Health Center Excellence: Essential Steps in Integrating Suicide Prevention in Primary Care & Supporting Healthcare Teams

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INTRODUCTION

Suicide is a growing public health crisis in the United States and a leading cause of death for patients and healthcare professionals.[1] To help prevent suicide in patients and healthcare team members alike, the American healthcare system must adopt evidence-based approaches to identify and care for those at risk of suicide. As essential providers of primary care to underserved communities, health centers can and should play a key role in this effort. Nearly half of individuals who die by suicide visit a primary care provider in the month before their death—making primary care visits at health centers unique opportunities to assess risk and intervene.[2,3]

To do so, health centers should ensure that primary care providers and their teams incorporate suicide prevention techniques into patient care and create holistic cultures that support employees and proactively address risks of staff suicide. The following fact sheet introduces the topic of suicide in patients and healthcare professionals and outlines essential steps that health centers can take to achieve excellence in suicide prevention by integrating Suicide Safer Care principles into primary care and addressing the risk of suicide in healthcare team members.

The Crisis of Suicide and How FQHCs Can Help

Primary care clinicians are confronting increasing concerns for patients who may be at heightened risk for suicide. **Suicide is a growing public health crisis and the tenth leading cause of death in the U.S.**[4] In 2018 alone, more than 48,000 individuals in the U.S. died by suicide—one death every 11 minutes.[5] Despite efforts to lower this suicide rate, it increased 35% from 1999-2018, becoming the second leading cause of death for individuals between the ages of 10-34.[6] The economic cost of actual and attempted deaths by suicide—to say nothing of its emotional toll—is staggering.[7]

Deaths by suicide rarely stem from a single cause or solely from behavioral health conditions. Less than half of those who die by suicide had diagnosed mental health conditions such as depression.[8] A variety of other factors contribute to deaths by suicide, ranging from relationship issues and life crises to substance use disorder and illnesses. To prevent such deaths, we must undertake a comprehensive approach to suicide prevention, and **the U.S. healthcare system, including health centers, must adopt evidence-based approaches to identify and care for those at risk of suicide.**

[1] Centers for Disease Control & Prevention. 2020. "Preventing Suicide." Violence Prevention.
[2] Ahmedani, BK, Simon GE, et al. 2014. "Health Care Contacts in the Year Before Suicide Death." *Journal of General Internal Medicine* 29(6): 870-877.
[3] Luoma JB, Martin CE, and Pearson JL. 2002. "Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence." *American Journal of Psychiatry* 159(6): 909-16.
[4] Centers for Disease Control & Prevention. 2020. "Preventing Suicide." Violence Prevention.
[5] CDC. 2020. "Web-Based Injury Statistics Query and Reporting System (WISQARS)." Atlanta, GA: National Center for Injury Prevention and Control. Accessed December 22, 2020. https://www.cdc.gov/injury/wisqars/index.html.
[6] Hedegaard, H, Curtin, SC, et al. 2020. "Increase in Suicide Mortality in the United States, 1999-2018." *NHSC Data Brief no. 362*. Hyattsville, MD: National Center for Health Statistics.
[7] CDC. 2020. "Web-Based Injury Statistics Query and Reporting System (WISQARS)."
[8] Stone, DM, Simon, TR, et al. 2018. « Vital Signs: Trends in State Suicide Rates – United States, 1999-2016 and Circumstances Contributing to Suicide – 27 States, 2015." *Morbidity and Mortality Weekly Report* 67(22): 617–624.

Suicide in Healthcare Professionals

Health centers must also actively support their healthcare team members and take action to reduce suicide risk in their employees. Healthcare professionals of all disciplines are no exception to the rising trend of suicide in the U.S. For nearly 150 years, it has been known that physicians have an increased propensity to die by suicide,[9,10] and one study found that **approximately 300 physicians die by suicide each year—nearly one a day.**[11] Because deaths by suicide often go unreported, the true rate is almost certainly higher.

The same is true of nurse practitioners (NPs) and physician assistants (PAs), which are increasingly surpassing physicians as providers, especially in FQHCs.[12] As PCPs, female NPs and PAs also have elevated suicide rates compared to general women of working age.[13] This issue also impacts nurses and other healthcare team members: nurses occupy unique frontline positions between patients and providers, and they, too, have significantly higher risks of suicide than the general population.[14]

Nevertheless, many professionals do not seek care,[15] and stigma against mental illness is pervasive in the medical community.[16] In addition to the incalculable human costs of deaths by suicide, suicide and suicide attempts cost the U.S. $95.3 billion each year, and investments in medical, counseling, and linkage services would result in an estimate 6:1 benefit-to-cost ratio.[17]

Why Health Centers Have a Unique Opportunity to Help

As dedicated—and sometimes sole—providers of care to medically underserved communities, health centers have a unique opportunity to help prevent suicide in their patient populations. For many health center patients, local FQHCs may represent their only chance to access and receive behavioral care, whether in a dedicated sense or through incorporation in primary care. Furthermore, many of the patient populations served by FQHCs have significant higher risks of suicide. These patients may not have access to or desire to

> *"Because they offer multiple service lines and because of their large numbers of uninsured patients, health centers have a unique opportunity of being the only system that many people interface with, particularly in rural areas. And given the increased suicide rates in youth of color and other populations that FQHCs serve, they're in a unique position to ask their patients about suicide."*
>
> - Dr. Virna Little, Chief Operating Officer, Concert Health

[9] Bucknill JC, Tuke, DH, eds. (1874.) *A Manual of Psychological Medicine, containing the Lunacy Laws, the Nosology, the Ætiology, Statistics, Description, Diagnosis, Pathology, and Treatment of Insanity.* 3rd Edition. London: J & A. Churchill: 806.

[10] Schernhammer, E. S., & Colditz, G. A. (2004). Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis). American Journal of Psychiatry AJP, 161(12), 2295-2302.

[11] Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., Laszlo, J., Litts, D.A., Mann, J., Mansky, P.A., Michels, R., Miles, S.H., Proujansky, R., Reynolds, C.F. 3rd, Silverman, M. M. (2003). Confronting Depression and Suicide in Physicians. *JAMA* 289(23), 3161.

[12] Mark, B. A., & Patel, E. (2019). "Nurse Practitioner Scope of Practice: What Do We Know and Where Do We Go?" *Western Journal of Nursing Research* 41(4), 483–487.

[13] Peterson, C., Sussel, A., et al. (2020). "Suicide Rates by Industry and Occupation – National Violent Death Reporting System, 32 States, 2016." *Morbidity and Mortality Weekly Report* 69(3): 57-62.

[14] Davis, M A, Cher, B A, et al. (2021). "Association of US Nurse and Physician Occupation with Risk of Suicide." *JAMA Psychiatry* 78(6): 651-658.

[15] Mata DA, Ramos MA, et al. (2015).

[16] Kalmoe, M C, Chapman, M B, et al. (2019).

[17] Shepard, D.S., Gurewich, D., et al. (2016). "Suicide and Suicidal Attempts in the United States: Costs and Policy Implications." *Suicide and Life-Threatening Behavior* 46(3): 352-362.

see behavioral health providers for fear of stigma, but those same patients will likely seek some form of primary care. **For these and other reasons, health centers must act to prevent suicide in patients and staff.**

An Integrated Approach to Reduce Suicide Risk in Patients and the Healthcare Teams that Care for Them

To reduce the risk of suicide in both patients and healthcare teams, health centers should take an integrated, trandisciplinary approach to achieve excellence in integrating suicide prevention in primary care. **This approach should implement a twofold care model that both integrates Suicide Safer Care principles into primary care and creates a supportive culture of Suicide Safer Care for its providers and healthcare teams.** The following is a brief list of recommended best practices for suicide prevention in primary care, as well as organizational techniques to address suicide risk in providers and healthcare team members.

Best Practices in Suicide Prevention in Primary Care

Health centers can meaningfully implement suicide prevention in primary care services by screening and identifying patients at risk for suicide, assessing patients at risk, and caring for patients at risk for suicide. The following is a condensed list of essential steps adapted from ACU's *Suicide Safer Care: A Toolkit for Primary Care Providers and Their Teams* to help health centers create cultures of care that emphasize evidence-based care practices to reduce suicide in their patients.

A Clinical Imperative: Creating a Culture of Suicide Safer Care

The first step to successfully implementing suicide prevention strategies at your health center is to **fully commit to acknowledging suicide prevention as a clinical priority.** Take stock of where your organization is at present:

- **Does my organization screen patients for suicide via the PHQ-9, and if so, do providers assess risk?**
- **Is risk for suicide included in patient electronic health records?**
- **Does my organization utilize shared care plans for suicide prevention?**
- **Have my providers and staff received training on evidence-based practices for suicide prevention?**

> *"Health centers face unique challenges to suicide prevention, but they can start with understanding that [prevention] is a clinical priority and not just another initiative. A helpful way to look at it is to think about the population of patients with a behavioral health need in the same way you would your population with diabetes, with the same level of accountability for testing via the Columbia Suicide Severity Rating Scale for patients at risk of suicide as testing A1C levels of patients with diabetes."*
>
> - Dr. Virna Little, Chief Operating Officer, Concert Health

These questions can help your organization better understand its gaps in understanding of Suicide Safer Care, particularly if the answer to these of any questions is "no."

Implementing Screening and Identifying Patients at Risk for Suicide

Suicide prevention efforts start with screening, and screening for suicide improves patient safety. Health centers should establish and train all healthcare team members in protocols for routine suicide screening utilizing evidenced-based tools and educate all staff in recognizing common warning signs and risk factors. A greater understanding of suicide itself is also needed: providers must understand both the social determinants of health that influence suicide and the fact that suicide is usually the result of multiple factors—of which mental health conditions are merely one of many.

A Vital Tool: The Patient Health Questionnaire-9

Most primary care settings utilize the Patient Health Questionnaire-9 (PHQ-9) for screening patients over the age of 12 for depression. This screening includes item 9, which specifically asks about suicidal ideation. If your FQHC utilizes the PHQ-2, consider adding in question 9 from the PHQ-9 to ensure that suicide is included in routine screening.

Adapted tools are available for special populations: the PHQ-A may be utilized for children and adolescents aged 12 to 18, and the Ask Suicide-Screening Questions (ASQ) may be used for children younger than 12 (*see Further Resources).* Most practices screen yearly, but it is important to screen patients more frequently if they are experiencing transitions in care, have substance use disorder, or other risk factors. The COVID-19 pandemic is another important factor, having significantly impacted numerous social determinants of health, from individuals' income and job security to their access to primary and behavioral healthcare. These stressful life events consistently identify as risk factors for suicide.[18] **Regardless of population, screening results should be included in electronic health records (EHRs) and alerts placed on EHRs of patients being monitored or treated for suicide risk.**

Assessing Patients at Risk

In addition to implementing standardized suicidal screening for patients of all ages, health centers should also train staff in suicide risk assessment methods if routine screenings show risk for suicide in patients. This should be part of a comprehensive Suicide Care Management Plan, an example of which is available in ACU's *Suicide Safer Care Toolkit*. Further detail on specific steps—such as safety planning—is provided below, but other key elements include:

- Adjusting the frequency of visits and acting if patients miss appointments
- Processes for communicating with patients about diagnosis and treatment expectations
- Requirements for continued contact with and support for patients during transition in care
- Referral processes for suicide-specific, evidence-based treatment
- Established protocols for documentation and conclusion of management plans

The Columbia Suicide Severity Rating Scale

[18] Wang, Y., et al (2012). Recent stressful life events and suicide attempt: Results from a nationally representative sample. Psychiatric Annals. 42.101.10.3928/00485713-20120217-07.

There are a variety of assessment tools health centers may utilize, such as the Columbia Suicide Severity Rating Scale (C-SSRS). Well scripted for non-behavioral health professionals, the C-SSRS guides providers through a series of questions for the patient, including whether they have been considering specific methods of ending their lives by suicide, whether they have clear intent, and if they have made any attempts. The tool includes triage guidelines, and online training is available.

When using the C-SSRS and working with patients identified as at risk for suicide, providers should utilize clear communication strategies asking direct, matter-of-fact questions regarding suicide. Health centers should also train non-clinical team members in simple curricula such as SafeTALK or Mental Health First Aid.

Caring for Patients at Risk for Suicide

As part of suicide care management plans, health centers should take action to mitigate risk for suicide in patients utilizing protocols for safety planning, reducing access to lethal means, and other intervention practices. **It is important that healthcare teams coordinate their treatment of such patients: suicide prevention cannot be the sole responsibility of any one provider.**

Safety Planning

One essential, evidence-based intervention includes working with patients at risk for suicide in the creation of safety plans. Apart from patients in need of emergency hospitalization, most patients at risk will benefit from this practice.[19] To create the plans, collaborate with the patient to write, in their own words, a brief document answering questions such as:

- "What are your warning signs and coping strategies?"
- "What people and settings provide distraction, and what people can I rely on for help?"
- "What steps can I take to make my environment safe?" *(See Safety Planning below)*
- "What are my reasons for living?" (e.g. protective factors).

Numerous examples of safety plans are available from organizations including NowMattersNow.org and the National Suicide Prevention Lifeline.

Restricting Access to Lethal Means

Whatever template your organization uses, each safety plan should include specific steps for reducing access to lethal means which the patient might use to end their lives. Rates of suicide decrease when access to common suicide methods is reduced,[20] and organizations should establish clear policies for what care team members can do to counsel patients on lethal means. Free training is available for clinical and non-clinical staff in Counseling on Access to Lethal Means (CALM) training from the Suicide Prevention Resource Center. While it is impossible to "suicide-proof" a patient's environment, establishing simple behavioral goals such as storing firearms away from home or keeping only small quantities of medications can help save lives.[21]

[19] Stanley, B, & Brown, GK. (2011) "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice* 19(2): 256-264.
[20] Harvard T. H. Chan School of Public Health. (2016). Means Matter. Retrieved from https://www.hsph.harvard.edu/means-matter/.
[21] Suicide Prevention Resource Center. (2019). "What Clinicians Can Do." Retrieved from https://www.sprc.org/sites/default/files/Handout-WhatCliniciansCanDo.pdf.

Other Brief, Evidence-Based Interventions

Health centers should also train providers and other healthcare team members in brief-evidenced based interventions such as caring contacts, provision of helpful resources, and knowledge of alternative levels of care. Sending brief communications via texts, phone calls, or emails to patients during care transitions such as discharge from treatment or when patients miss appointments—caring contacts—has been shown to be effective in suicide prevention. Health centers can also develop partnerships with local crisis centers to provide follow-up contacts.

Care teams should also be aware of national patient resources such as the National Suicide Prevention Lifeline (1-800-273-8255) and NowMattersNow.org website. Knowledge of appropriate referrals through protocols such as the Stepped Care Model[22] is also crucial to ensure appropriate care for patients with moderate-to-high risk scores on assessment or who pose threats to themselves or others who cannot be treated in least restrictive settings.

Best Practices for Organizational Action to Reduce Staff Suicide Risk

The best response to suicide prevention and postvention is comprehensive and planned before incidents occur. The following is a condensed list of essential steps adapted from ACU's *Organizational Approaches to Address Suicide Risk in Providers in Staff* that institutions can take for suicide prevention and postvention in their workforce.

Assess How Your Organization Supports Staff and Addresses Suicide Risk

The best way to start is by honestly assessing your organization and how it incorporates suicide prevention, if at all, in its practices. Some key questions include:

- **Does your organization include training on Suicide Safer Care for providers and staff and HR?**
- **Does your institution train managers in how to respond and address suicide risk in employees?**
- **Is your Employee Assistance Program trained in evidence-based suicide prevention?**
- **Does my organization effectively integrate with other local behavioral health services, community resources, or other support systems?**

Understand the Impact of Social Determinants of Health and How They May Affect Mental Health and Suicide Risk

It is also important to understand trends in your health center teams' professions and the impact of stressors such as burnout or fatigue, including those exacerbated by the COVID-19 pandemic.

[22] Jobes, D. A., Gregorian, M. J., et al. (2018). *Psychological Services* 15(3) : 243-250.

Nearly 50% of all healthcare workers reported significant psychological distress during COVID-19,[23] and the effects of the pandemic on mental health may linger after the pandemic subsides.[24]

Train Managers to Understand Warning Signs & Create Response Systems

Managers can play significant roles in creating holistic cultures of care at their workplaces, and that includes supporting the mental health of their employees. To ensure that they can take advantage of these opportunities, managers should know what to do through established systems.[25]

Recognize Warning Signs

Supervisors are well-positioned to notice if employees are struggling or exhibit warning signs. Whether via self-disclosure, concern from other staff, social media posts, or simple observation, it is critical that supervisors know and recognize signs of suicide risk.

Know What Help Is Available

Many healthcare professionals avoid seeking help for fear of professional repercussions. As such, it is crucial for employers to answer common questions related to employee assistance such as:[26]

- "Will my employer have access to my counseling records?"
- "Will a diagnosis hinder my chances for a promotion?"
- "What will this cost or involve?"
- "Who will know if I use the employee assistance services provided by my workplace?"

Understand both your own organizations' services and what community systems exist. Take steps to make providers and staff aware of your own and other supports, from local behavioral health services to national helplines such as the National Suicide Prevention Lifeline (800-273-8255).

Act Quickly to Intervene

There is no "foolproof" way for managers to know that a healthcare team member may be thinking of ending their lives. However, once they become aware of threats of suicide or warning signs, they should act quickly to address the issue with the employee with concern, support, and understanding to encourage them to receive professional help:

- **Reach out to the person.** Meet with them privately, ask how they're doing, and give them space and time to share their thoughts while listening without judgment.
- Mention that you have noticed changes in their behavior or became aware of their potential intentions. **Ask them if they've experienced thoughts of ending their life.**

[23] Young, K. P., Kolcz, D. L., et al. 2020. "Health care workers' mental health and quality of life during COVID-19: Results from a mid-pandemic, national survey." *Psychiatric Services* 72(2): 122-128.
[24] Banerjee, D., Kosagisharaf, J. R., and Rao, T.S. S. 2021. "'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention." *Psychiatry Research* 295.
[25] Little, V., & Stoll, B. (2020). "Caring for the Healers: Preventing Suicide Among Providers." ACU.
[26] Ibid.

- Show concern without asking about personal problems or offering advice. Instead, **note that there is help for their problem with appropriate support.** Mention that you are not equipped to help them, but that they do have access to Employee Assistance Programs (EAP) and/or licensed counselors who are trained experts.
- **Get them to agree to accept help from an EAP Counselor and to not hurt themselves.**
- Mention that you will protect their privacy, but don't promise confidentiality: instead, say you will share information only if necessary to protect their safety.[27]

Cultivate a Culture of Physical and Mental Wellness for Employees

Organizations should create supportive, flexible workspaces that emphasize provider and staff wellness and self-care. In addition to offering essential benefits such as generous Paid Time Off, consider investing in wellness resources such as 24/7 Employee Assistance Programs and other "life" benefits such as onsite food or dry-cleaning services. Also important is creating a professional work environment that honors employee wellness. Furthermore, organizations should acknowledge how healthcare team members' social determinants impact them and work to create culturally responsive environments that incorporate justice, equity, diversity, and inclusion (JEDI).

Take Effective Steps for Postvention After Deaths by Suicide

Effective suicide postvention—activities that reduce risk and promote healing after deaths by suicide—can be as important as effective suicide prevention.[28] Survivors of others' deaths by suicide have elevated risks of developing suicide risk themselves,[29] and deaths by suicide of healthcare team members can have ripple effects throughout organizations, workforces, and communities. Postvention initiatives should take a comprehensive, *compassionate* approach to acknowledge and respond to the emotional needs of employees in the aftermath, accomplishing one or more of the three aims identified by the Survivors of Suicide Loss Task Force's National Guidelines:

- "To facilitate the healing of individuals from the grief and distress of suicide loss."
- "To mitigate other negative effects of exposure to suicide."
- "To prevent suicide among people who are at high risk after exposure to suicide."[30]

Organizations should create postvention plans involving being prepared to monitor and assist colleagues, patients, and other survivors of healthcare team members' deaths by suicide, to offer effective staff support via providing opportunities for individual and group assistance, and to provide opportunities both for active outreach to survivors and for self-referral. Transparent, compassionate communication—to survivors, patients, and the community—is key.[31]

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[27] Ibid.
[28] Norton, K. "Postvention as Prevention." (2015). Suicide Prevention Resource Center. "Director's Corner Blog." Retrieved from https://www.sprc.org/news/postvention-prevention.
[29] Young, I. T., Iglewicz, A. et al. (2012). "Suicide Bereavement and Complicated Grief." *Dialogues in Clinical Neuroscience* 14(2): 177-86.
[30] Survivors of Suicide Loss Task Force. (2015). "Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines." Washington, DC: National Action Alliance for Suicide Prevention. Retrieved from http://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines
[31] Little, V., & Stoll, B. (2020).

Further Resources

Integrating Suicide Prevention in Primary Care

- **Publications:**
  - Zero Suicide Organizational Self-Study
  - Suicide Safer Care: A Toolkit for Primary Care Clinicians and Leaders
  - Suicide Safer Care: A Toolkit for Pediatric PCPs & School-Based Health Centers
  - Geriatric Suicide Prevention and the Role of Primary Care Providers: A Fact Sheet

- **Webinars:**
  - Suicide Safer Care for Primary Care Providers and Their Teams
  - Identifying and Caring for Patients at Risk for Suicide During COVID-19
  - Pediatric Suicide Prevention for PCPs and School-Based FQHCs: An SSC Approach
  - Geriatric Suicide Prevention: Suicide Safer Care Principles for Primary Care Providers and Their Teams

Addressing Suicide Risk in Healthcare Professionals

- **Publications:**
  - Organizational Approaches to Address Suicide Risk in Providers in Staff
  - Building an Inclusive Organization Toolkit
  - Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines
  - A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide
  - COVID-19: The Need for Increased Awareness Around Risk for Suicide

- **Webinars:**
  - Caring for the Healers: Preventing Suicide Among Providers
  - Building Back Better: Utilizing Lessons Learned During COVID-19 for Inclusivity and Retention