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Managing Suicide Risk in Primary Care: Practice Recommendations for Behavioral Health Consultants

Craig J. Bryan
Wilford Hall Medical Center

Kent A. Corso
Eglin Hospital

Tracy A. Neal-Walden
Wilford Hall Medical Center

M. David Rudd
Texas Tech University

Psychologists working in primary care clinics can have a significant positive impact on preventing suicide. For psychologists working within the behavioral health consultant (BHC) model in primary care, however, the issue of how to appropriately manage suicide risk within this model has yet to be adequately addressed. Given the time-limited and focused nature of the BHC model, it is important to establish a framework for psychologists to provide adequate care that is practical within this model of health care. This article offers 26 empirically supported recommendations for suicide screening, accurate and time-efficient risk assessment, and effective risk management strategies, as well as suggestions for consultation with primary care physicians, all of which are consistent with the BHC model.

Keywords: behavioral health consultation, suicide, integrated primary care, collaborative care

Considering that 45% of individuals who die by suicide make contact with a primary care provider (PCP) in the month prior to their death (Luoma, Martin, & Pearson, 2002), and nearly 20% make contact within 1 day of their death (Pirkis & Burgess, 1998), it is not surprising that primary care and family medicine clinics have been identified as potentially key settings for addressing suicide (Luoma et al., 2002; Pirkis & Burgess, 1998; Schulberg et al., 2005). This is particularly noteworthy for older and elderly adults, who have elevated depression and suicide rates but often do not receive adequate primary care or specialty mental health treatment to address these health problems (Unutzer et al., 2002). As psychologists are increasingly placed in primary care clinics to improve and expand the general population's access to mental health care, however, the potential for having a positive impact on reducing the incidence of suicidal behaviors through earlier detection and treatment is enhanced (Schulberg et al., 2004).

The concept of integrated primary care—referred to by a variety of names, including *primary care psychology* and *collaborative care*—has gained increased attention in recent years as an effective and important mental health care delivery system for a range of medical and mental health problems (see, e.g., Blount et al., 2007) across racial groups (Miranda, Schoenbaum, Sherbourne, Duan, & Wells, 2004) and all stages of life

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CRAIG J. BRYAN received his PsyD in clinical psychology from Baylor University. He is chief of primary care psychology services at Wilford Hall Medical Center, Lackland Air Force Base, Texas, and is a faculty member in the Department of Psychology's predoctoral internship program. His research interests include clinical suicidology, suicide prevention, cognitive behavioral treatments, and primary care psychology.

KENT A. CORSO received his PsyD in clinical psychology from Argosy University/Washington, DC. He is a behavioral health consultant at Eglin Hospital, Eglin Air Force Base, Florida. His research interests include primary care psychology, suicidality, and severe aggression in mentally retarded and developmentally disabled populations.

TRACY A. NEAL-WALDEN received her PhD in clinical psychology from Hahnemann University. She was a fellow in clinical health psychology at Wilford Hall Medical Center, Lackland Air Force Base. She is now chief of population health enhancement and Air Force Behavioral Health Optimization in Primary Care program manager at the Air Force Medical Operations Agency, Brooks City-Base, Texas. Her research interests include body image dissatisfaction, cultural diversity, and clinical efficacy of behavioral treatments.

M. DAVID RUDD received his PhD in clinical psychology from the University of Texas. He is professor and chair of the Department of Psychology at Texas Tech University. His research interests include clinical suicidology and cognitive behavioral therapy.

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CORRESPONDENCE CONCERNING THIS ARTICLE SHOULD BE ADDRESSED TO Craig J. Bryan, Kelly Family Medicine Clinic, 204 Paul Wagner Drive, San Antonio, TX 78241. E-mail: craig.bryan@us.af.mil

Table 1
Models of Integrated Primary Care and Associated Primary Treatment Decision Maker

Model	Characteristics	Primary responsibility for treatment decisions
Collocated clinics and primary mental health care provider	Specialty mental health care located in primary care clinic	Psychologist
	Limited integration of mental health care with primary care clinic, though primary care serves as source of referrals	
	Mental health treatment delivered separate from PCP care	
Behavioral health consultant	Psychologist is member of primary care team	PCP, with input from psychologist
	PCPs refer to psychologist for expertise in behavioral, emotional, and psychosocial aspects of health care	
	Psychologist evaluates patients and makes recommendations to PCPs	
Staff adviser	Psychologist serves as expert consultant to PCPs	PCP
	Psychologist does not have office collocated in primary care clinic and is generally available via pager or phone	

Note. PCP = primary care physician.

(Asarnow et al., 2005; Unutzer et al., 2002). Various models of integrated primary care have been proposed and implemented (Gatchel & Oordt, 2003), each of which varies in terms of the extent to which the psychologist interacts with patients and—more important—maintains primary responsibility for treatment decisions (see Table 1).

The focus of this article is the behavioral health consultant (BHC) model, which is typically marked by treatment decisions made collaboratively by the psychologist and PCP, though PCPs maintain ultimate responsibility for patient care coordination.[1] In this model, PCPs refer patients to BHCs, who conduct brief evaluations and interventions with the patient and then provide the PCP with feedback and recommendations for ongoing care that are related to the patient's mental health concerns. The mental health provider's role in this model is as an embedded consultant within the primary care clinic, allowing for quicker access to a mental health provider and streamlined care. Patient contact with a BHC is brief and problem focused, and the typical course of care spans one to four appointments, each lasting 15 to 30 min in length. These defining features of the BHC model—brief appointments, time-limited contact with patients, collaborative decision making, and PCP responsibility for patient care—contribute directly to many BHCs' concerns about the acceptable level of care for suicidal patients.

Unfortunately, suicide risk is an area that is often overlooked or omitted in most BHC practice manuals and texts. As a result, BHCs often find themselves confronted in these settings with a host of issues related to suicidal patients that have not yet been adequately addressed, including the level of suicide risk that can be effectively and safely managed in primary care, appropriate interventions (including antidepressants), thresholds for referral to specialty mental health care, and extent of follow-up. Each of these issues reflects the ambiguity of the appropriate management of suicidal patients within the BHC model, which can lead to inconsistencies in clinical care. In this article, specific practice recommendations for the management of suicide risk within the BHC model are proposed and discussed, based on the need to clearly outline good clinical care for patients, that remain practical within the scope of BHC practice.

Routinely Screen for Suicide Risk During Each Initial Consultation and as Clinically Indicated at Follow-up Contacts

Because suicide is such a low base-rate phenomenon, it is not possible to predict its occurrence with any reasonable level of reliability or consistency. BHC screening of every referred patient for suicide risk during initial contact is therefore recommended for increasing the likelihood of identifying individuals who might be at elevated risk. Screening is a brief and straightforward strategy conducted to identify individuals at risk for suicide, in contrast to assessment, in which a more thorough understanding of the nature and intensity of suicide risk is obtained following positive screenings (cf. Robinson & Reiter, 2007). Screening can be accomplished in a variety of ways according to the needs and demands of each clinic, whether through clinician questioning during the clinical encounter or through the use of brief, standardized measures that include screening items for suicidal ideation and/or behaviors, such as the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) or the Behavioral Health Measure (BHM-20; Kopta & Lowry, 2002).

For positive screenings, the BHC should assess the nature and content of the ideation to clarify whether the patient is experiencing suicidal ideation or nonsuicidal morbid ideation. Nonsuicidal morbid ideation includes thoughts about death or wishing one were dead without suicidal content (e.g., "If I didn't wake up tomorrow, that would be okay" or "I just wish it would all be over"). This differentiation is key, as specific suicidal ideation has a much

[1] From this point forward, a psychologist working within the behavioral health consultation model will be referred to as a BHC (behavioral health consultant) to differentiate them from psychologists working in other settings, particularly traditional specialty mental health care settings.

stronger association with suicidal behaviors than does nonsuicidal morbid ideation (Joiner, Rudd, & Rajab, 1997), therefore implicating different clinical responses. Patients who screen positive for suicidal ideation should be further assessed for suicide risk, whereas patients who screen negative do not require further risk assessment. Although the U.S. Preventive Services Task Force (2004) neither recommends nor discourages routine suicide screening in primary care, this two-stage strategy (i.e., screening followed by assessment) has since been found to improve the identification of suicidal patients in an approach that fits well within the integrated primary care setting (Schulberg et al., 2005).

Recommendations for BHC Practices

1. Screen every patient for suicide risk during the initial BHC visit and as clinically indicated.
2. Differentiate between suicidal ideation and nonsuicidal morbid ideation.

For Positive Screenings, Conduct a Brief but Thorough Risk Assessment

For patients screening positive for suicide risk, further evaluation is required, as dispositional decisions and appropriate clinical response depends on accurate assessment of current risk level (Bryan & Rudd, 2006; Rudd, Joiner, & Rajab, 2001). On the basis of our experience as BHC trainers, we have found that a frequently asked question from BHCs surrounds how to accurately assess suicide risk and appropriately manage that risk within the brief window of the typical BHC appointment. As with any other aspect of BHC clinical work, the BHC should approach risk assessment in a manner that accounts for the greatest amount of suicide risk with the smallest number of variables. It is therefore recommended that BHCs sequence their risk assessment questions so they focus on those areas that have been empirically supported to most robustly predict suicidal behaviors. Sequencing entails asking questions in a particular order to minimize patient anxiety, which can result in more accurate self-reports and optimal clinical decision making (Shea, 2002), as well as maximization of the information gained in the most practical, efficient, and clinically useful manner. A suggested format for the sequencing of questions for BHCs, along with sample queries, is presented in Figure 1 and discussed below. With practice and experience, it is possible to complete a risk assessment within the typical 25- to 30-min window allotted for BHC appointments.

During the typical BHC appointment, the issue of suicide risk usually emerges in terms of current or recent suicidal thoughts or behaviors. It is important, however, for the BHC to obtain a brief history of the patient's suicidal behaviors. This can be accomplished by first asking whether the patient has ever had suicidal thoughts in the past and then asking whether the patient has ever attempted suicide. If the patient responds negatively, the BHC can follow up with a third question that directly probes for specific methods of self-harm and rehearsal behaviors. By sequencing questions in this order, the BHC gradually increases the intensity and sensitivity of the information being requested, which can result in more accurate reporting (Shea, 2002). Furthermore, asking about suicidal history in a repeated and increasingly specific manner is important because some patients will withhold information about their suicidal thoughts and behaviors unless directly asked (Rudd, Joiner, & Rajab, 2001). To decrease the chances of missing an important piece of the patient's history, BHCs can ask whether the patient has considered or engaged in "any other way" or method of suicidal behavior that was not specifically asked about.

It is imperative that BHCs assess suicide attempt history. Of the many risk factors that have been empirically identified as associated with increased risk for suicide, the single most significant and robust predictor of future suicide attempts and death by suicide across the entire life span is previous suicide attempts (Clark, Gibbons, Fawcett, & Scheftner, 1989; Forman, Berk, Henriques, Brown, & Beck, 2004; Joiner et al., 2005; Ostamo & Lonnqvist, 2001). Specifically, multiple attempters (those who have made two or more previous suicide attempts) are at much greater risk for suicide than nonmultiple attempters (those who have made no previous suicide attempts or one previous suicide attempt only; Rudd, 2006). As such, history of suicide is a critical component of the BHC's risk assessment. In most cases, however, patients will not report a history of past suicidal behaviors, in which case the BHC returns to assessing the current suicidal episode.

Multiple Attempters

If a patient endorses previous suicidal behaviors, the BHC should ask how often and when these behaviors occurred. Because it is crucial that patterns in behavior and intent over time be assessed, assessing multiple attempters in primary care can understandably be daunting for the BHC. The BHC's goal should not be to obtain a thorough and detailed history of suicide-related behaviors, but rather to establish a snapshot of the patient's behavioral pattern and intent over time to better understand the patient's current risk.

This snapshot of the patient's suicidal history can be achieved by starting with the first episode, then jumping forward to the "worst" or "most serious" episode, then returning to the current episode. Among multiple attempters, specifically asking about the patient's "worst-point" suicide attempt has been found to predict future suicidal behavior more robustly than asking about other suicidal episodes because it provides an indicator of the trajectory of suicidal behavior over time (Joiner et al., 2003). In each of these time frames, it is important to assess behavioral intent through direct questioning regarding the patient's intended or desired outcome, as well as through indirect indicators of intent, such as the context of the behavior (e.g., the probability of survival). A brief and straightforward method for determining suicidal intent and estimating the risk for another attempt is gauging the patient's reaction to surviving a previous attempt—those wishing they were dead are more likely to attempt again than are those glad to be alive (Brown, Steer, Henriques, & Beck, 2005).

Assessing the Current Suicidal Episode

When assessing the current suicidal episode, BHCs should focus on those suicidal symptoms termed *resolved plans and preparation* (Joiner, Rudd, & Rajab, 1997). Resolved plans and preparation consist of a sense of courage to make an attempt,

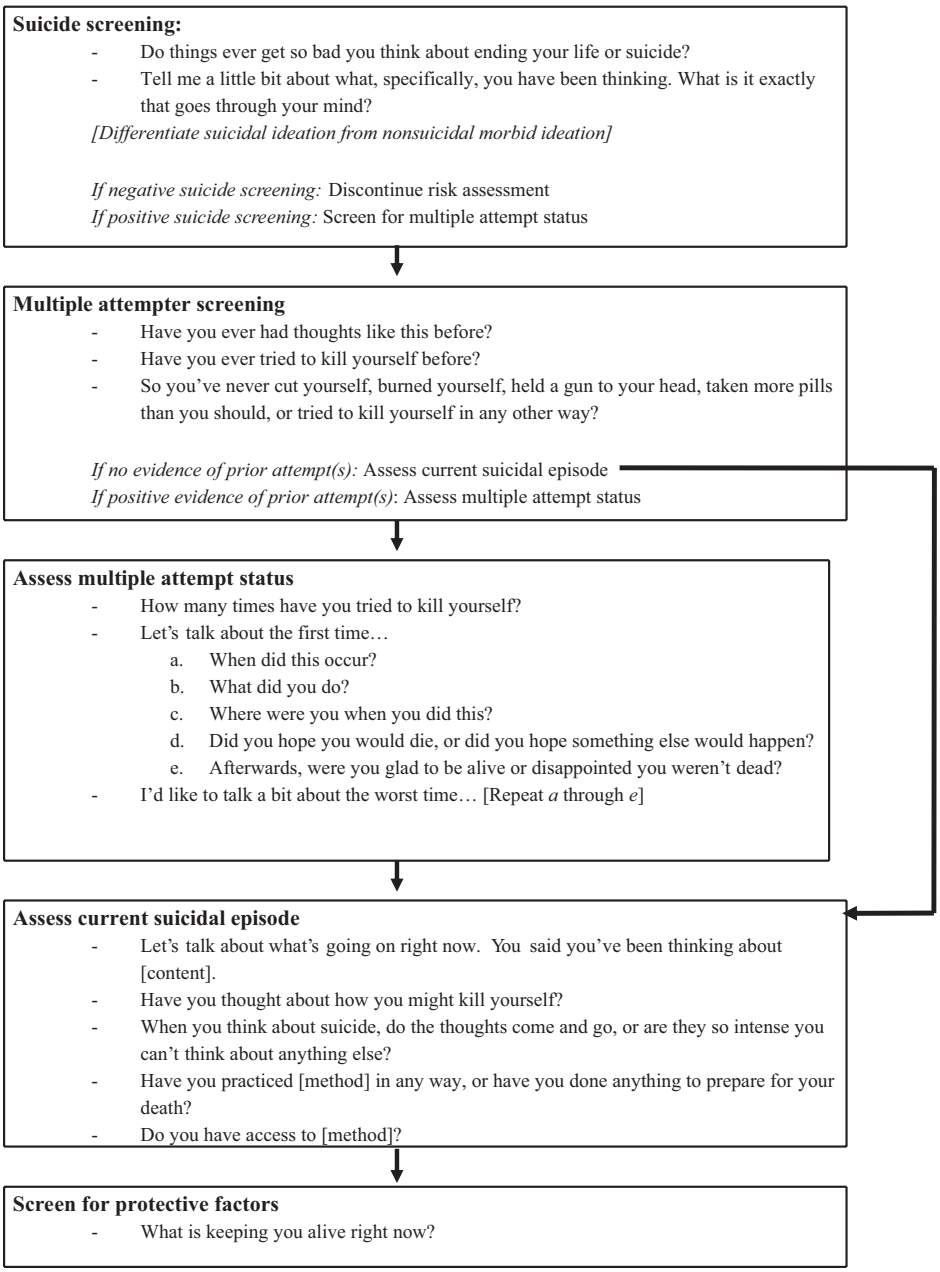

Figure 1. Suggested sequencing of suicide risk assessment questions by behavioral health consultants.

the availability of the means and the opportunity for making an attempt, the specificity of the plan for making an attempt, preparatory and rehearsal behavior, the duration of suicidal ideation, and the intensity of suicidal ideation. Because suicidal planning predicts suicidal behavior much more strongly than do a lack of reasons for living, a wish for death, the frequency of suicidal ideation, the desire and expectancy for making a suicide attempt, the lack of deterrents to making an attempt, and suicidal communication (Beck, Brown, & Steer, 1997; Joiner, Rudd, & Rajab, 1997; Joiner et al., 2003; Mieczkowski, Sweeney, Haas, & Junker, 1993), BHCs who focus their risk assessments on symptoms of resolved plans and preparation can maximize the clinical accuracy of risk assessment in a time-efficient manner.

BHCs are also encouraged to ask about current protective factors, as this can provide clues for developing interventions for short-term management. For example, activating a patient's social support network and increasing their reasons for living are simple and straightforward strategies that can lead to positive clinical outcomes (Bryan, 2007; Joiner, 2005). Obtaining consent to communicate with a pa-

tient's family members, friends, partners, or significant others about treatment recommendations and crisis response plans can, in addition, enable the BHC to enhance outpatient safety and treatment adherence through social support.

Recommendations for BHC Practices

3. For positive suicide screenings, conduct a more thorough risk assessment emphasizing previous suicidal behaviors and current suicidal planning.

4. Screen for multiple-attempt status. For positive screenings, briefly identify behavioral patterns and intent over time and specifically assess worst-point suicide attempts.

5. Focus on resolved plans and preparation when assessing the current suicidal crisis.

6. Screen for protective factors to develop interventions and activate social support.

7. Obtain consent to involve social support networks when appropriate and possibly to enhance outpatient safety and treatment adherence.

Provide Short-term Management of Suicide Risk Through Crisis Management Interventions and Follow Up Until Specialty Mental Health Services Are Established

The vast majority of patients that the BHC assesses will not meet criteria for inpatient treatment and can be effectively treated on an outpatient basis, whether through the primary care clinic or referral to specialty mental health care. As such, the BHC needs to follow risk assessments with interventions designed to manage risk in the short term. One such strategy is the crisis response plan (see Rudd, Mandrusiak, & Joiner, 2006, for a detailed description), which is a decisional aid that outlines a set of specific instructions for the patient to follow during periods of crisis. Crisis response plans can be written on a 3 × 5 card, a business card, or a BHC behavioral prescription pad. The first steps typically involve self-management strategies frequently used by BHCs (e.g., behavioral activation and social support) that work to develop crisis management skills and affect regulation. Incorporating identified protective factors in these early steps can be particularly useful, especially increasing any positive social relationships (e.g., family, friends, significant others). The final steps involve the use of external interventions, such as accessing clinical and crisis support services.

Because BHCs are not typically "on call" for patients, crisis response plans should include emergency contact information for times when the BHC will be unavailable to patients (e.g., suicide hotlines and local hospitals). It is important that BHCs develop crisis response plans collaboratively with patients to obtain buy-in, as well as briefly practice the crisis response plan to avoid the assumption of basic skills that the patient might actually lack. For example, having a patient practice dialing the BHC's phone number during the appointment provides an opportunity for behavioral rehearsal and exposure to the BHC's voicemail system (including leaving a practice message for the BHC to call back). Crisis response plans can typically be developed and practiced in 5 to 10 min. Note that crisis response plans are not the same as no-suicide contracts or contracts for safety, which lack the scientific support and legal protection they are often believed to provide (see Rudd et al., 2006, for a discussion). It is recommended that BHCs avoid the use of no-suicide contracts and discourage their use by all members of the primary care team.

Follow-up clinical contacts for suicidal patients follow a format that is no different from that of the follow-up appointment in the BHC model, in that appointments are focused on assessing changes in presenting symptoms and problem solving about barriers to change. BHCs should assess any changes in suicidal symptoms or risk factors since the previous clinical encounter, determine whether the patient has followed through with recommendations (including making contact with specialty mental health services), assist the patient with overcoming obstacles to following recommendations, and provide new interventions and recommendations based on the current clinical presentation. Because suicide risk is inherently dynamic and time limited, ongoing monitoring of changes in risk level enables the BHC and PCP to respond adequately to patient needs and modify treatment appropriately. Patients at a higher risk will naturally demand more intensive and frequent clinical monitoring until they can be connected with specialty mental health care. Follow-up clinical contact can often be accomplished through office visits or telephone contacts by any member of the primary care team, not necessarily just by the BHC. BHCs should aim, wherever feasible, to connect suicidal patients with specialty mental health services within 1 to 2 weeks of the appointment during which suicide risk was identified. Strategies for managing risk in the intervening period are discussed in greater detail below.

Recommendations for BHC Practices

8. Use crisis response plans and other strategies that incorporate protective factors and target emotional regulation, self-management, and crisis response skills. Avoid no-suicide contracts and discourage their use by PCPs.

9. During follow-ups, review recommendations with patients, help problem solve to combat obstacles, and develop new interventions as indicated.

10. Follow up with suicidal patients via office visits and/or telephone contacts to monitor changes in risk level until specialty mental health care is initiated.

11. Connect suicidal patients with specialty mental health care as appropriate.

Notify PCP of Elevated Suicide Risk and Provide Treatment Recommendations

Once patients are identified as elevated in risk for suicide, BHCs should notify PCPs to discuss strategies for treatment and risk management. This coordination is imperative so that PCPs can make safe and effective decisions about medication issues (e.g., prescribing only nonlethal amounts and dosages of drugs). Antidepressant medications should also be considered if initiation of pharmacotherapy can contribute to symptom management or relief. Widespread concerns about antidepressant use following placement of the Food and Drug Administration's black box warning on antidepressant labels have contributed to a decrease in antidepressant prescriptions (see, e.g., Kurian et al., 2007) despite scientific evidence that antidepressant treatment contributes to

decreased suicide rates (Bostwick, 2006; Gibbons et al., 2007). Antidepressants appear to have a particularly positive effect when obtained in primary care clinics or connected with the initiation of outpatient psychotherapy (Simon & Savarino, 2007). BHCs therefore play an important role in educating PCPs about the research on antidepressants and suicide and the provision of short-term follow-up during the month following initiation of a new antidepressant—the time frame during which suicide risk can increase among a small subpopulation of depressed patients with irritable or agitated symptoms (Bostwick, 2006; Rihmer & Akiskal, 2006).

In addition, primary care clinics might benefit from instituting a tracking procedure that monitors patients identified as elevated in risk for suicide, such as a high-risk log that compiles a centralized list of high-risk patients that is routinely updated on the basis of professional consultation or the flagging of medical charts to serve as a visual cue of elevated risk for any clinic staff member accessing the chart during a clinical encounter. Tracking systems—no matter what form they take—offer protection for the patient, the provider, and ultimately the clinic, because they categorize patients by their ongoing level of risk, thus facilitating and documenting clinical decision making (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). Continuous risk-tracking procedures are also useful for managing suicidal patients by providing a safety net in the event that the patient's assigned provider is unavailable.

Recommendations for BHC Practices

12. Notify PCPs of the results of risk assessments, provide recommendations, and collaborate on treatment coordination.
13. Educate PCPs about the benefits and limitations of antidepressant medications for patients at risk of suicide and assist in short-term clinical monitoring of side effects.
14. Consult with primary care clinics to develop tracking procedures for suicidal patients.

Facilitate Referrals to Specialty Mental Health Care

Patients at moderate or higher risk for suicide should be referred to specialty mental health care. To ensure consistency with recommended operationalizations of risk level for specialty mental health care (Wingate et al., 2004), for BHC practices it is recommended that moderate risk for patients with no previous suicide attempts or one previous suicide attempt only (nonmultiple attempters) be defined as the presence of one or more symptoms of resolved plans and preparation. For multiple attempters, it is recommended that any significant level of emotional distress or suicidal crisis—regardless of symptomatic level—be considered as at least moderate risk and appropriate for referral to specialty mental health care. Though patients at mild risk for suicide can be effectively managed in primary care through PCP–BHC collaboration (Schulberg et al., 2004), encouraging a patient to engage in specialty mental health care is still recommended.

Patients are often unaware of how to gain access to specialty mental health care, particularly when they have to navigate through what might seem to be a confusing administrative maze of managed care. BHCs and primary care teams can therefore provide considerable assistance to patients by helping them to identify skilled specialty care providers that are covered by their managed care organization. Many suicidal patients also benefit from role-playing their initial contact with specialty mental health care (e.g., inquiring whether new patients are being accepted, whether the psychologist accepts the patient's insurance, and what the typical format of an intake session is), which can reduce any anxiety or uncertainty about initiating treatment.

BHCs should also consult with their clinic to establish a transfer policy, in which the primary care team continues to monitor suicidal patients until initiation of treatment with specialty mental health care can be confirmed. Confirmation of a successful transfer can be obtained in a number of ways, the simplest of which is obtaining an objective indicator of proof of attendance from the patient, such as the signing of a consent form to release information to the specialty mental health clinician or the provision of the new clinician's contact information or business card. Instituting a transfer policy is a highly recommended risk management strategy for "closing the loop" on high-risk cases in BHC practices.

Recommendations for BHC Practices

15. Recommend referral of patients at moderate or higher risk for suicide to specialty mental health care and assist them in getting connected.
16. Encourage patients at mild risk for suicide to consider specialty mental health care, although they can be managed effectively through PCP–BHC collaboration.
17. Consult with primary care clinics to establish a transfer policy to ensure suicidal patients are connected with specialty mental health care.

Recommend Severely Suicidal Patients Be Referred for Inpatient Evaluation

Due primarily to a lack of clinical training in managing suicide risk, BHCs have noted through personal experience that it is not uncommon for PCPs to react to suicide risk with an alarmist attitude—responding to any mention of suicide with a recommendation for psychiatric hospitalization. Inpatient hospitalization is commonly assumed to be the "gold standard" for treatment of suicide risk among medical professionals when, in fact, inpatient hospitalization has never been found to be efficacious in a clinical trial (Comtois & Linehan, 2006), and its effectiveness has been described as "questionable" by the Institute of Medicine (2002, p. 251). Hospitalization also carries with it the added burdens of increased financial costs and social stressors resulting from missed work, inability to take care of personal responsibilities, and possible stigma. In contrast, outpatient psychosocial treatments that specifically target problem-solving strategies and suicidal symptoms and behaviors demonstrate the greatest level of efficacy (Comtois & Linehan, 2006) and are more effective at retaining the patients at highest risk than is inpatient treatment (Rudd et al., 1996).

The BHC plays a critical role in educating PCPs about the judicious and clinically appropriate use of hospitalization to manage suicide risk. Occasionally, extremely high-risk patients will present to the primary care clinic, and further evaluation for hospitalization will be deemed necessary to maintain patient safety. However, the detailed risk assessment needed to make an accurate determination about hospitalization is outside the scope of

the BHC; it is therefore recommended that BHCs encourage PCPs to refer patients assessed as being at extreme risk for suicide to a local emergency services facility for further evaluation. Consistent with operationalizations of risk in specialty mental health care (Wingate et al., 2004), inpatient evaluations should be recommended when a nonmultiple attempter reports two or more symptoms of resolved plans and preparation, significant emotional distress, and the absence of a social support network that can assist with outpatient safety. For multiple attempters, BHCs should recommend further evaluation in the presence of two or more symptoms of resolved plans and preparation. It is important to note that decisions about whether or not to refer a patient for inpatient evaluation ultimately lie with the PCP, who should initiate this process as the clinician with primary treatment responsibility for the patient.

To facilitate the process of inpatient evaluation, BHCs should consider the value of implementing several strategies before such a crisis occurs in the clinic. First, BHCs need to be aware of the criteria for voluntary and involuntary hospitalization in their jurisdictions to reduce confusion during a suicidal crisis. Next, by developing formal relationships with local psychiatric inpatient facilities regarding the sharing of clinical information and coordination of discharge planning in advance of suicidal crises, BHCs can improve treatment provision and minimize miscommunication. BHCs might also benefit from obtaining copies of release-of-information consent forms from the most frequently used inpatient facilities so that signatures can be obtained from patients prior to hospitalization. In addition, clinics should consider developing policies for patient transport to inpatient facilities, which might entail contracting with an ambulance company. BHCs and PCPs need to be aware of heightened suicide risk upon patient discharge from inpatient status, which implicates immediate outpatient evaluation (Bryan & Rudd, 2006). In light of mounting evidence that suicide risk actually increases following inpatient care (Gladstone et al., 2001; Goldston et al., 1999), it is a mistake for BHCs and PCPs to assume that the "case is closed" once inpatient care has been obtained. BHCs are encouraged to work with PCPs to be aware of heightened suicide risk following discharge and to assist patients in getting connected with outpatient specialty mental health care, which should be accomplished as part of their inpatient discharge plan.

Recommendations for BHC Practices

18. Recommend that PCPs refer nonmultiple attempters reporting significant emotional distress, two or more symptoms of resolved plans and preparations, and an absence of social support for inpatient evaluation by emergency services.

19. Recommend that PCPs refer multiple attempters reporting two or more symptoms of resolved plans and preparations for inpatient evaluation.

20. Educate PCPs about the limitations of inpatient care and the empirical support for outpatient mental health care.

21. Assist primary care clinics in developing formal relationships with frequently used inpatient facilities to improve coordination of patient care.

22. Encourage clinics to develop a plan for transporting patients requiring inpatient evaluation.

Thoroughly Document Risk Assessments and Clinical Decisions

Thorough documentation is an important factor for providing a record of clinical care and documenting the clinician's decision-making process. To thoroughly document consultations within the fast-paced environment of the primary care clinic, it is important that BHCs "work smarter, not harder." Use of standardized forms or templates can dramatically decrease documentation time, and the inclusion of direct quotes of actual patient statements is ideal. Each note should include the results of the suicide screening, whether positive or negative. For positive screenings, BHCs should also record the content of the risk assessment, interventions with patients, any consultations with PCPs or other professionals, and plans for follow-up. Similarly, documentation for follow-up appointments should include changes in risk factors, patient adherence (or lack thereof) with recommendations, additional consultations, and plans for further follow-up. Once a patient has been connected with specialty mental health care, this should be documented as well to close the loop. Ideally, the BHC will produce a record of his or her decision-making process across the course of treatment.

Recommendations for BHC Practices

23. Document results of suicide screening, whether positive or negative, for every patient visit.

24. Document presence (or absence) of risk factors, interventions and recommendations, consultations, and plans for follow-up.

25. For follow-up appointments, document changes in risk factors, patient adherence with interventions and recommendations, consultations, and plans for further follow-up.

26. Document when patients are successfully connected with specialty mental health care.

Closing Remarks

Twenty-six succinct practice recommendations for managing suicidal patients have been offered for psychologists working as BHCs in integrated primary care clinics. These recommendations fit within the time-limited and problem-focused primary care setting. This is only a start for establishing clear and consistent expectations for BHC practice, based on a foundation of current, empirical findings. These recommendations will continue to evolve in response to further scientific investigation and considerable collegial and professional debate. However, this serves as a first step in improving the care for individuals in the greatest need of mental health services, which could ultimately lead to a significant positive impact on this major public health problem.

References

Asarnow, J. R., Jaycox, L. H., Duan, N., LaBourde, A. P., Rea, M. M., Murray, P., et al. (2005). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized trial. *Journal of the American Medical Association, 293,* 311–319.

Beck, A. T., Brown, G. K., & Steer, R. A. (1997). Psychometric characteristics of the Scale for Suicide Ideation with psychiatric outpatients. *Behaviour Research and Therapy, 35,* 1039–1046.

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M.,

O'Donohue, W., et al. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38,* 290–297.

Bostwick, J. M. (2006). Do SSRIs cause suicide in children? The evidence is underwhelming. *Journal of Clinical Psychology: In Session, 62,* 235–241.

Brown, G. K., Steer, R. A., Henriques, G. R., & Beck, A. T. (2005). The internal struggle between the wish to die and the wish to live: A risk factor for suicide. *American Journal of Psychiatry, 162,* 1977–1979.

Bryan, C. J. (2007). Empirically-based outpatient treatment for a patient at risk for suicide: The case of "John." *Pragmatic Case Studies in Psychotherapy, 3*(2), Article 1. Retrieved March 19, 2009, from: http://ejbe.libraries.rutgers.edu/index.php/pcsp/article/viewFile/897/2275

Bryan, C. J., & Rudd, M. D. (2006). Advances in the assessment of suicide risk. *Journal of Clinical Psychology: In Session, 62,* 185–200.

Clark, D. C., Gibbons, R. D., Fawcett, J., & Scheftner, W. A. (1989). What is the mechanism by which suicide attempts predispose to later suicide attempts? A mathematical model. *Journal of Abnormal Psychology, 98,* 42–49.

Comtois, K. A., & Linehan, M. M. (2006). Psychosocial treatments of suicidal behaviors: A practice-friendly review. *Journal of Clinical Psychology: In Session, 62,* 161–170.

Forman, E. M., Berk, M. S., Henriques, G. R., Brown, G. K., & Beck, A. T. (2004). History of multiple suicide attempts as a behavioral marker of severe psychopathology. *American Journal of Psychiatry, 161,* 437–443.

Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration.* Washington, DC: American Psychological Association.

Gibbons, R. D., Brown, C. H., Hur, K., Marcus, S. M., Bauhmik, D. K., & Mann, J. J. (2007). Relationship between antidepressants and suicide attempts: An analysis of the Veterans Health Administration data sets. *American Journal of Psychiatry, 164,* 1044–1049.

Gladstone, G. L., Mitchell, P. B., Parker, G., Wilhelm, K., Austin, M. P., & Eyers, K. (2001). Indicators of suicide over 10 years in a specialist mood disorders unit sample. *Journal of Clinical Psychiatry, 62,* 945–951.

Goldston, D. B., Daniel, S. S., Reboussin, D. M., Reboussin, B. A., Frazier, P. H., & Kelley, A. E. (1999). Suicide attempts among formerly hospitalized adolescents: A prospective naturalistic study of risk during the first 5 years after discharge. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 660–671.

Institute of Medicine. (2002). *Reducing suicide: A national imperative.* Washington, DC: National Academies Press.

Joiner, T. E. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.

Joiner, T. E., Conwell, Y., Fitzpatrick, K. K., Witte, T. K., Schmidt, N. B., Berlim, M. T., et al. (2005). Four studies on how past and current suicidality relate even when "everything but the kitchen sink" is covaried. *Journal of Abnormal Psychology, 114,* 291–303.

Joiner, T. E., Rudd, M. D., & Rajab, M. H. (1997). The Modified Scale for Suicidal Ideation: Factors of suicidality and their relation to clinical and diagnostic variables. *Journal of Abnormal Psychology, 106,* 260–265.

Joiner, T. E., Steer, R. A., Brown, G., Beck, A. T., Pettit, J. W., & Rudd, M. D. (2003). Worst-point suicidal plans: A dimension of suicidality predictive of past suicide attempts and eventual death by suicide. *Behaviour Research and Therapy, 41,* 1469–1480.

Kopta, S. M., & Lowry, J. L. (2002). Psychometric evaluation of the Behavioral Health Questionnaire-20: A brief instrument for assessing global mental health and the three phases of psychotherapy outcome. *Psychotherapy Research, 12,* 413–426.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16,* 606–613.

Kurian, B. T., Ray, W. A., Arbogast, P. G., Fuchs, C., Dudley, J. A., & Cooper, W. O. (2007). Effect of regulatory warnings on antidepressant prescribing for children and adolescents. *Archives of Pediatric and Adolescent Medicine, 161,* 690–696.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159,* 909–916.

Mieczkowski, T. A., Sweeney, J. A., Haas, G. L., & Junker, B. W. (1993). Factor composition of the Suicide Intent Scale. *Suicide and Life-Threatening Behavior, 23,* 37–45.

Miranda, J., Schoenbaum, M., Sherbourne, C., Duan, N., & Wells, K. (2004). Effects of primary care depression treatment on minority patients' clinical status and employment. *Archives of General Psychiatry, 61,* 827–834.

Ostamo, A., & Lonnqvist, J. (2001). Excess mortality of suicide attempters. *Social Psychiatry and Psychiatric Epidemiology, 36,* 29–35.

Pirkis, J., & Burgess, P. (1998). Suicide and recency of health care contacts: A systematic review. *British Journal of Psychiatry, 173,* 462–474.

Rihmer, Z., & Akiskal, H. (2006). Do antidepressants t(h)reat(en) depressives? Toward a clinically judicious formulation of the antidepressant-suicidality FDA advisory in light of declining national suicide statistics from many countries. *Journal of Affective Disorders, 94,* 3–13.

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services.* New York: Springer.

Rudd, M. D. (2006). Fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic risk. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 355–367). Washington, DC: American Psychological Association.

Rudd, M. D., Joiner, T. E., & Rajab, M. H. (2001). *Treatment of suicidal behavior: An effective, time-limited approach.* New York: Guilford Press.

Rudd, M. D., Mandrusiak, M., & Joiner, T. E. (2006). The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology: In Session, 62,* 243–251.

Rudd, M. D., Rajab, M. H., Orman, D. T., Stulman, D. A., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology, 64,* 179–190.

Schulberg, H. C., Hyg, M. S., Bruce, M. L., Lee, P. W., Williams, J. W., & Dietrich, A. J. (2004). Preventing suicide in primary care patients: The primary care physician's role. *General Hospital Psychiatry, 26,* 337–345.

Schulberg, H. C., Lee, P. W., Bruce, M. L., Raue, P. J., Lefever, J. J., Williams, J. W., et al. (2005). Suicidal ideation and risk levels among primary care patients with uncomplicated depression. *Annals of Family Medicine, 3,* 523–528.

Shea, S. (2002). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors.* Hoboken, NJ: Wiley.

Simon, G. E., & Savarino, J. (2007). Suicide attempts among patients starting depression treatment with medications or psychotherapy. *American Journal of Psychiatry, 164,* 1029–1034.

Unutzer, J., Katon, W., Callahan, C. M., Williams, J. W., Hunkeler, E., Harpole, L., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of the American Medical Association, 288,* 2836–2845.

U.S. Preventive Services Task Force. (2004). Screening to identify primary care patients who are at risk for suicide: Recommendations from the U.S. Preventive Services Task Force. *Annals of Internal Medicine, 140,* I49.

Wingate, L. R., Joiner, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (2004). Empirically informed approaches to topics in suicide risk assessment. *Behavioral Sciences and the Law, 22,* 651–665.

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