

What's New in the Patient Safety World

March 2016

TJC Sentinel Event Alert on Preventing Suicide

Acknowledging that suicide is now the 10th leading cause of death in the US, the Joint Commission has just published a new Sentinel Event Alert on “Detecting and treating suicide ideation in all settings” ([The Joint Commission 2016](#)). This alert actually replaces two previous Joint Commission Sentinel Event alerts on suicide and differs from the others in that its focus is on detecting suicidal risk factors and suicidal ideation at all levels of the healthcare continuum, not just in hospitals.

While it should be no surprise that we need to focus outside the hospital as well as within, this Sentinel Event Alert is very useful in its links to a host of valuable resources to help with those tasks.

The Joint Commission stresses the importance of detecting and identifying risk factors for suicide since many patients with suicidal ideation may not be overt with that ideation. The alert stresses the following risk factors:

- Mental or emotional disorders, particularly depression and bipolar disorder
- Previous suicide attempts or self-inflicted injury
- History of a recent loss or trauma (eg. bereavement, economic loss)
- Serious illness or chronic pain or physical impairment
- Alcohol and drug abuse
- Social isolation
- Previous aggressive or antisocial behavior
- Discharge from a psychiatric facility (particularly in the first weeks or months after discharge)
- Access to lethal means

The alert suggests use of a brief, standardized evidence-based screening tool such as the [PHQ-9](#). It notes also the common practice of using the 2-question tool [PHQ-2](#) as an initial screen and moving to the PHQ-9 if the answer to either question is “yes”. The PHQ-9 includes the specific question “Thoughts that you would be better off dead or of hurting yourself in some way”. If you don’t move on to the PHQ-9 you’d need to add some other assessment for suicidal ideation. The alert notes several other brief screening tools that might be used.

The timing of the alert is good since you'll recall that the US Preventive Services Task Force just finalized its updated recommendation that screening for depression be conducted in the general adult population, including pregnant and postpartum women ([USPSTF 2016a](#)). USPSTF, of course, noted that such screening needs to take place with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Similarly, the USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years ([USPSTF 2016b](#)).

In our March 20, 2012 Patient Safety Tip of the Week "[Adverse Events Related to Psychotropic Medications](#)" we noted that many communities are adopting the DIAMOND model ([ICSI 2007](#)) for management of depression in the primary care setting. That model is based on the great work from the [IMPACT](#) study led by the University of Washington. That approach utilizes the PHQ-9 for both screening and monitoring outcomes, a stepped care approach for treatment modification and intensification, and use of care coordinators embedded in the primary care practices. One of the key elements is a regular interaction with a psychiatrist or other behavioral health provider.

The Joint Commission alert goes on to describe secondary screeners such as the **Columbia-Suicide Severity Rating Scale** ([Posner 2011](#)). The [C-SSRS may be found online](#) and has been demonstrated to be valid in several different patient populations (see our December 2011 What's New in the Patient Safety World column "[Columbia Suicide Severity Rating Scale](#)").

The alert then discusses what to do if a patient screens positive for suicidal ideation but either denies it or refuses treatment. It notes the need to seek corroborating information from secondary sources (such as family, friends, other providers). It specifically states that if a patient declines to consent to such contact, HIPAA permits the clinician to make such contacts without consent if he/she feels the patient may be a danger to self or others.

The alert goes on to describe the immediate steps that must be undertaken to keep the high-risk patient in a safe environment, and steps for lower-risk patients such as providing the phone number of the National Suicide Prevention Lifeline, developing a safety plan, arranging for psychiatric followup within one week, and especially restricting access to firearms or other lethal means (such as drugs or chemicals).

This is where we think the sentinel event alert needs to go further and help communities develop better **systems of care**. Ironically, we tried for years to get primary care providers to screen their patients for depression, with mixed results. The biggest barrier we encountered was the disruption to the day's workflow caused when a patient screened positive. Because of that possibility many PCP's simply refused to do such screening. For that reason we think that organizations like hospital outpatient clinics or accountable care organizations need to have in place **lightning response teams** so that the PCP can make a single phone call and have a team respond with the capabilities of managing such patients. While we agree with TJC that everyone in the office of a PCP or other provider should be educated on how to deal with potentially suicidal patients, we think it is

impractical without the capability of immediately mobilizing other personnel more skilled in dealing with such cases.

The alert goes on to discuss management of the potential suicidal patient by behavioral health professionals, including the need for collaboration with family and other social supports, and development of longer term treatment plans and discharge plans that take into account the very vulnerable period in the weeks or months immediately following discharge from an inpatient facility. They describe mechanisms to deal with patients who do not keep followup appointments. And they discuss the need for detailed documentation of all aspects of care and communication regarding the at risk patient.

Our October 6, 2015 [“Suicide and Other Violent Inpatient Deaths”](#) noted that, given the nationwide shortage of psychiatrists, getting timely followup arranged can be problematic. The “Zero Suicide” approach, as adopted by NYS Office of Mental Health ([NYSOMH 2013](#)), stresses the importance of the “**warm handoff**” and use of “**bridger**” staff. The latter are peer specialists who meet with patients either face-to-face or by phone prior to discharge and accompany the patients to their first outpatient appointment. They also ensure that additional appointments are scheduled and educate the patients about other support services.

The Joint Commission sentinel event alert has great references and links to a plethora of great tools, such as those in the national [“Zero Suicide”](#) campaign, to help in the management of the potentially suicidal patient.

Overall, this Sentinel Event Alert is a valuable resource. We also encourage you to visit our many previous columns on suicide, the majority of which have been primarily hospital-focused (both behavioral health and general hospitals). But we also encourage you to work with your larger organizational or community partners to think about developing those “**lightning response teams**” that we think are essential to implementing safety nets that are truly needed to achieve a “Zero Suicide” goal.

Some of our prior columns on preventing hospital suicides:

- January 6, 2009 Patient Safety Tip of the Week [“Preventing Inpatient Suicides”](#)
- February 9, 2010 Patient Safety Tip of the Week [“More on Preventing Inpatient Suicides”](#)
- March 16, 2010 Patient Safety Tip of the Week [“A Patient Safety Scavenger Hunt”](#)
- December 2010 What’s New in the Patient Safety World column [“Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units”](#)
- September 27, 2011 Patient Safety Tip of the Week [“The Canadian Suicide Risk Assessment Guide”](#)
- December 2011 What’s New in the Patient Safety World column [“Columbia Suicide Severity Rating Scale”](#)
- July 2012 [“VA Checklist Reduces Suicide Risk”](#)

- August 2013 “[Suicide Attempts on Med/Surg Units](#)”
- August 25, 2015 “[Checklist for Intra-hospital Transport](#)”
- October 6, 2015 “[Suicide and Other Violent Inpatient Deaths](#)”

References:

The Joint Commission. Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings. February 24, 2016

http://www.jointcommission.org/sea_issue_56/

Patient Health Questionnaire-9 (PHQ-9). Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues (accessed February 24, 2016)

PHQ-9 (Patient Health Questionnaire-9).

http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Kroenke K, et al. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003; 41: 1284-1294 (accessed February 24, 2016)

PHQ-2 (Patient Health Questionnaire-2).

http://www.cqaimh.org/pdf/tool_phq2.pdf

USPSTF (US Preventive Services Task Force). Final Recommendation Statement. Depression in Adults: Screening. February 2016

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1>

USPSTF (US Preventive Services Task Force). Depression in Children and Adolescents: Screening (draft summary). Release Date: February 2016

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1>

ICSI. DIAMOND Initiative. Depression Improvement Across Minnesota. 2007

http://www.icsi.org/colloquium_-_2007/diamond_panel.html

IMPACT. Evidence-Based Depression Care.

<http://impact-uw.org/>

Posner K, Brown GK, Stanley B, et al. The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies With Adolescents and Adults. *Am J Psychiatry* 2011; 10.1176/appi.ajp.2011.10111704

Published online November 8, 2011

<http://ajp.psychiatryonline.org/article.aspx?articleID=180115>

C-SSRS scales for clinical practice.

http://www.cssrs.columbia.edu/scales_practice_cssrs.html

New York State Office of Mental Health. Getting to the Goal. Suicide as a Never Event in New York State. August 2013

<https://www.omh.ny.gov/omhweb/dqm/bqi/suicideasaneverevent.pdf>

Zero Suicide in Health and Behavioral Healthcare. website

<http://zerosuicide.sprc.org/>

 The
Truax
Group
Healthcare Consulting
www.patientsafetysolutions.com

<http://www.patientsafetysolutions.com/>

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