PROTOCOL FOR THE MANAGEMENT OF PATIENT SUICIDALITY AND SELF-HARM

DAWN
Depression Attention for Women Now

Rationale:

1. The PHQ-9 – used in DAWN patient assessments and contacts (in-person or by phone) – includes a question regarding thoughts of self-harm/suicide. If a patient reports thoughts of current self-harm or suicide on the PHQ-9 or spontaneously during an encounter, then a clinical response is indicated. This protocol refers to suicide intent reported as follows:
   - Responding '2' ('more than half the days to nearly every day') or '3' ('nearly every day')to the PHQ-9 self-harm question ('thoughts that you would be better off dead or hurting yourself in some way')
   - Spontaneously reporting thoughts of self-harm in a telephone or in-person encounter
2. Any clinic staff that has contact with patients may become aware of suicidal ideation. It is important, therefore, that all staff – regardless of discipline or clinic role – understand the potential for self-harm and know the appropriate steps to take to ensure that patients receive appropriate care.
3. It is also critical that the clinic have a written protocol for how to handle patient suicidality, and staff need to be trained to implement the protocol. All clinic staff should know:
   - where the written protocol is located for quick reference
   - which clinic staff are designated to conduct a suicide assessment
   - what documentation procedures are required
   - what clinic staff follows up with the patient

Procedure:

1. If a patient endorses thoughts of self-harm or suicide on the PHQ-9 or spontaneously during other contacts, the clinic staff asks the patient:

   "Do you feel these thoughts are a problem for you OR something you MIGHT act on?"

   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Refused

2. If the patient answers "yes", "don't know", or refuses to answer this follow-up question, then the staff member should implement their clinic's suicide protocol. Convey to the patient the seriousness of these statements:

   "I am concerned about these thoughts and feelings that you are having. It is important that you get proper medical attention. Therefore, I am going to get someone to talk with you to discuss these thoughts and feelings. I would also like to offer you some telephone contact numbers in case these feelings and thoughts get worse and you need help immediately."

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3. It is suggested that if an assessment cannot be conducted immediately (e.g., when the patient is in the clinic), then the patient should be contacted within 24 hours for a clinical assessment of suicide risk and determination of further treatment necessary.
4. The *Suicide & Self-Harm Risk Assessment Form* at the end of this document is an example of one way to assess for suicidality and how to implement a treatment plan. It is template to assist your clinic to develop its own protocol and tools.

Developing a Suicide Protocol:

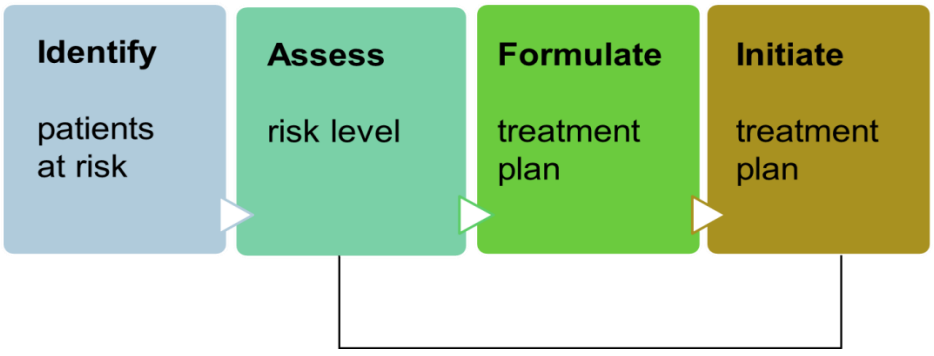
1. Need for Having a Protocol

Any agency providing medical and/or mental health care to individuals should have an established, written protocol for responding to patients' suicidal and/or self-harm statements and behaviors. By implementing DAWN, a clinic and its staff will be caring for women who identify with having some degree of depression. Over 30,000 people die by suicide each year in the United States, and over 650,000 attempt suicide. However, collaborative care programs like DAWN have been found to decrease hopelessness and suicidal ideation by providing more support and effective treatment of depression.

Each agency must develop a protocol that functions within its internal system of care, as well as community resources available in the area. The protocol should be documented and accessible to all staff. Staff should be trained in the protocol (including practicing how to assess and treat) on a regular basis. These situations may be infrequent, so staff may have problems remembering the procedures and require periodic refresher training for appropriate implementation.

The following information provides some general guidelines to consider. At a minimum, a protocol should include:

- Screening
- Assessment
- Treatment Planning



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The graphic above illustrates the elements of a suicide protocol. These elements should also address:

- Who is responsible for screening, assessment, and treatment planning
- Who is consulted
- How the assessment is done
- How the treatment plan is developed
- What is done immediately for the patient
- What kind of follow-up with the patient is done
- When any activities are planned (timeframe)

2. Screening for Suicidality or Self-Harm

In the DAWN program, a patient's suicidal or self-harm thoughts and/or behaviors will most likely be identified when the depression care manager administers the PHQ-9. Question #9 on the PHQ-9 assessment tool specifically asks about suicidal thoughts. Sometimes, however, a patient may spontaneously volunteer such information to either DAWN staff or clinic providers.

- PHQ-9 Question #9:
  Any positive answer of self-harm thoughts or behaviors on question #9 of the PHQ-9 requires further assessment:
  - *Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way.*
- Spontaneous Patient Statements:
  Other types of patient self-harm statements elicited outside of the PHQ-9 administration require further assessment and may include:
  - *I just wish this were over.*
  - *I'm ready to end all this.*
  - *There's no point in going on.*

Any indication of self-harm statements or behaviors requires further assessment.

3. Assessing

If further assessment is required, then the provider tries to determine the patient's level of risk. Depending upon each individual clinic/organization, this further assessment may be completed by the depression care manager, another clinic medical provider, or contacting a mental health provider (individual or community program). Concern for the patient's well-being must be weighed against the patient's autonomy and confidentiality.

A. Ideation vs. Intent vs. Action

Part of the assessment process distinguishes among ideation, intent, and action.

- **Ideation**
  - Thoughts of death only
  - No concrete plan
  - No action (e.g., not obtaining the means)
- **Intent**
  - Thoughts are more definite
  - Plan is in place
  - Means are available to implement plan

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- **Action**
  - Preparatory or rehearsing activities
  - Recent attempts

B. Questions

Here are some suggested questions to complete an assessment. Answers to the questions below help to clarify the patient's thoughts and behaviors and, thereby, their level of risk.

- **Frequency, Duration and Intensity**
  - *When did you begin having suicidal thoughts?*
  - *Did any event precipitate the suicidal thoughts?*
  - *How often do you have thoughts of suicide? How long do they last?*
  - *How strong are the thoughts of suicide?*
  - *What is the worst they have ever been?What do you do when you have suicidal thoughts?*
  - *What did you do when they were the strongest ever?*
- **Suicide Plans**
  - *Do you have a plan or have you been planning to end your life?*
  - *If so, how would you do it? Where would you do it?*
  - *Do you have the means [e.g., drugs, gun, rope] that you would use? Where is it right now?*
  - *Do you have a timeline in mind for ending your life?*
  - *Is there something [event] that would trigger the plan?*
  - *Have you attempted to kill yourself in the past?*
- **Intent**
  - *What would it accomplish if you were to end your life?*
  - *Do you feel as if you're a burden to others?*
  - *How confident are you that your plan would actually end your life?*
  - *What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do [e.g., held the gun or pills, tied the rope]?*
  - *Have you made other preparations [e.g., updated your life insurance, made arrangements for pets]?*
  - *What makes you feel better [e.g., contact with family, use of substances]?*
  - *What makes you feel worse [e.g., being alone, thinking about a situation]?*
  - *How likely do you think you are to carry out your plan?*
  - *What stops you from killing yourself?*

C. Risk Factors

Listed below are some factors that increase a person's risk of suicide.

- Current or Past Psychiatric Disorders:
  - Mood disorders
  - Psychotic disorders
  - Alcohol/substance abuse
  - Traumatic brain injury
  - Posttraumatic stress disorder
  - Personality disorders
  - *Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.*
- Key Symptoms:
  - Loss of pleasure (anhedonia)
  - Impulsivity
  - Hopelessness

- Anxiety/panic
- Insomnia
- Command hallucinations
- Intoxication

- Suicidal Behavior:
  - History of prior suicide attempts
  - Aborted suicide attempts
  - Self-injurious behavior
- Family History:
  - Suicide or attempts
  - Psychiatric diagnoses, especially those requiring hospitalization
- Precipitants or Stressors:
  - Triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial, or health status)
- Chronic Medical Illness:
  - Especially central nervous system disorders or pain
- History of or Current Abuse or Neglect

D. Protective Factors

Listed below are some factors than can reduce a person's risk of suicide.

- Internal:
  - Ability to cope with stress
  - Religious beliefs
  - Frustration tolerance
- External:
  - Responsibility to children or pets
  - Positive therapeutic relationships
  - Social supports of friends and family

E. Risk Level

Only when risk is perceived as "high" is an <u>immediate</u> response required.

- **Low Risk:**
  - Vague thoughts of death
  - No immediate plan to kill themselves
  - Few risk factors
  - Good physical and psychosocial characteristics (e.g., good physical health, competent support system, positive self-image)
- **Moderate Risk:**
  - Some thoughts of suicide
  - No immediate plan to kill themselves
  - Several chronic or historical risk factors (e.g., prior suicide attempts or substance abuse)
  - Acute physical and/or psychosocial stressors (e.g., poor physical health, lack of support system, poor problem solving skills)
- **High Risk:**
  - Definite thoughts (intent)
  - Plans in place to kill themselves in immediate future
  - Means available
  - Recently attempted suicide with lethal means

- Clinical impression that carrying out suicide intent is strong due to high-risk factors (e.g., severity of depression, active substance abuse, etc.

4. Treatment Planning

It is important to develop a plan that is appropriate to the patient's level of risk.

A. Components of Treatment Plan

- **Psychiatric**
  - Ensure that any psychiatric disorders are being effectively treated.
  - This may involve prescribing medications, referring to psychotherapists, and/or involving a psychiatric specialist.
- **Education**
  - Educate the patient about suicide being a permanent solution to a temporary problem or feeling.
  - Teach the patient about resources available in your area (e.g., hospital emergency room, local crisis services, national phone hotline numbers, etc.).
- **Behavioral**
  - Guide the patient to restrict their access to the means to commit suicide (e.g., guns, poisons, drugs, medications).
  - Involve the participation of family and/or friends to assist (taking possession of the gun or helping the patient throw out the drugs).
- **Follow-up**
  - Create a specific plan for follow-up with the patient.
    - *Who will call whom?*
    - *When will they call?*
    - *When will appointments be called for referrals?*
  - Be sure to execute the plan.
  - Review the assessment and plan with supervisors in your agency and/or appropriate consultants.
  - Document everything clearly and promptly in the patient's record, according to your agency's procedures.
  - Notify all providers, as appropriate, about the assessment and plan.

B. Risk Level

These guidelines are only suggestions. Specific patients and situations may warrant other measures.

- **Low Risk:**
  - Support patient's intention to stay alive. Ask to be informed if these thoughts change.
  - Share the ideation and discussion with patient's primary care provider, as well as other appropriate providers of the patient (e.g., psychotherapist).
  - Discuss coping tools for when the thoughts occur.
  - Ensure the patient has crisis/emergency contact information.
- **Moderate Risk:**
  - Support patient's intention to stay alive. Ask to be informed if these thoughts change.
  - Share the ideation and discussion with patient's primary care provider, as well as other appropriate providers of the patient (e.g., psychotherapist).
  - Arrange for the patient to see their current mental health providers (if the patient has any).
  - Discuss options for referral to mental health providers, if wanted or indicated.

- Contact the patient within 24-48 hours to check in. This may be an in-person appointment or by phone.
- Discuss coping tools for when the thoughts occur.
- Enlist the assistance of family or friends. The patient may do this directly, or give the provider consent to contact them.
- Ensure the patient has crisis/emergency contact information.

- **High Risk:**
  - If the patient is in critical condition and harm seems imminent, arrange for the patient to go to the hospital emergency room. Staff at the hospital can provide a more comprehensive evaluation, as well as determine the appropriate level of care the patient needs (inpatient or outpatient).
  - Depending on the services at your agency and in your area, that may mean calling the police or an ambulance.
  - Follow up with the emergency room staff, providing the information you obtained through your assessment.
  - Share the ideation and discussion with patient's primary care provider, as well as other appropriate providers of the patient (e.g., psychotherapist).

5. Resources

- National Suicide Prevention Lifeline
  - 800-273-8255
- National Crisis Help Line
  - 800-784-2433
- Depression Hotline
  - 630-482-9696
- Suicide Prevention Resource Center
  - www.sprc.org
  - 877-438-7772
- American Foundation for Suicide Prevention
  - www.afsp.org
  - 888-333-2377
- Suicide Prevention Services of America
  - www.spsamerica.org
  - 630-482-9699
- *The Depression Helpbook*
  By Katon, Wayne; Ludman, Evette; and Simon, Gregory. 2008. 2nd edition. Boulder, CO: Bull Publishing

Disclaimer

This protocol for managing suicidality and self-harm ideation/behaviors is for information purposes only. It includes some of the procedures and guidelines that were used in the DAWN study. This protocol is in no way meant to be definitive or inclusive of all issues/needs that clinics, providers, or patients may have. Clinic administration and providers must consider their individual situations, resources, and capacities when developing their own protocol to meet their needs. The ideas provided here are suggestions and the DAWN program and the University of Washington cannot be held responsible for their use and modification.

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Suicide & Self-Harm Assessment Form

Patient Name: _____ Date: _____

Patient ID: _____ Staff: _____

SUICIDAL INDICATION

- ❑ Endorsed PHQ item #9: "Thoughts that you would be better off dead or thoughts of hurting yourself in some way."
  - ❑ Several days (1) ❑ More than half the days (2) ❑ Nearly every day (3)
- ❑ Spontaneously reported thoughts of self-harm to a clinic staff member.

_____

_____

ASSESSMENT

Has the patient specifically thought about hurting herself?

- ❑ No
- ❑ Yes (list thoughts/plans) _____

_____

_____

Has the patient discussed these thoughts with her physician or other health care provider?

- ❑ No
- ❑ Yes Provider's Name & Phone _____

Date of Last Contact _____

Risk factors to review with patient:

Current drug or alcohol use?	❑ Yes	❑ No
History of prior suicide attempt?	❑ Yes	❑ No
Availability of firearms in the home?	❑ Yes	❑ No

RISK ASSESSMENT

- ❑ **Low:** patient has no immediate plan to kill herself, has few risk factors, and has good physical and psychosocial characteristics (e.g., good physical health, competent support system, positive self-image)
  - Notify patient's OB-GYN provider and clinic social worker
  - Discuss options if symptoms worsen

- ❑ **Moderate:** patient has no immediate plan to kill herself, but has several chronic or historical risk factors (e.g., prior suicide attempts, substance abuse) or acute physical and/or psychosocial stressors (e.g., poor physical health, lack of support system, poor problem solving skills)
  - Discuss with patient's OB-GYN provider and clinic social worker
  - Arrange for follow-up in the clinic within 24-48 hours
  - Discuss options if symptoms worsen.

- ❑ **High:** patient plans to kill herself in the immediate future, recently attempted suicide with lethal means, AND the clinician's impression of carrying out her suicidal intent is strong due to one or more high-risk factors (e.g., severity of depression, active substance abuse)
  - Discuss with patient's OB-GYN provider and clinic social worker
  - Assist with arranging an emergent evaluation in clinic, emergency room or crisis team

Additional Assessment Comments/Information:

OUTCOME NOTES / ACTION PLAN

DOCUMENTATION

Patient's OB-GYN Provider Notified ❑ Yes ❑ No

Date _____ Provider Name _____

Reason not notified _____

Clinic Social Worker Notified ❑ Yes ❑ No

Date _____ Social Worker Name _____

Reason not notified _____

Other Provider Notified ❑ Yes ❑ No

Date _____ Provider Name _____

Reason not notified _____

Record of Attempts to Contact Patient

Date (mm/dd/yyyy)	Time (am/pm)	Outcome