VERMONT SUICIDE PREVENTION & INTERVENTION PROTOCOLS FOR PRIMARY CARE PROFESSIONALS

- **CONTEXT & RESOURCES**
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- **RESPONDING TO A THREAT OF SUICIDE: REMOTELY**
- **RESPONDING TO A PERSON AT RISK OF SUICIDE**

I. CONTEXT & RESOURCES

CONTEXT:

Prevention is applied to three situations: 1) immediate threat of suicide in person, 2) immediate threat of suicide remotely, and 3) recognizing and responding to suicidal ideation and risk behaviors.

In the course of performing professional duties, **Primary Care Professionals** may encounter a person attempting a suicide, at risk for suicidal behavior, or be one of the first on the scene following a suicide attempt or a death by suicide. This protocol covers intervention during a suicidal crisis, and prevention of suicidal behavior. This is a companion document to *SUICIDE POSTVENTION PROTOCOLS FOR **PRIMARY CARE PROFESSIONALS***, offering guidance on response after an attempted suicide and/or a death by suicide.

The following are **suggested** suicide prevention and intervention protocols.

As a medical practitioner, you are likely to be much more familiar with emergencies, particularly those of a medical and/or mental health nature, than people in other professions. As a matter of professional duty, your office likely already has protocols in place for responding to a patient in crisis either in person or over the telephone. These samples may help in reviewing your existing protocols.

Primary Care Professionals are in a unique role regarding suicide prevention. Research indicates that a great many people see their primary care providers in the months and weeks prior to suicide attempts and deaths by suicide. There is an opportunity present in the primary care office to screen for potential suicidality.

- 83% of persons who died by suicide received health services in the year prior to death.
- 50% made a medical visit within four weeks of death.
- 70% of older men had contact with primary care within a month before suicide. ,
- Over 60% of those who died visited a medical specialist or primary care without a mental health diagnosis.
- Primary care doctors – including family physicians and pediatricians – write four out of every five prescriptions for antidepressants.

Because of this, current Best Practice recommends primary care physicians and their staff become well-versed in suicide warning signs and risk factors, and in talking directly with patients about depression, mental health, and suicide.

From asking directly, to referring for services, to helping a patient make a safety plan, there are a number of excellent resources available for physicians, for working directly with suicidal patients, including the following:

ONLINE TOOL FOR SMART PHONES: The SAMHSA "SUICIDE SAFE" app is available for all smart phones, whatever the platform. This app is an online version of SAMHSA's previously-released Suicide Assessment Five-Step

Evaluation and Triage (SAFE-T) "pocket guide" with additional information and resources added. It is an excellent, user-friendly app intended to be used by clinicians as an educational resource, and is highly recommended. It is available for free from GooglePlay or the iTunes Store.

QUICK GUIDES FOR FREE DOWNLOAD:

- Safety Plan QUICK GUIDE for Clinicians. Published by the Department of Veteran Affairs. One page folded guide, downloaded from: http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf
- Safety Planning: A Quick Guide for Clinicians. Published by the Suicide Prevention Resource Center. Two page guide, downloaded from: http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf
- A Pocket Guide for Primary Care Professionals: Assessment & Interventions with Potentially Suicidal Patients. Four fold wallet card, downloaded from: http://www.sprc.org/sites/sprc.org/files/PCPocketCard.pdf
- Patient Safety Plan Template. One page simple template for immediately safety lists. http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

COMPLETE TOOLKITS FOR FREE DOWNLOAD:

- Suicide Prevention Toolkit for Rural Primary Care Practices: available for download at www.sprc.org
- Zero Suicide Toolkit: Suicide Care in Systems Framework. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

WEBINARS & ONLINE LEARNING AT NO COST:

- Zero Suicide provides webinars, e-learning workshops, and Power Point presentations, available at: http://zerosuicide.actionallianceforsuicideprevention.org/

We would greatly appreciate it if you would bring to the attention of the *Vermont Suicide Prevention Center*, a program of the Center for Health and Learning (info@healthandlearning.org), any statutes or regulations that impact your implementation of suicide response protocols, so that we may add them to the Appendices as a resource for others.

Many of the steps in these protocols **rely on a solid basic knowledge of the warning signs of suicidal thoughts and actions**, along with risk and protective factors, and basic facts about suicide. These protocols outline **WHAT** to do, but it is important to understand **WHY, HOW** and **WHEN** these steps are used. Therefore, along with the resources above, an important part of these guidelines is a straightforward summary of these topics, included in these appendices:

- APPENDIX A: Warning Signs
- APPENDIX B: Sample Verbal Responses
- APPENDIX C: When You May be Unsafe
- APPENDIX D: Screening Tools PHQ2, PHQ9
- APPENDIX E: HIPAA & FERPA Guides
- APPENDIX F: Media Guide
- APPENDIX G: Risk & Protective Factors
- APPENDIX H: Resource

SPECIAL NOTE: INTOXICATION AND SUBSTANCES

When looking over these protocols, take into account that a person expressing suicidal intent or risk may be under the influence of substances, including alcohol, drugs, and/or prescription medications. If you believe a person in crisis is drunk, high, or otherwise compromised, and they show suicidal intent or make suicidal statements, treat the situation as an **immediate emergency, and call 911**.

I. RESPONDING TO A THREAT OF SUICIDE: IN PERSON

A threat of suicide is when a person says they plan to hurt themselves in a way that will cause death. The person may have a tool that can cause death, such as a gun or drug – a "lethal means" – but sometimes it may be hard to tell if lethal means are close by or easy to get. It is still a threat of suicide if the person says they plan to die, even if you don't immediately see a means of causing death.

As a primary care physician, you and your office staff will be more familiar with medical and health emergencies than other professions may be, and therefore you are likely to have response protocols already in place for medical and mental health emergencies that present a threat to the person, to yourself, or to others. The following abbreviated list of Best Practices is provided for comparison with your current practice.

STEP ONE: Take the Threat Seriously

1. **Always** take a threat of suicide seriously.

2. Remain calm. Speak calmly, slowly, and in a normal tone of voice.

3. Speak to the person directly. Say "I believe you and would like to help you to get help."

STEP TWO: Check Your Immediate Safety

1. If guns or weapons are not present, proceed to Step Three.

2. If guns or weapons are present, call 911 immediately.
    a. Tell the 911 operator if there is a weapon.
    b. If you can't call 911, speak to another person by name and tell them to call 911.
        - *"Jane, please go out into the hall and call 911."* Tell them there is a weapon.
    c. Clear the scene.
    d. Try to withdraw and get to safety.
    e. If you can withdraw, **WAIT FOR EMERGENCY HELP TO ARRIVE**.
    f. If you cannot safely withdraw, try to keep the person as calm as possible.
    g. **DO NOT ATTEMPT TO DISARM AN ARMED PERSON YOURSELF.**
        i. **If you must act** before emergency help arrives, speak calmly at a normal volume and firmly tell the person to hand the gun to you, or to put it down.
        ii. Don't shout or speak angrily or aggressively.
        iii. Be gently directive. Don't ask them, tell them to give it to you.
            i. "John, hand me the gun."
        iv. If you can get the weapon from them, secure it – unload it, lock it away and hold onto the key.
        v. Ask if there are any other guns. Secure them as well.
    h. Stay alert for chances to withdraw to safety.
    i. **WAIT FOR EMERGENCY HELP TO ARRIVE**.

STEP THREE: Do Not Leave Them Alone

1. Do not leave a suicidal person alone, even for a short time. Make sure one person is with them at all times until emergency help arrives.

2. Speak calmly and conversationally to the person, at a normal volume, and don't yell or get angry.

3. Decrease outside interruption and noise as much as possible.

4. Do not let the person leave.

STEP FOUR: Call for Professional Mental Health Help

As a trained medical professional, you may or may not have experience working with individuals with mental illness, depending on your specialty and circumstances. Helping a suicidal person to connect with a mental health professional is the best first step.

1. Find out if the person has a mental health counselor.
    a. If yes, call that counselor and try to get the person in crisis in to see them as soon as possible.
    b. If no, or if you can't get that person on the phone, continue here.

2. Call your local Emergency Mental Health Crisis Team.
    a. Tell the Crisis Team that you are with a suicidal patient. Follow their instructions.
    b. **LAW ENFORCEMENT STRONGLY RECOMMENDS THAT EMERGENCY TRANSPORT BE CALLED FOR ANY TRANSPORTATION OF SUICIDAL INDIVIDUALS.**
    c. Do not let the person drive themselves.
    d. Try to arrange to have mental health personnel come to the patient.
    e. If you can't reach any mental health help at all, and you think it is dangerous to wait for a call back, you can have the person brought to the Emergency Room.

3. Make sure someone stays with the person until their transportation or counselor arrives.

STEP FIVE: Waiting for Emergency Help or Transportation

1. **Do not leave the person alone**.

2. Continue to talk to the person in a calm voice.
    a. LISTEN.
        i. Tell them you believe them and invite them to tell you what is going on, how they are feeling.
        ii. Listen to their answers, without interrupting.
        iii. Show you have heard their answers.
            - *"It sounds like you are really sad and angry because of the divorce. Is that right?"*
    b. DON'T…
        i. DON'T joke, or try to make light of the situation.
        ii. DON'T judge them – *"This is a terrible thing to do!"* -or- *"Suicide is a sin."*
        iii. DON'T guilt them – *"Think of how your family will feel."* -or- *"You can't do this to us!"*
        iv. DON'T minimize their feelings – *"Everything will look better tomorrow, you're just having a bad day."*
        v. DON'T downplay the seriousness of the crisis – *"You're overreacting, it's really not that big of a deal"* -or- *"By next week, you'll have forgotten all about this."*
        vi. DON'T make empty promises – *"I know you'll find a new job fast."* -or- *"I know your wife will come back to you."*
        vii. DON'T tell them you *"know exactly how they feel"* or talk about your own experiences.

STEP SIX: Call Them After the Crisis

Suicide prevention research is showing us that hearing from care professionals after the crisis is helpful in keeping people safe. If it is safe and appropriate, get in touch after the crisis. Research shows that ANY form of contact from people who helped during the crisis has a positive effect. Visit in person, call on the phone, write a note/postcard or send an email or text.

II. RESPONDING TO A THREAT OF SUICIDE REMOTELY

A threat of suicide is when a person says they plan to hurt themselves in a way that will cause death. The person may have a tool that can cause death, such as a gun or drug – a "lethal means" – but sometimes it may be hard to tell if lethal means are close by or easy to get. It is still a threat of suicide if the person says they plan to die, even if you don't immediately see a means of causing death.

As a medical office, it is likely you will already have protocols in place for emergency telephone calls. The following abbreviated list of Best Practices can be compared to your current protocol.

STEP ONE: Take the Threat Seriously

1. Always take a threat of suicide seriously.

2. Remain calm. Speak calmly, slowly, and in a normal tone of voice.

3. Say you believe them and you would like to help.

STEP TWO: Ask about Immediate Safety

1. Ask the person if they are in a safe place.

2. Ask if they have they been using any drugs or drinking alcohol. **Call 911 if they have been drinking or using drugs.**

3. Ask if they have **taken any action** yet – have they injured themselves or anyone else?
    a. **If YES, CALL 911** immediately for an ambulance.
    b. Ask for details – such as what type of injury, how long ago, what kind of medication, how many pills – and tell the 911 operator.
    c. Ask if there are weapons around, and tell 911 operator.
    d. Contact the person's mental health counselor if they have one and tell them emergency services have been sent to their client.
    e. Call your local Emergency Mental Health Crisis Team and alert them that a mental health emergency has been called in to 911, and give them the details.

4. If the person **has not acted yet**, ask if there are any guns (or other weapons) nearby.
    a. If **guns are nearby** call 911.
    b. **ALWAYS** identify if weapons are present when you call 911.
    c. Be gently directive about the gun/weapon.
        i. Tell the person to put the gun down, or to move away from any weapons.
        ii. Do not ask – use their name and speak calmly but firmly.
        "Joe, put the gun down and talk to me."
    f. Contact the person's mental health counselor if they have one and tell them emergency services have been sent to their client.
    g. Call your local Emergency Mental Health Crisis Team and alert them that a mental health emergency has been called in to 911, and give them the details.

5. If the person has not acted yet, no weapons are present, and they do not appear to be drinking or using drugs, move on to **STEP THREE**.

STEP THREE: Get Help to the Person in Crisis

1. Ask if they have a mental health counselor.
    a. Help them get in touch with their counselor.
    b. If their counselor can't be reached or they don't have one, call the local Emergency Mental Health Crisis Team.

2. Help the person find someone to be with them in person.
    a. Ask them to think of someone first. A person of their choice would be best.
    b. If they can't think of anyone, offer suggestions – friends, family members, a counselor.
    c. Make the call to the third party yourself, to make sure the call is made and that the third party understands this is a crisis.
        i. Tell them why this is a crisis – say the word suicide.
        ii. Stress that the person in crisis should not be left alone, and should get follow up mental health care as quickly as possible.
        iii. Suggest the Emergency Mental Health Crisis Team as a resource.

3. Call your Emergency Mental Health Crisis Team.
    a. If there is no one who can go to them in person to help decide if the Crisis Team should be called, make the safe choice and call them yourself.
    b. Make the call to the Crisis Team yourself so you know for sure it has been made.

4. If you cannot contact the Emergency Mental Health Crisis Team, call 911.

5. Try to stay on the phone with the person until help arrives.

6. Continue to talk to the person in a calm voice.

    a. LISTEN. Listening can be your most powerful tool in a mental health emergency.
        i. Tell them you believe them and invite them to tell you what is going on, how they are feeling.
        ii. Listen to their answers, without interrupting.
        iii. Show you have heard their answers
        "It sounds like you are really sad and angry because of the divorce. Is that right?"
    b. DON'T fall into some of the common reactions that can make things worse.
        i. DON'T joke, or try to make light of the situation.
        ii. DON'T judge them.
            - *"This is a terrible thing to do!"*
            - *"Suicide is a sin."*
        iii. DON'T guilt them.
            - *"Think of how your family will feel."*
            - *"You can't do this to us!"*
        iv. DON'T minimize their feelings.
            - *"Everything will look better tomorrow, you're just having a bad day."*
        v. DON'T downplay the seriousness of the crisis.
            - *"You're overreacting, it's really not that big of a deal."*
            - *"By next week, you'll have forgotten all about this."*
        vi. DON'T make empty promises.
            - *"I know you'll find a new job fast."*
            - *"I know your wife will come back to you."*
        vii. DON'T tell them you *"know exactly how they feel"* or talk about your own experiences.

STEP FOUR: Call Them After the Crisis

Suicide prevention research indicates that hearing from care professionals after the crisis is helpful in keeping people safe. If it is safe and appropriate, get in touch after the crisis. Research shows that ANY form of contact from people who helped during the crisis has a positive effect. Visit in person, call on the phone, write a note/postcard or send an email or text.

III. RESPONDING TO A PERSON AT RISK OF SUICIDE

A person is "at risk of suicide" when:

- They talk about suicidal thoughts or intentions to you, or show warning signs. **(Appendix A)**
- Another person tells you that someone has talked about suicidal thoughts or intentions, or they have seen warning signs.

Current Best Practice recommendations are outlined in the Zero Suicide framework and approach. http://zerosuicide.actionallianceforsuicideprevention.org/ The Zero Suicide approach recommends directly asking patients in care about depression, mental health, and suicide.

STEP ONE: ASK EVERYONE

Half of all people who go on to die by suicide have seen a general practitioner in the preceding months. Among older men, 70% of those who had died by suicide had seen a doctor in the last thirty days. The Zero Suicide approach that is becoming a best practice standard is to bring mental health, depression and the potential of suicidality into preventative, wellness care.

1. Ask about depression.
    a. Ask everyone.
    b. Use the PHQ2 – Patient Health Questionnaire 2 – a two-question screen.
        - "Over the past 2 weeks, how often have you been bothered by any of the following problems?"
            - Little interest or pleasure in doing things
            - Feeling down, depressed or hopeless
        - Patient rates on a zero to 3 scale.
    c. See **Appendix D.**

2. If the patient screens positive for depression on the PHQ2, evaluate with the PHQ9.
    a. PHQ9 – Patient Health Questionnaire 9 – is a simple nine-question screen, on a scale of zero to 3.
    b. Ends on a suicide-specific question.
    c. See **Appendix D.**

STEP TWO: Ask About Plans & Means

1. If the person tells you they HAVE had thoughts of suicide, **ask two specific questions**:
    a. "Do you have a **plan** for how to carry out suicide?"
    b. "Do you have **immediate access to a way** to carry out suicide?"

2. Ask about **firearms**, specifically.
    a. Even if the person does not identify a plan, ask specifically if there are any guns in the home or easily accessible.
    b. Talk with the person about having a friend hold onto their guns for them, until they are feeling better.

3. ***CALM: Counseling on Access to Lethal Means*** is a free online training in how to talk to patients and their families about lethal means. It is highly recommended for care professionals in primary care settings.

STEP THREE: Connect to Mental Health Help

1. Based on the level of immediate assessed risk, choose how to connect the individual with mental health care.

2. In the case of an immediate emergency, contact the individual's mental health professional if they have one, or the Emergency Mental Health Crisis Team if they do not.

3. If you assess the person to be at risk but not in immediate danger, make a direct referral.
    a. Have mental health referral resources at hand.
    b. Assist the person with calling for an appointment with a counselor.

STEP FOUR: Follow-up

Suicide prevention research indicates that hearing from care professionals after the crisis is helpful in keeping people safe. If it is safe and appropriate, get in touch after the crisis. Research shows that ANY form of contact from people who helped during the crisis has a positive effect. Visit in person, call on the phone, write a note/postcard or send an email or text.

STEP FIVE: Self Care

Helping someone with suicidal thoughts or behaviors is difficult. Depending on how well you know the person or how involved you are with talking with them directly, this could be a traumatizing event for you, and at the very least is highly stressful. **Find someone to talk to**. Look at the local resources for counselors, or support groups.