TAKING IMMEDIATE ACTION AND SAFETY PLANNING

Who: Behavioral health clinicians are added to the care team. The care team should:

• Access to lethal means coupled with suicidal thoughts
• Discharge from inpatient psychiatric care within the first year after, and
• Social isolation or a pattern/history of aggressive or antisocial behavior

Suicide risk factors:

• Mental or emotional disorders, particularly depression and bipolar disorder
• Serious illness, or physical or chronic pain or impairment
• Substance use disorders
• History of trauma or loss, such as a child, family history of suicide, bereavement, or
• Posttraumatic stress disorder
• Serious illness, or physical or chronic pain or impairment
• Social isolation or a pattern/history of aggressive or antisocial behavior
• Discharge from inguinal surgical care within one week from the time of discharge
• Inpatient psychiatric care within the first week and months after discharge
• Suicide attempt or history

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DETECTING SUICIDE IDEATION IN NON-ACUTE OR ACUTE CARE SETTINGS

Who: All care providers in all settings

1. Review each patient’s personal and family medical history for suicide risk factors.

While suicide may affect certain demographics—such as military veterans—more than others, it’s important to identify the risk factors, rather than membership in a group, when considering suicide risk.

2. Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool.

A waiting room questionnaire can include a specific asking if the patient has had thoughts about killing him or herself.

3. Review screening questionnaires before the patient leaves the appointment or is discharged.

Conduct or refer for secondary screening and assessment patients determined to be at risk for suicide. For patients who screen positive for suicide ideation and deny or electrical suicide risk or decline treatment, obtain corroborating information from family, friends, or outpatient treatment providers.

DETECTING AND TREATING SUICIDE IDEATION

For details, references and resources, see Sentinel Event Alert #56: Detecting and Treating Suicide Ideation in All Settings

Detecting and Treating Suicide Ideation

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Who: Primary, emergency and behavioral health clinicians

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4. Take the following actions, using assessment results to inform the level of safety measures needed:

• Keep patients in acute suicidal crisis in a safe health care environment under one-to-one observation.

Do not leave these patients by themselves.

• Keep patients away from anchor points for hanging and material that can be used for self-injury.

• Provide immediate access to care.

• Check patients and visitors for items that could be used to make a suicide attempt or harm others.

• For patients at lower risk of suicide, make personal and direct referrals and linkages to outpatient providers having responsibility for the patient’s well-being.

• For all patients with suicide ideation:

• Provide the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), and to local crisis and peer support contacts.

• Conduct or refer for secondary screening and assessment patients determined to be at risk for suicide. For patients who screen positive for suicide ideation and deny or electrical suicide risk or decline treatment, obtain corroborating information from family, friends, or outpatient treatment providers.

• Discuss the treatment and discharge plan with the patient and share the plan with other providers having responsibility for the patient’s well-being.

• Be generous in documentation, as it becomes the main method of communication among providers.

• Every step in the decision-making process.

• Explore the patient’s prior suicide attempts.

• Why the patient is at risk for suicide.

• Communicate with the patient, family members, significant others, and other caregivers about the patient’s risk for suicide.

• Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient’s well-being.

• Directly addressing patients’ thoughts about suicide at every interaction.

5. Establish a collaborative, engaging, and systematic assessment and treatment process with the patient, involving the patient’s other providers, family, and friends, as appropriate.

A valuable support to traditional risk assessment is to use a risk formulation model that can help providers to understand a patient’s current thoughts, plans, access to lethal means, and acute risk factors.

• Safety planning (collaboratively identifying possible coping strategies with the patient).

• Restraint access to lethal means.

6. To improve outcomes for all risk patients, develop treatment and discharge plans that directly target suicidality.

Focus on evidence-based approaches that emphasize patient engagement, collaborative discharge planning to promote effective coping strategies, and follow-up care with the patient’s other providers.

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Examples of collaborative interventions:

• Engaging the patient and family members/significant others in collaborative discharge planning to promote effective coping strategies.

• Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient’s well-being.

• Determining how often patients will be called and seen.

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• Determining how often patients will be called and seen.

The Joint Commission

For details, references and resources, see Sentinel Event Alert #56: Detecting and Treating Suicide Ideation in All Settings

Detecting and Treating Suicide Ideation

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