide

Reductionistic
Suicide as a symptom of mental illness
Directive
“Expert” clinician who actively provides treatment to a passive recipient

(Jobes, 2006)
A Collaborative Approach

Collaborative approach to mental illness & suicide

Suicide is a problem distinct from mental illness

Patient is the expert of their own suicidal experience

Clinician works alongside the patient to view suicide through the eyes of the patient
A Collaborative Approach

Critical communications:
• Reinforce help-seeking behaviors
• Ending patient’s distress is most important goal
  • Emotional regulation
  • Distress tolerance
  • Adaptive coping (i.e., crisis response plan)
• Protecting safety is essential
  • Means restriction
  • Involving others
• Communicating to patient that help is available, and it works (instill hope)
Don’t try to talk the patient out of killing themselves
A Collaborative Approach

Respect the patient’s autonomy and ability to kill themselves

Don’t moralize

Avoid power struggles about options that limit the patient’s autonomy

Recognize that suicidality is marked by ambivalence...address this head-on
Acknowledging Ambivalence

If a suicidal patient is talking with you, there is a part of them that wants to live, even if only a little bit.

The patient is suicidal because they don’t know how else to alleviate their suffering, not because they actually want to die.

It is one solution in the patient’s problem-solving repertoire.
Challenges to Addressing Suicide

- Unpredictability/Volatility
- Time
- Trust
- Anxiety (…our own)
- Training
- Liability
- Paternalism/Maternalism
- Our perceived responsibility...what’s our responsibility?
- Low base rate
  - Challenges to researching it
Standard of Care

A legal concept defined by statutes that vary by jurisdiction, established by experts who retrospectively judge whether

- a given event of interest (e.g., suicide) was foreseeable
- the clinician provided reasonable care (Berman, 2006)

→ What yardstick will our “reasonable peer” use?
Standard of Care

Essentially, the standard of care has been shaped more by *failures* in standard clinical practice with suicidal patients than empirical findings demonstrating what actually works (or does not work) with this population.
Standard of Care

It is not directly defined by efficient, clear, and scientific investigation, but rather by decisions rendered by the legal system in malpractice cases, based largely upon the testimony of hired professionals who express opinions regarding clinical practice.
Standard of Care

- What are the implications of this?
- What does this mean for us?
Let’s Do a Lunge

Can You Touch a Ceiling Tile?
Basic Suicide Risk Assessment: Part Two
Standardizing Suicide Language

Consider eliminating the following terms:

- Suicide gesture
- Parasuicide
- Suicide threat
- Self-mutilation
- “Commit” suicide
- “Cry for Help”
# Suicide-Related Terms

**Suicide attempt**

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

**Suicidal ideation**

Thoughts of ending one’s life or enacting one’s death

**Nonsuicidal self-injury**

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

**Nonsuicidal morbid ideation**

Thoughts about one’s death without suicidal or self-enacted injurious content
A Few Words about Nonsuicidal Self-Injury

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

--Cutting
--Branding
--Burning

Avoid dismissing these patients as unlikely to need further suicide-related care.
A Few Words about Nonsuicidal Self-Injury

In the year following treatment for nonsuicidal self-injury, 1 out of 5 people repeat the act and over 20% die by suicide (Owens et al. 2002)

Almost half of those who seek medical care following an incident of nonsuicidal self-injury, had consumed alcohol in the period prior to the incident (Hawton et al. 1989; Touquet et al. 2008)
A Team-Based Collaborative Approach

Critical communications:

- This is a problem like any other medical problem
- I am not afraid to address it
- Reinforce help-seeking behaviors
- Decreasing patient’s distress is most important goal
- Protecting safety is essential
- “Help is available, and it works”
Accurate & Brief Risk Assessment
Myth:

Suicide assessment must be a lengthy and time-consuming process
Reality:
Suicide assessment and management can be adapted to the context
<table>
<thead>
<tr>
<th>Psychosocial features</th>
<th>Demographic features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent lack of social support (including living alone)</td>
<td>Male gender&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Widowed, divorced, or single marital status, particularly for men</td>
</tr>
<tr>
<td>Drop in socioeconomic status</td>
<td>Elderly age group (age group with greatest proportionate risk for suicide)</td>
</tr>
<tr>
<td>Poor relationship with family&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Adolescent and young adult age groups (age groups with highest numbers of suicides)</td>
</tr>
<tr>
<td>Domestic partner violence&lt;sup&gt;b&lt;/sup&gt;</td>
<td>White race</td>
</tr>
<tr>
<td>Recent stressful life event</td>
<td>Gay, lesbian, or bisexual orientation&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Childhood traumas</td>
<td>Additional features</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Access to firearms</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Substance intoxication (in the absence of a formal substance use disorder diagnosis)</td>
</tr>
<tr>
<td>Genetic and familial effects</td>
<td>Unstable or poor therapeutic relationship&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Family history of suicide (particularly in first-degree relatives)</td>
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<tr>
<td>Family history of mental illness, including substance use disorders</td>
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<tr>
<td>Comorbidity of axis I and/or axis II disorders</td>
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<tr>
<td></td>
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<tr>
<td>Physical illnesses</td>
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<tr>
<td>Diseases of the nervous system</td>
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<tr>
<td>Multiple sclerosis</td>
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<tr>
<td>Huntington’s disease</td>
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<tr>
<td>Brain and spinal cord injury</td>
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<td>Seizure disorders</td>
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<tr>
<td>Malignant neoplasms</td>
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<tr>
<td>HIV/AIDS</td>
<td></td>
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<tr>
<td>Peptic ulcer disease</td>
<td></td>
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<tr>
<td>Chronic obstructive pulmonary disease, especially in men</td>
<td></td>
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<tr>
<td>Chronic hemodialysis-treated renal failure</td>
<td></td>
</tr>
<tr>
<td>Systemic lupus erythematosus</td>
<td></td>
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<tr>
<td>Pain syndromes</td>
<td></td>
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<tr>
<td>Functional impairment</td>
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</table>

<sup>a</sup> Indicates significant association with suicide risk.
<sup>b</sup> Indicates less substantial association with suicide risk.
Proximal vs. Distal Risk Factors

Suicide
Suggested Assessment Approach

1. Suicide screening
2. Differentiate suicidal from nonsuicidal morbid ideation
3. Assess for past suicidal behaviors
   ◦ If positive history, assess multiple attempt status
4. Assess current suicidal episode
5. Screen for protective factors
Suicide screening:
- Do things ever get so bad you think about ending your life or suicide?
- Tell me a little bit about what, specifically, you have been thinking. What is it exactly that goes through your mind?

[Differentiate suicidal ideation from nonsuicidal morbid ideation]

If negative suicide screening: Discontinue risk assessment
If positive suicide screening: Screen for multiple attempt status

Multiple attempt screening
- Have you ever had thoughts like this before?
- Have you ever tried to kill yourself before?
- So you’ve never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way?

If no evidence of prior attempt(s): Assess current suicidal episode
If positive evidence of prior attempt(s): Assess multiple attempt status

Assess multiple attempt status
- How many times have you tried to kill yourself?
- Let’s talk about the first time…
  a. When did this occur?
  b. What did you do?
  c. Where were you when you did this?
  d. Did you hope you would die, or did you hope something else would happen?
  e. Afterwards, were you glad to be alive or disappointed you weren’t dead?
- I’d like to talk a bit about the worst time… [Repeat a through e]

Assess current suicidal episode
- Let’s talk about what’s going on right now. You said you’ve been thinking about [content].
- Have you thought about how you might kill yourself?
- When you think about suicide, do the thoughts come and go, or are they so intense you can’t think about anything else?
- Have you practiced [method] in any way, or have you done anything to prepare for your death?
- Do you have access to [method]?

Screen for protective factors
- What is keeping you alive right now?

(Bryan, Corso, Neal-Walden, & Rudd, 2009)
Two-Stage Approach

Suicide screening

Positive screen → Risk assessment

Negative screen → Primary complaint
Potential Survey Screening/Assessment Methods

- Patient Health Questionnaire-9 (PHQ-9)
- Behavioral Health Measure-20 (BHM-20)
- Outcomes Questionnaire-30 (OQ-30)
- Beck Depression Inventory-Primary Care (BDI-PC)
- Columbia Suicide Severity Rating Scale
Sequencing

Presenting problem / current ideation

Past suicidal episodes
(Start with first and move forward in time)

Current suicidal episode

(Shen, 2002)
Differentiate suicidal from nonsuicidal ideation
Suicidal ideation has stronger relationship with suicidal behaviors than nonsuicidal morbid ideation

(Joiner, Rudd, & Rajab, 1997)
Suicidal ideation associated with significantly higher levels of psychological distress than nonsuicidal morbid ideation

(Edwards et al., 2006; Fountaoulakis et al., 2004; Liu et al., 2006; Scocco & DeLeo, 2002)
Assess for past suicidal behaviors
Past suicide attempts are the most robust predictor of future suicidal behaviors, even in the presence of other risk factors

(Clark et al., 1989; Forman et al., 2004; Joiner et al., 2005; Ostamo & Lonnqvist, 2001)
Assess for multiple attempt history
Why Bother?

Three distinct groups:

- Suicide ideator: Zero previous attempts
- Single attempter: One previous attempt
- Multiple attempter: 2 or more previous attempts

(Rosenberg et al, 2005; Rudd, Joiner, & Rajab, 1996; Wingate et al, 2004)
Multiple Attempters

Objective indicators are better predictors than subjective indicators (Beck et al., 1974; Beck & Steer, 1989; Harriss et al., 2005; Hawton & Harriss, 2006)

Survival reaction can serve as indirect indicator of intent (Henriques et al., 2005)

“Worst point” suicidal episode better predictor than other episodes (Joiner et al., 2003)
Assess the current suicidal episode
## Current Suicidal Episode

<table>
<thead>
<tr>
<th>Resolved Plans &amp; Preparation</th>
<th>Suicidal Desire &amp; Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Sense of courage</td>
<td>▪ Reasons for living</td>
</tr>
<tr>
<td>▪ Availability of means</td>
<td>▪ Wish for death</td>
</tr>
<tr>
<td>▪ Opportunity</td>
<td>▪ Frequency of ideation</td>
</tr>
<tr>
<td>▪ Specificity of plan</td>
<td>▪ Desire and expectancy</td>
</tr>
<tr>
<td>▪ Duration of suicidal ideation</td>
<td>▪ Lack of deterrents</td>
</tr>
<tr>
<td>▪ Intensity of suicidal ideation</td>
<td>▪ Suicidal communication</td>
</tr>
</tbody>
</table>

>2 factors of suicidal desire and ideation = mild  
>1 factor of resolved plans and preparation = moderate  
Anything above these = Severe or Extreme
Current Suicidal Episode

Intent

**Objective**
- Isolation
- Likelihood of intervention
- Preparation for attempt
- Planning
- Writing a suicide note

**Subjective**
- Self-report of desired outcome
- Expectation of outcome
- Wish for death
- Low desire for life
Sample Questions

Have you thought about how you might kill yourself?

Do you know where or when you might do this?

When you think about suicide, do the thoughts come and go, or are they so intense you can’t think about anything else?

Have you practiced [method] in any way, or have you done anything to prepare for your death?

Do you have access to [method]?

What do you hope will happen?
Assess Access to Lethal Means

Suicidal intent has weak relationship with lethality of suicide attempt

(Brown et al., 2004; Plutchik et al., 1988; Swahn & Potter, 2001)

Patients tend to have inaccurate expectations about lethality of methods

(Beck, Beck, & Kovacs, 1975; Brown, Henriques, Sosdjan, & Beck, 2004)

Availability of means demonstrates strong association with lethality

(Eddleston et al, 2006; Peterson et al, 1985)
Assess Access to Lethal Means

Among survivors of highly lethal suicide attempts:

- 24% made the decision to act within 5 mins
- 70% made the decision to act within 60 mins

(Simon et al., 2001)

Strong link between suicide and length of time from firearm purchase

(Wintemute et al., 1999)
Assess Access to Lethal Means

Due to:

(1) firearms’ high fatality rate relative to all other methods, and
(2) the importance of availability relative to suicidal intent,

all suicidal patients should be asked about the availability of firearms regardless of the content of their ideation
Assess protective factors
Protective Factors

Less empirical support than risk factors

Buffer against suicide risk, but do not necessarily reduce or remove risk

Provide clues for intervention

Often prime positive emotional states
<table>
<thead>
<tr>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact reality testing</td>
</tr>
<tr>
<td>Children in home</td>
</tr>
<tr>
<td>Spiritual beliefs / practices</td>
</tr>
<tr>
<td>Moral beliefs</td>
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<tr>
<td>Social stigma</td>
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<tr>
<td>Future-oriented thought</td>
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<tr>
<td>Presence of positive social relationships</td>
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<tr>
<td>Fear of death / suicide</td>
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<tr>
<td>Problem-solving skills</td>
</tr>
<tr>
<td>Goals / aspirations</td>
</tr>
<tr>
<td>Risk level</td>
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<td></td>
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<tr>
<td>Very Low</td>
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<tr>
<td>Mild</td>
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<td></td>
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<tr>
<td>Risk level</td>
</tr>
<tr>
<td>------------</td>
</tr>
</tbody>
</table>
|            | Ideator or Single Attempter | Multiple Attempter | 1. Crisis response plan  
2. Routinely reevaluate suicide risk, noting specific changes that reduce or elevate risk  
3. Consider medication change if symptoms worsen or persist  
4. Obtain professional consultation with a colleague following each appointment  
5. Specifically target suicidal symptoms in the treatment plan  
6. Means restriction counseling |
<p>| Moderate   | Frequent suicidal ideation with moderate intensity and duration, some specific plans, minimal objective markers of intent, limited rehearsal or preparatory behaviors, identifiable protective factors | Suicidal ideation of limited intensity and duration, no identifiable plans, no intent, identifiable protective factors |</p>
<table>
<thead>
<tr>
<th>Risk level</th>
<th>Clinical features</th>
<th>Indicated Clinical Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ideator or Single Attempter</td>
<td>Multiple Attempter</td>
</tr>
</tbody>
</table>
| High       | Frequent, intense, and enduring suicidal ideation, specific plans, clear objective markers of intent, rehearsal or preparatory behaviors, few if any protective factors | Frequent suicidal ideation with moderate intensity and duration, some specific plans, minimal objective markers of intent, limited rehearsal or preparatory behaviors, few if any protective factors | 1. Consider referral for inpatient hospitalization evaluation (voluntary or involuntary, depending on situation)  
2. Obtain professional consultation with a colleague following each appointment  
3. Specifically target suicidal symptoms in the treatment plan  
4. Crisis response plan  
5. Means restriction counseling |
How Do We Document Our Analysis?

“RISK ASSESSMENT:
- Static factors – blah, blah, blah
- Dynamic factors – blah, blah, blah
- Protective factors – blah, blah, blah
- The patient committed to outpatient treatment with use of a crisis response plan.
- Patient’s current risk category for suicide is considered to be (acute/chronic) and level of risk is (very low/mild/moderate/high).”
Practice Brief Risk Assessment
Pose like the traffic 
“Walk Sign”

Start the first pose for the song 
“Y –M –C – A”
Advanced Suicide Prevention Training
What do Patients Believe about their Suicidal Symptoms?

◦ I’m going crazy
◦ Since I’ve never felt this way before, I can’t relate to myself – I don’t feel like me
◦ I am losing control of myself
◦ I might not be able to stop myself from acting on my suicidal thoughts
◦ I’m not who I thought I was
Practice Educating the Patient about Suicide and Discussing Ambivalence
Strategies for Managing Suicide Risk
Brief Interventions
What Works

Adaptation of empirically-supported, effective strategies for risk assessment and management from specialty MH care and applying it to the PC context
“Rules of Thumb”

- Eliminate psychobabble and complex theories, both for patients and for PCPs
- 5-10 minute rule: if it can’t be explained and taught in 5-10 minutes, then it’s too complex
- Strategies must be evidenced-based
- Intervention MUST be values-based
Brief Interventions

Interventions must target suicide risk by “deactivating” one or more components of the suicidal mode.

During acute crises, interventions should emphasize emotion regulation and crisis management skills.
Treatments

*Pharmacotherapy
*Cognitive Behavioral Therapy
*Dialectic Behavioral Therapy
Acceptance and Commitment Therapy (ACT)

Other Interventions
◦ Mindfulness
◦ Yoga

*The research is strongest for these modalities (Bryan & Rudd, 2010).
Brief Interventions

Reasons for living list
Survival kit ("Hope Box")
Behavioral activation
Relaxation skills training
Mindfulness skills training
Cognitive restructuring
  ◦ ABC worksheets
  ◦ Coping cards
  ◦ Challenging beliefs worksheets
Brief Interventions

- A stronger sense of meaning in life is significantly associated with lower emotional distress, less severe suicidal ideation, and better functioning across multiple domains of life (Bryan et al., 2013).

- “Effective” Crisis Response Planning reduces suicide attempts up to 76% (Bryan et al., 2017 a, b)

- BCBT reduces suicidal behavior by 60% compared to treatment as usual (Bryan et al., 2015)
53 psychosocial clinical trials targeting suicidality (Bryan & Rudd, 2010)

- “Clinical trial” = study including both treatment and control (or comparison) condition
- Randomization not required
- 28 (53%) were cognitive-behavioral
- One RCT included military personnel
Antidepressant and the Role of BH Providers

Patients initiated on antidepressants can be followed by nurses or BHCs for PCPs

- Meets FDA recommendations and intent of warning label
- Enables psychoeducation focused on medication adherence
- Combines medication therapy with behavioral therapy, which is more effective than either alone
- Meets HEDIS requirements for antidepressant follow-up and adherence
Crisis Response Plan versus Safety Contract
Crisis Response Plan Literature

- Individuals who develop a CRP are 76% less likely to make a suicide attempt during the 6 month follow-up period. The CRP also contributed to faster reductions in suicidal ideation.

- The CRP was also a central component of Brief Cognitive Behavioral Therapy (BCBT), which reduces suicidal behavior by 60% as compared to treatment as usual.

- Versions of the CRP have been used in treatments shown to reduce suicidal behaviors:
  - Attempted suicide short intervention program (ASSIP);
  - Cognitive Therapy for Suicide Prevention (CT-SP); and
  - Emergency Department Safety Assessment and Follow-Up Evaluation (ED-SAFE).

- Other CRP research findings:
Crisis Response Plan

The CRP immediately reduces negative emotional distress and suicidal intent among suicidal individual (Bryan et al., 2017a).

Discussing an individual's reasons for living during the CRP increases hope, leads to larger reductions in suicidal intent, and decreases the likelihood of psychiatric hospitalization (Bryan et al., 2017b).
Crisis Response Plan

Decision-making aid

Specific instructions to follow during crisis

Developed collaboratively

Purposes:

1. Facilitate honest communication
2. Establish collaborative relationship
3. Facilitate active involvement of patient
4. Enhance patient’s commitment to treatment
5. Develop healthier coping skills

(Rudd, Mandrusiak, & Joiner, 2006)
Crisis Response Plan

Written on 3x5 card, behavioral rx pad or smartphone

Four primary components / sections:
1. Personal warning signs of emotional crises
2. Self-management strategies
3. Social support
4. Professional support & crisis management
SAMPLE

Go for a 10-15 min walk
Practice breathing exercise
Call family member to talk: xxx-xxxx
Repeat above
Contact Dr. Me at xxx-xxxx & leave message
Call hotline: 1-800-273-TALK
Go to ED or call 911
Practice Crisis Response Plan
Supporting Medication Adherence

MH providers emphasizing adherence concurrent with CBT can increase medication adherence by 10% (Kolbasovsky et al., 2005)

Talking with patients about prior experiences with antidepressants (focusing on motives and beliefs about medications) and scheduling pleasant behavioral activities increases early adherence (Lin et al., 1995)
Supporting Medication Adherence

Key messages (Bull et al., 2002; Lin et al., 1995):

1. Antidepressants must be taken consistently for 2-4 wks for noticeable effect
2. Specific instructions for resolving questions about meds
3. Take meds daily
4. Continue taking meds even if feeling better
5. Do not discontinue without first talking to prescriber
6. Keep taking meds for full 6 months despite side effects or improvement
Transitions to/within Specialty MH

The “black hole of MH”

...consult reports back from specialty MH are exceedingly rare, even when PCP made referral

Develop system to document transfer of care to specialty MH tx
  ◦ Confirm MH appt during f/u appt or phone call
  ◦ Document “proof of attendance”
Don’t assume patients can easily access MH care (or even know how to)

Teach patients how to find a MH provider:
- Searching for possible providers
- Rehearsing / practicing what to say on the phone
- Educating patients about the first appt
- Educating patients about the importance of therapeutic relationship
Transitions to/within Specialty MH

Follow-up with patients in-person or over the phone

Document “proof of attendance”
- Provider name
- Business card
- Release of medical information

Remember there are no “closed cases” in primary care
Recommending Hospitalization

- Providers tend to respond to suicide risk with “alarmist” or “better safe than sorry” attitude
- Inpatient hospitalization often mistakenly assumed to be “gold standard” for suicide risk
- Use hospitalization judiciously and appropriately
- PCPs should make ultimate decision about referring patient for inpatient evaluation in collaboration with BH provider and/or nurse
Post-Discharge Follow-Up

- The week immediately following discharge from inpatient hospitalization is highest risk period for suicidal patients (Qin & Nordentoft, 2005)

- Same-day / next-day walk-in appointments can be useful for risk management
Book Recommendation

Managing Suicide Risk in Primary Care
Craig J. Bryan
M. David Rudd