

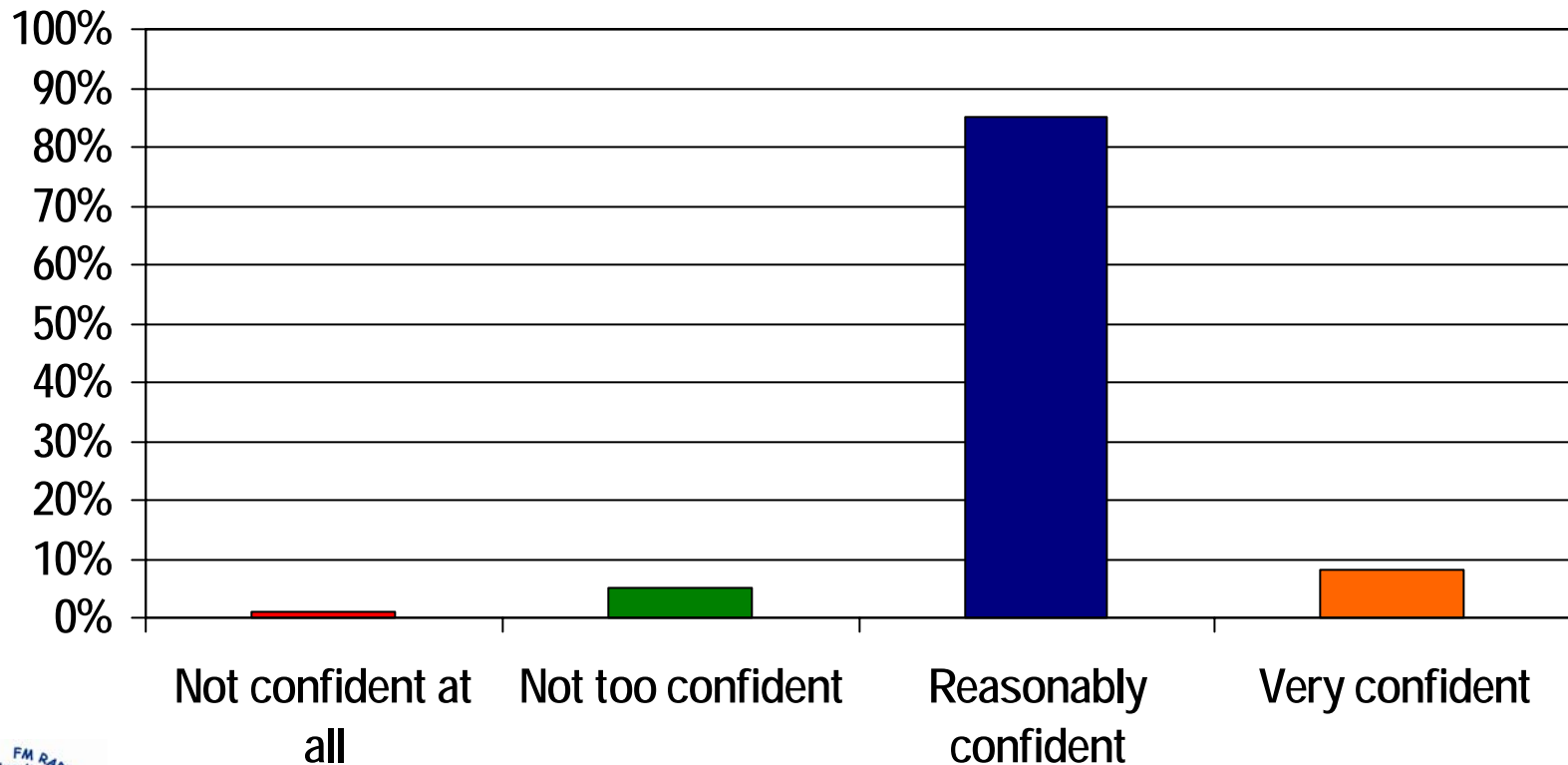
# Family Physician Self Efficacy in The Management of Patients at Risk For Suicide



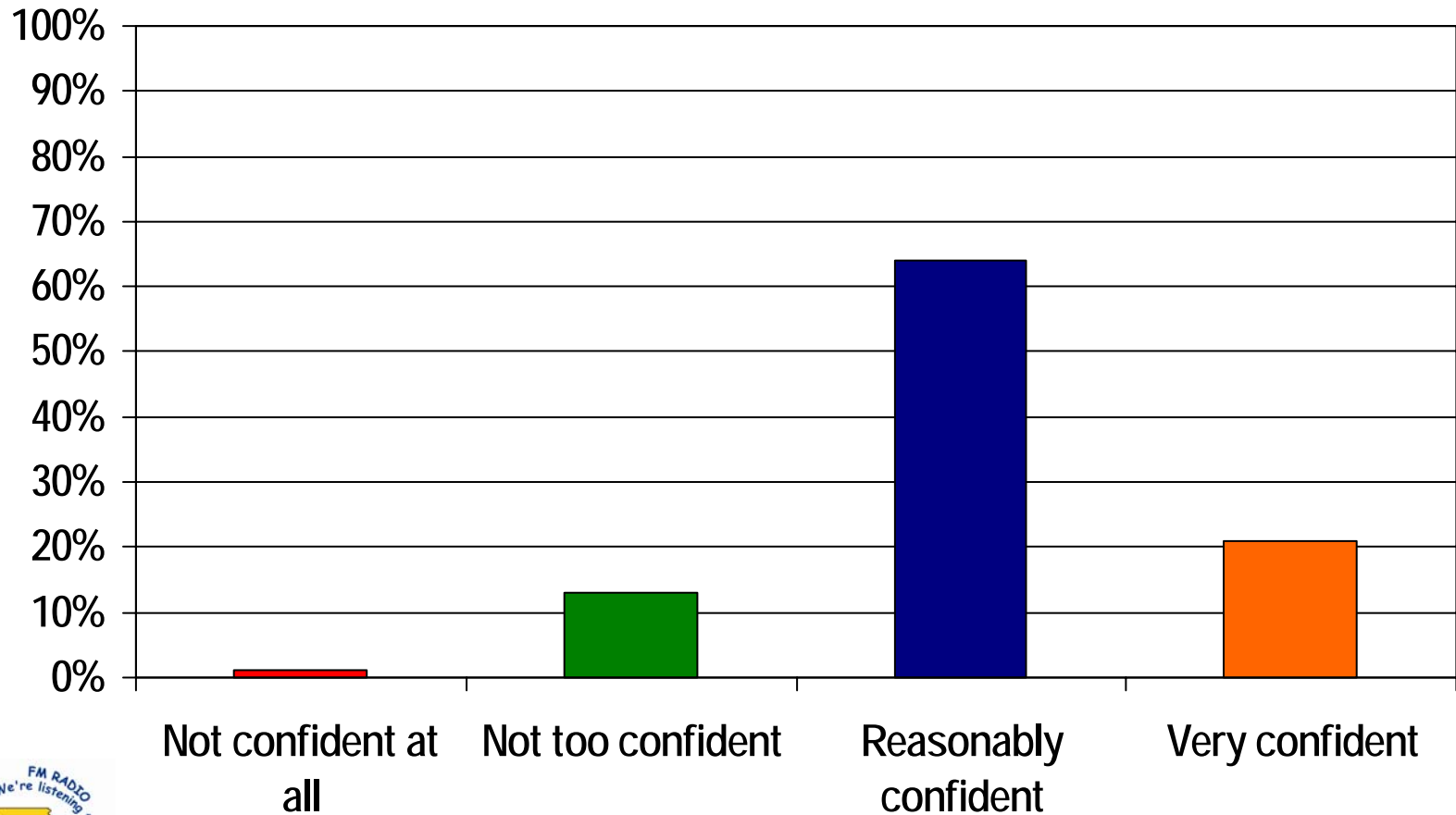
# In the past year, how many patients have you identified at risk for suicide?

- Range = 0-55
- Average = 8
- Median = 5

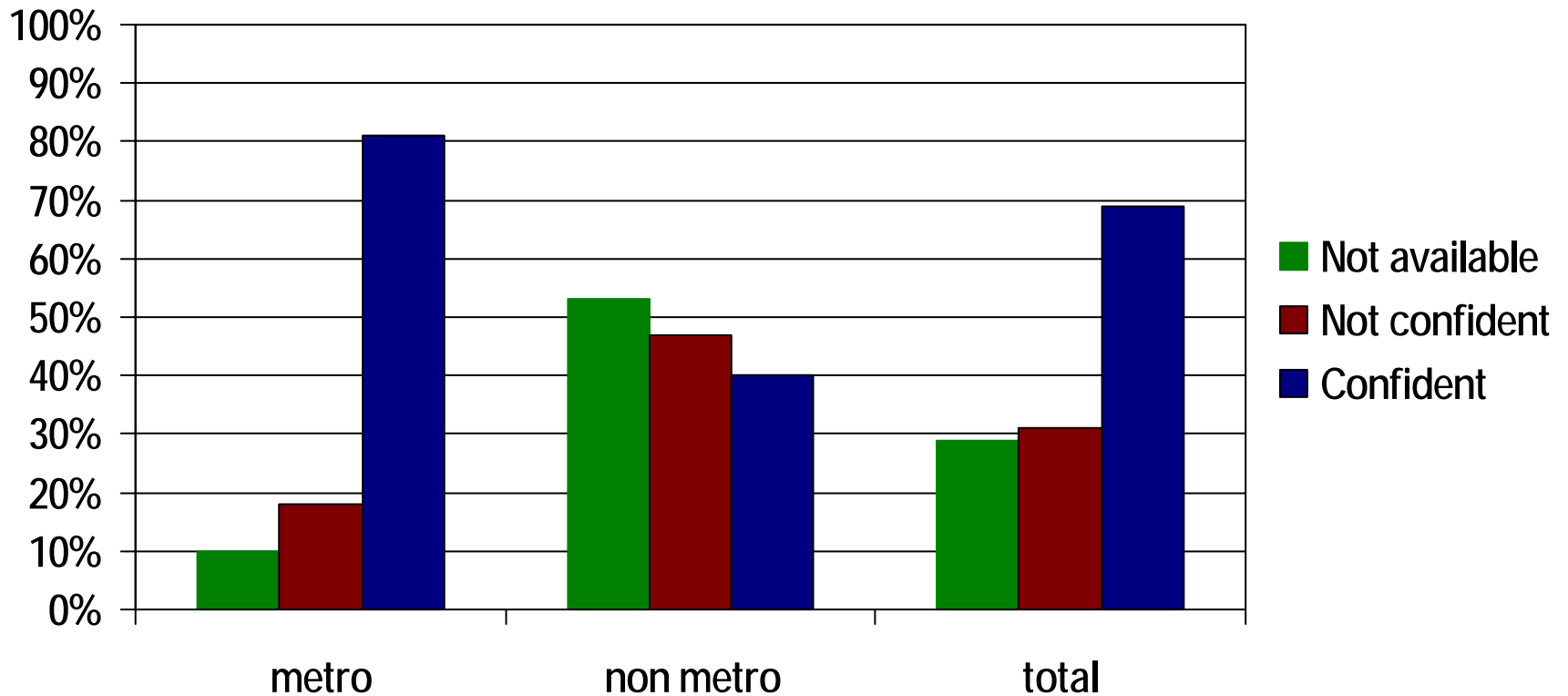
# How confident are you in identifying the patient at risk for suicide?



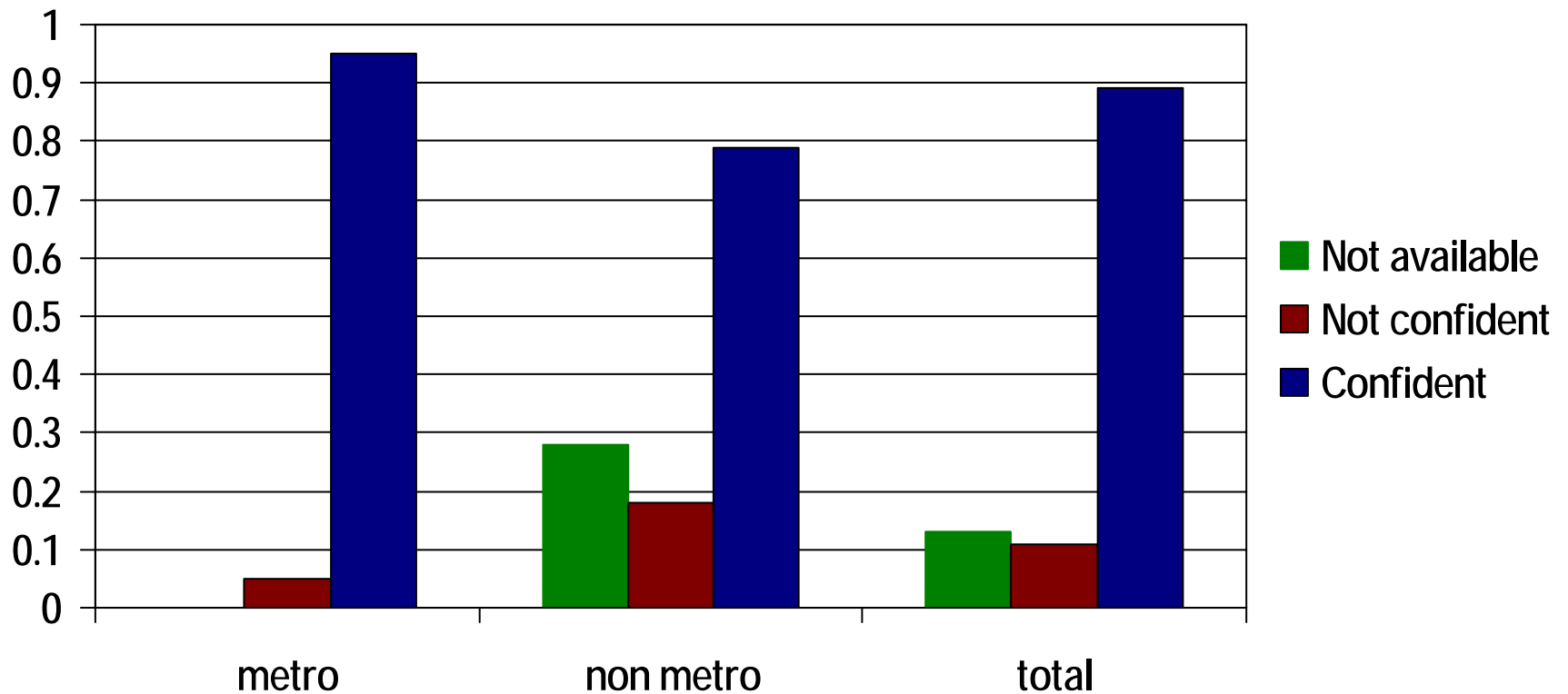
# Once you have identified a patient as high risk for suicide, how confident are you of what to do next?



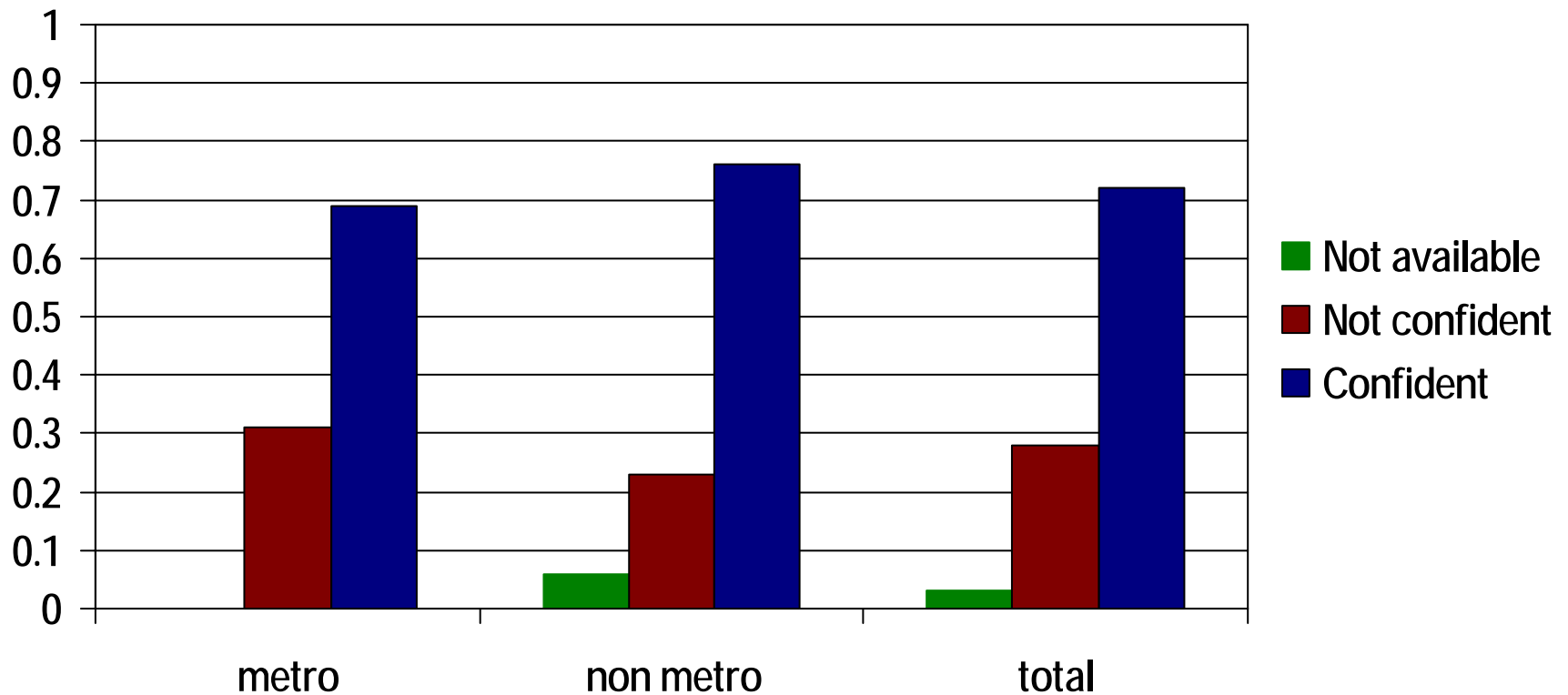
# Emergency Room Suicide Risk Evaluation Team



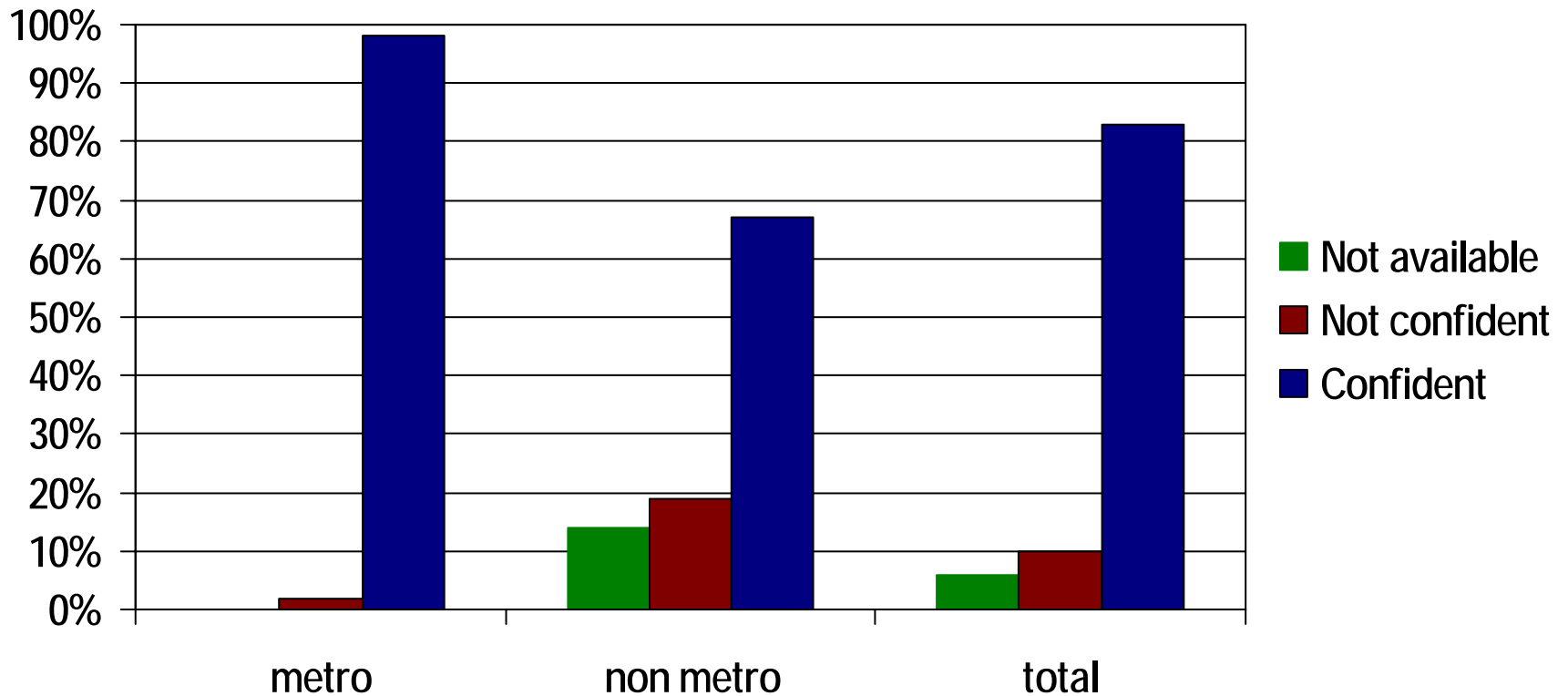
# Psychiatrist



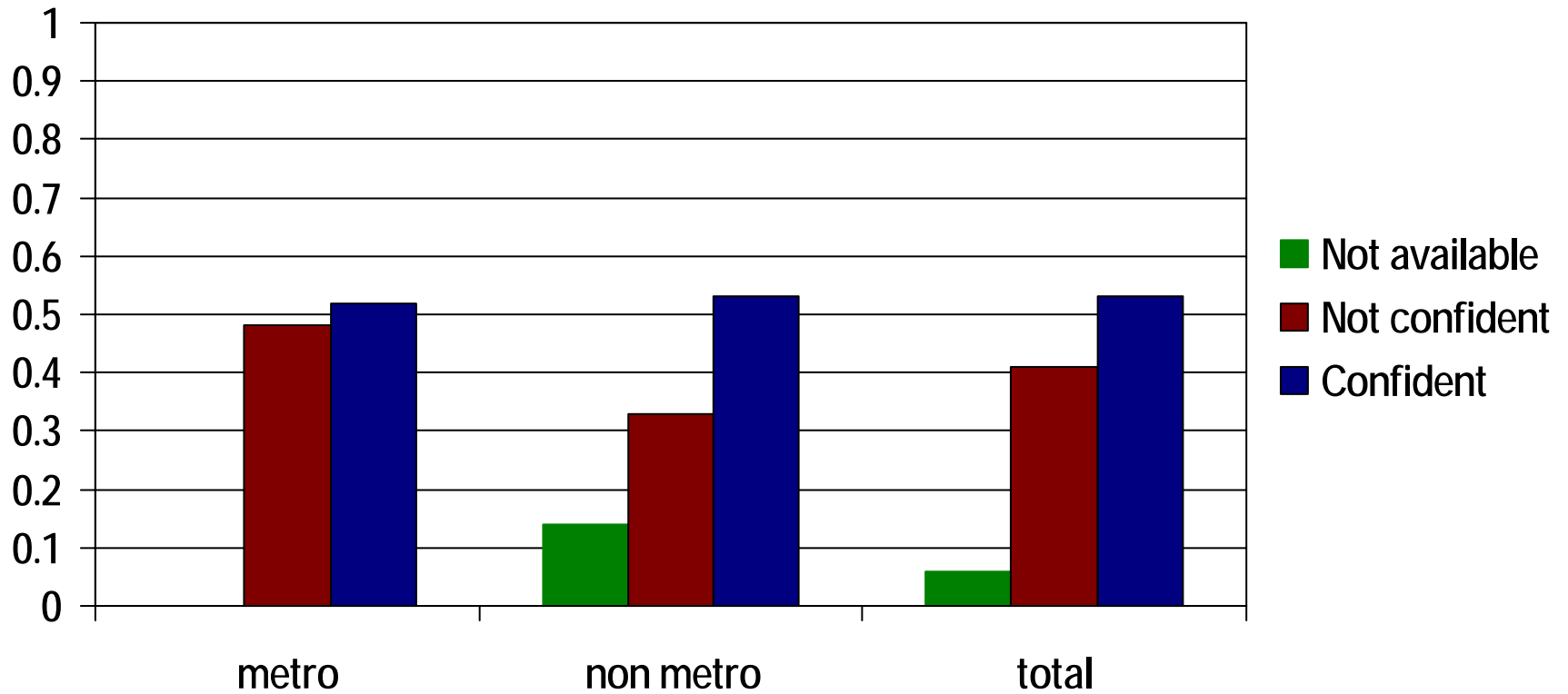
# Community mental health facility or clinic



# Private Mental Health Professional



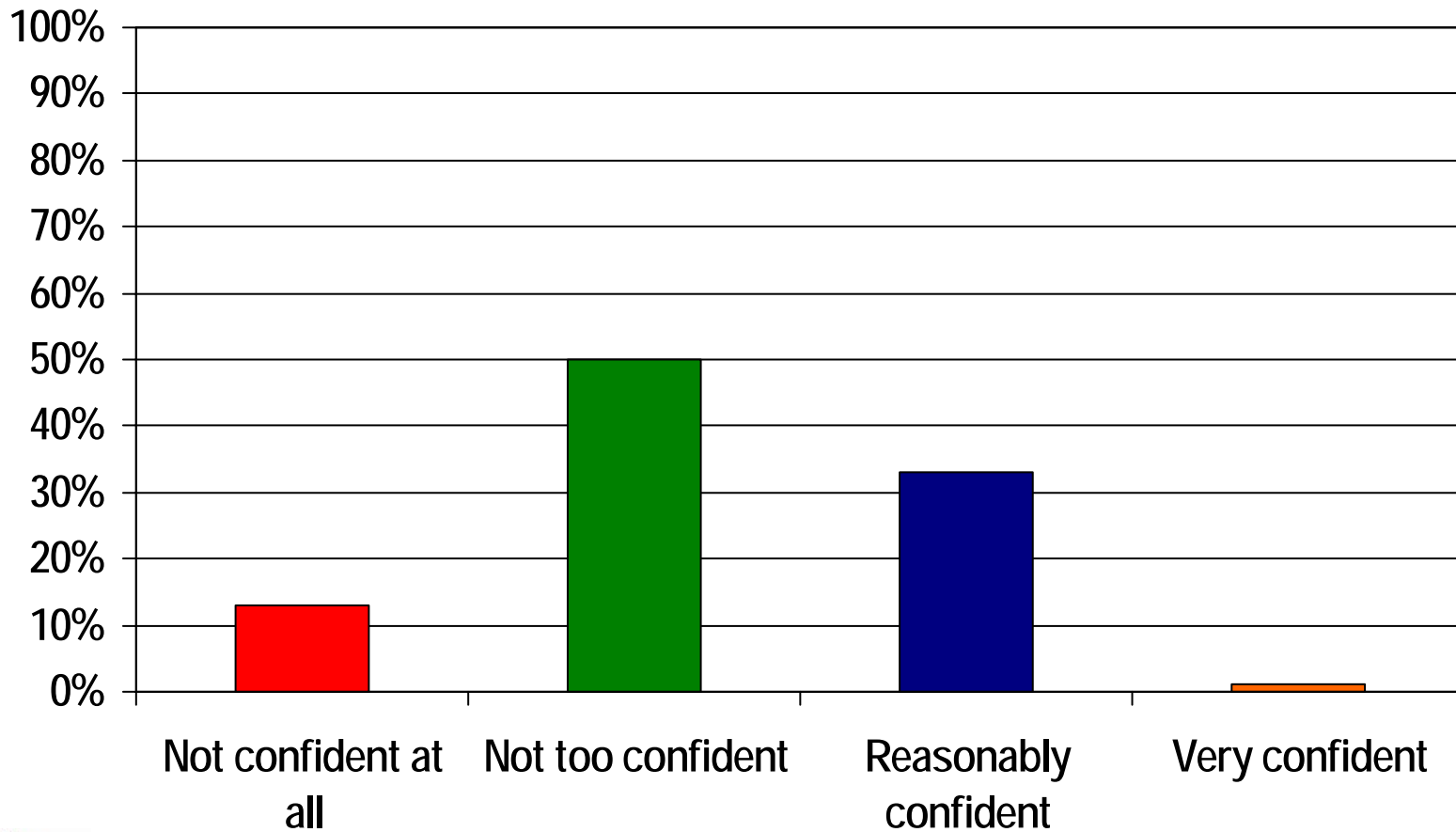
# Clergy



# What other resources are available in your community and your confidence in those resources

Resource	Confidence Level
Geropsych inpatient unit	Reasonably confident
Responsible family member	Not too confident
Contracting in the office or ER	Not too confident
Office psychologist	
Psychiatric assessment nurses	Not specified

# How confident are you in managing patients at high risk for suicide without referral?



## What recommendations do you have for family physicians regarding the identification and care of patients at high risk for suicide?

### IDENTIFYING PATIENT

- A very high level of suspicion is required to identify patients at risk.
- Abrupt changes in affect bear watching, watch for completion scenarios; i.e.: one way tickets, divestiture of favorite things-assets, etc.
- Always ask the person with signs of depression, are you thinking of hurting yourself? They will answer honestly more times than not, from what I experienced in the ER.
- Ask about suicide with appropriate follow-up questions
- Always ask if the patient has previously tried or contemplated suicide.
- First of all ask about suicidal and homicidal ideation. Most patients are upfront about it. Then gauge how serious they are. Do they have a plan? Do they have a weapon? Patients that have a plan are at extreme high risk. Also if they have attempted the plan but then "chickened" out. Also don't forget about the elderly - especially men.
- You have to ask the patient if there is any suspicion on your part. A contract should be made with the patient to call for help before they feel out of control.
- You have to ask.
- Assess for depression, for suicide, do they have a plan? Means to fulfill the plan?
- Be aware of high risk profiles, listen, and ask.
- Have a low index of suspicion before screening the elderly.
- Keep a high index of suspicion. Get comfortable with discussing psychosocial issues with patients and use simple screening tools. Don't rely on and in fact don't use "no suicide contracts".
- Look at age, support structures, prior history and types of attempts. Ask the patient if they were trying to hurt themselves.
- Screen proactively all patients with known affective disorders; consider screening all those with significant medical problems at high risk for co-morbidities.
- Should have very low threshold to refer as risk for missing any is too high.
- So much depends on the setting. The most important thing is to ask the patient if he/she is considering suicide, and if there is a plan. The 2nd is the patient agrees not to do it!
- Take serious attempts seriously, especially in the elderly.
- Take the time required to assess risk level, social support system, etc.
- Use depression inventories (i.e. Beck) as a place to begin conversation.
- Be sure to ask about firearms at home.

### MANAGEMENT OF PATIENT

- Ask the questions then get help from mental health persons to help in management.
- Have a system in place for evaluation and treatment including appropriate mental health professionals. Have a relationship with mental health professionals that allows cooperative management not only acutely but over the long term
- Find referrals in your area to help send patients that day for further assistance.
- protocol for managing potentially suicidal patients if you are in a small town hospital, as you may not get anyone to answer the phone or accept the patient based on insurance or lack thereof.
- Have an established plan for referring these patients. Be prepared to spend extra time with these patients.

- Know where to refer and who to ask for help and how to get a hold of them in a time of need.
- Be honest, open. Let them know they're not alone, it is not their fault but they can change the way they feel.
- Be prepared to give them the time they need, and listen more than talk. Establish reasonable follow-up. Don't be afraid to refer for inpatient psych eval and treatment during the acute phase.
- Be proactive. Identify risk factors. Establish a support system early. Routine appointments. Utilize community resources.
- Counseling and religion/faith
- Don't assume that the mental health community will take adequate care of your patient; remain closely involved in the case.
- Don't be afraid to identify these patients.
- Find out who will help you without having to wait 3 hours for a return call. Establish a Get them assistance ASAP.
- High index of suspicion. Faithfully asking depressed patients. Protocol for reassessing pt after starting SSRI
- Identify them early and treat soon.
- If a patient has a plan or intent and not just ideation, then mental health needs to be contacted. Patients can "contract for safety" but must still be under constant supervision by friends/family until the crisis has passed.
- If I think someone is at risk for suicide, I make a referral right away. I don't wait to see if they feel better or if the antidepressant works.
- Insist on patient appointments rather than refilling meds by phone; be very cautious about ongoing prescriptions of narcotics and/or anxiolytics.
- Have family, clergy, close friend or even police to escort patient directly to consultant for further evaluation and treatment.
- Limit medicine availability, involve family and supports systems, refer early, listen.
- Many managed care plans require the patient to call them and arrange care without guidance from their PCP. It works easier when I can make a referral to a specific specialist and send the patient to them directly. It would be nice if the KAFP/AAFP or other groups could help open the routes to care for these high risk patients.
- Try to get the community to recognize need for resources
- Use resources such as psychiatry, mental health and the ER.

## OTHER

- A set of well-researched and well-written out recommendations for primary care physicians on further management once a patient at high risk for suicide is identified, would be very helpful.
- Safest to err on side of caution and admit those at high risk or arrange reliable person to be with them at all times.
- You won't forget the ones you miss; don't miss.