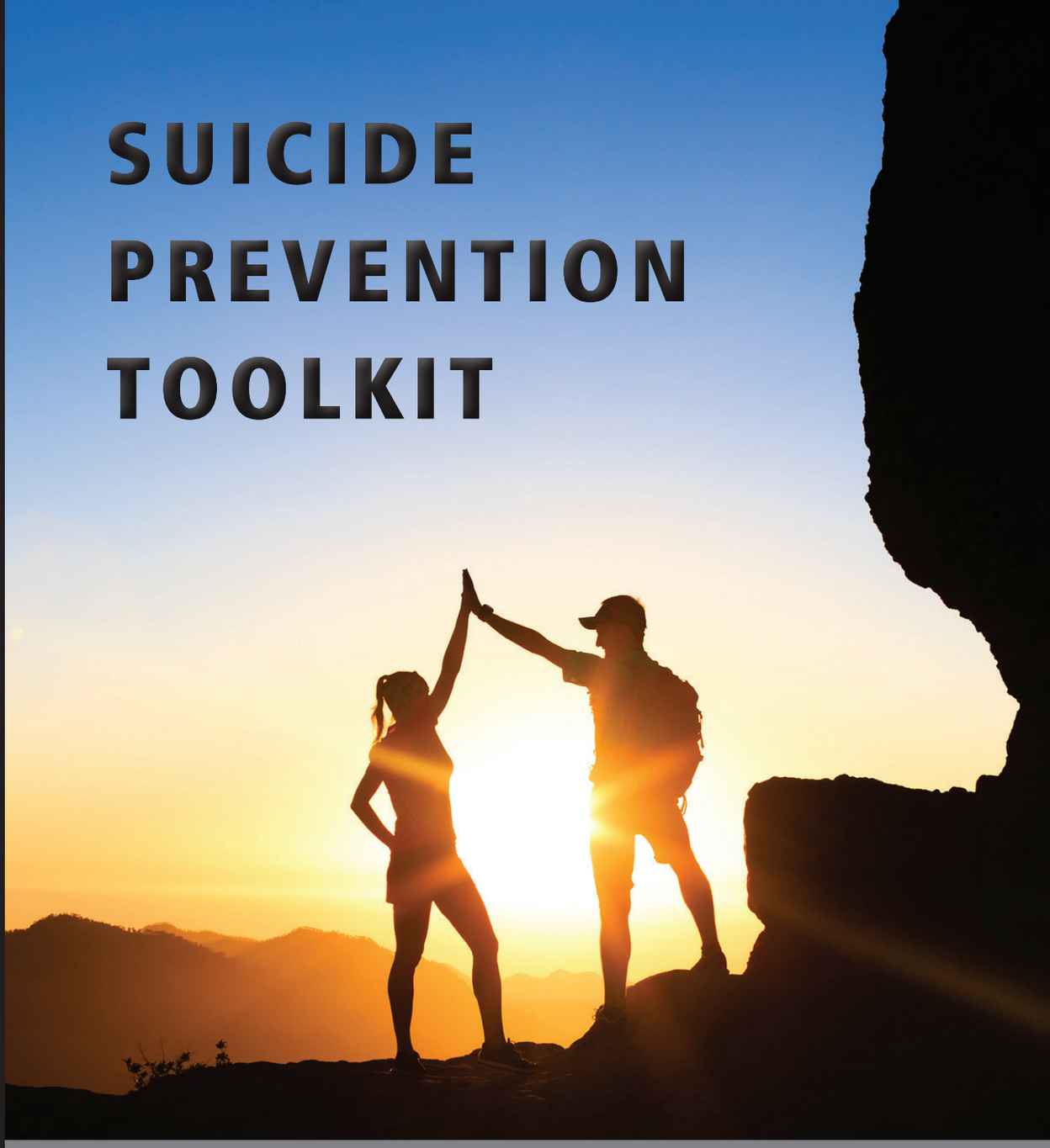
A GUIDE FOR PRIMARY CARE PROVIDERS AND MEDICAL PRACTICE MANAGERS

SUICIDE PREVENTION TOOLKIT



for

COLORADO PRIMARY CARE PRACTICES

SPRC

WICHE Mental Health Program

CDPHE CO

COLORADO
Department of Public Health & Environment

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The *Suicide prevention toolkit for primary care practices* can be accessed in the following ways:

1. **Online PDF version**. The PDF version provides continuous content in a PDF document format. Links to individual materials are provided. The PDF version can be downloaded and printed as one cohesive document and is available at https://www.colorado.gov/cdphe/suicide-provider-resources. This version is available at no cost.
2. **Hard copy**. Hard copies of the Toolkit are available for purchase through WICHE MHP at mentalhealthmail@wiche.edu or by calling 303-541-0311.

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Dear Primary Care Provider:

Thank you for taking the time to learn about suicide prevention for your patients.

As a provider of primary care services, you are in a unique position to prevent suicides among your patients. They may come to your exam rooms presenting with many different concerns, but the one they may not be telling you about could be the one that will kill them – unless you and your staff are prepared. While no prevention strategy is fail-safe for every patient, use of this Toolkit will facilitate development of a comprehensive office strategy that will save lives. This Toolkit is consistent with Zero Suicide, the national approach to providing safer suicide prevention care in health and behavioral health care settings. We encourage you to learn more about Zero Suicide using the links and resources provided in the Toolkit and consider committing to the approach in your practice.

Start your suicide prevention efforts by familiarizing yourself with the Quick Start Guide in this Toolkit. It will walk you step-by-step through the process of seamlessly integrating suicide prevention into your practice. Whether for an adolescent struggling with a life crisis, a war veteran suffering from PTSD or traumatic brain injury, a middle-aged worker with depression and alcohol dependence, or a lonely elder with a terminal illness, your practice can soon have systems in place that will allow you to intervene effectively without significantly disrupting the flow of patients.

Please do not delay. This Toolkit should not sit in your in-basket or on the shelf for even a minute. Take the first step to saving lives as soon as you possibly can. Open the Quick Start Guide and get on your way to helping some of your most troubled patients find a pathway to a satisfying life.

Sincerely,

Western Interstate Commission for Higher Education – Mental Health Program

Suicide Prevention Resource Center

Table of Contents

Getting Started

As a provider of primary care services, you are in a unique position to prevent suicides among your patients. Research tells us that people who die by suicide are more likely to have seen their primary care provider shortly before their death than any other health care professional.

At any given time, some of your patients are having thoughts of suicide. They may come to your exam rooms presenting many different concerns, but the one they may not be telling you about could be the one that will kill them – unless you and your staff are prepared.

In This Section

Quick Start Guide

Start your suicide prevention efforts by checking out the Quick Start Guide. It will walk you step-by-step through the process of seamlessly integrating suicide prevention into your practice.

Implementation Checklist

Ensure that your efforts are organized and thorough by using the Implementation Checklist provided in this section. Check off each element of the suicide prevention efforts outlined in the Toolkit as you put it into place.

Office Protocol for Suicidal Patients Development Guide

Your practice can soon have systems in place that will allow you to intervene effectively without significantly disrupting the flow of patients. After you have familiarized yourself with the entire Toolkit, use the Office Protocol for Suicidal Patients Development Guide to establish the roles and responsibilities, as well as the procedures you will follow when you find that a patient is suicidal. If everyone in the clinic knows what he or she is expected to do, the process will be smoother than you might expect.

Office Protocol for Suicidal Patients Template

Use this template and the Office Protocol for Suicidal Patients Development Guide above to proactively complete an individualized Office Protocol for Suicidal Patients for your practice.

Quick Start Guide

Steps for using the Suicide Prevention Toolkit for Primary Care Practices

1. Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.

2. Meet to develop the "Office Protocol" for potentially suicidal patients. See the "Office Protocol Development Guide" instruction sheet in the Toolkit.

3. Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

4. Develop a referral network to facilitate the collaborative care of suicidal patients. Use the "Developing Mental Health Partnerships" materials in the Toolkit.

5. Read the Toolkit's "Primer." Providers may wish to study the last two sections on Suicide Risk Assessment and Intervention first. The first three sections may then be reviewed in order to gain knowledge about Prevalence, Comorbidity, Epidemiology, and Prevention.

6. Order community and patient education tools, such as suicide prevention posters and brochures, for your office. See the "Patient Education Tools" section of the Toolkit.

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Implementation Checklist for the Suicide Prevention in Primary Care Toolkit

- [ ] Discuss suicide prevention initiative with all Office Staff and determine lead coordinator for the office.
- [ ] Read Chapter 2: Educating Clinicians and Office Staff of the Toolkit (all Office Staff).
- [ ] Identify which depression and suicide screens and assessments will be utilized in your office (e.g., PHQ-9, C-SSRS); determine:
  - When will patients complete this screen/assessment (e.g., with intake paper work)?
  - Who will review it and how is this information flagged? (e.g., flag depression/suicide like any other condition for provider follow-up).
- [ ] Proactively complete Office Protocol Template in Toolkit to establish procedures for working with a suicidal patient. Information here includes:
  - What professionals can be called upon to assist with suicide risk assessment
  - Name and location of nearest Crisis Stabilization Unit or Emergency Department
  - Responsible office staff contacts for documentation and follow-up
- [ ] Have Toolkit resources and individual patient intervention templates regarding suicide assessment and safety planning available to Office Staff and clinicians such as:
  - Pocket Guide: Assessment and Interventions with Potentially Suicidal Patients
  - Safety Planning Guide: A Quick Guide for Clinicians
  - Patient Safety Plan Template
  - Crisis Support Plan
- [ ] Develop a referral network to facilitate the collaborative care of suicidal patients.
- [ ] Conduct a mock drill for safely and sensitively working with and potentially hospitalizing a patient.
- [ ] Follow-up/Outreach. Identify who will follow-up with patients who have expressed suicidal ideation and how follow-up will occur (e.g., office visit, phone call).

In case of the need for hospitalization:

- [ ] Hospitalization is always the last resort, if efforts at illness management, safety planning, and referral fail to mitigate risk.
- [ ] Identify and label where all necessary forms, such as M-1 Mental Health Hold and Evaluation forms, for hospitalizing suicidal patients will be kept (it is assumed that the patient's physician will fill out all necessary paperwork for hospitalization).
- [ ] Identify who will sit with the patient while waiting for transport to the emergency department if necessary.
- [ ] Identify how soon a patient should be seen back in your clinic after being evaluated by the emergency department and/or being hospitalized. How frequently should they be seen and for what duration should more intensive contact with the PCP occur?

Office Protocol for Suicidal Patients – Development Guide

The purpose of an Office Protocol for Suicidal Patients is to anticipate and have an appropriate plan in place before a suicidal patient is identified. This office suicidal patient care management plan allows providers and office staff to be prepared when treating a patient who is assessed to be at high risk for suicide. Initial assessment of a potentially suicidal patient can be conducted by a member of the office staff or by an external consultant. An office protocol template, to simplify the process of further assessing and potentially hospitalizing a high-risk patient, can be found on the following page of this Toolkit. It will help a practice to proactively answer the logistical questions related to getting additional psychiatric care for patients before a crisis occurs, and guide providers quickly and efficiently when a patient is in need of such care.

The office protocol is an essential component of a comprehensive office strategy for suicide prevention, and may be developed during staff meetings. Once the protocol is developed, it may be useful for the office to implement a "dry run" with a mock patient to ensure that the protocol can be followed seamlessly. Suicide prevention trainings, including warning signs to look for, inquiring about suicidal ideation, and how to respond to suicidal individuals, can be provided to all office staff as an in-service. See Module 3: Effective Prevention Strategies, in the Primer section of this Toolkit, for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies may require an investment of time and money, they constitute best practices for care and may save lives.

Consider involving all office staff in suicide prevention efforts. Staff members are frequently in positions to observe changes in behavior or hear patients express suicidal ideation that the patient may be reluctant to share with the provider. Office staff can play a crucial role by detecting concerning behaviors and alerting the patient's provider.

Locate specific information about Colorado's involuntary treatment laws and post this in the office along with contact information for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the crisis hotline number for Colorado Crisis Services, Colorado's statewide behavioral health crisis response system, 1-844-493-TALK (8255), as well as the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), which also offers free materials, including posters and cards with the Lifeline number. Professionals at that number can also direct practices to community mental health service providers in their area.

Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions ...

- _____ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
- _____ should be called/paged to assist with collaborative safety planning.
- Identify and call patient's support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization ...

- Our nearest Emergency Department or CCS Walk-in Crisis Center is _____
- Phone # _____
- _____ will call _____ to arrange transport.
  (Name of individual or job title) (Means of transport [Colorado Crisis Services mobile response, ambulance, police, etc.] and phone #)

  Backup transportation plan: Call _____
- _____ will wait with patient for transport.

Documentation and follow-up ...

- _____ will call ED or CCS Walk-in Crisis Center to provide patient information.
- _____ will document incident in _____
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms/instructions/chart-flagging materials are located _____
- _____ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- _____ will follow-up with patient within _____
  (Name of individual or job title) (Time frame)

Educating Clinicians and Office Staff

The educational section of this Toolkit contains a primer presented in five modules. The first two modules are background material that may be of interest to the entire staff. The third module provides an understanding of general prevention practices that should be implemented to benefit the entire patient population and should be read and discussed by the entire primary care staff. Modules 4 and 5 are designed to educate clinicians for the specialized suicide prevention roles they will play. Module 4 provides the information necessary to evaluate patients who may be at heightened risk for suicide and to make a clinical assessment of that risk. Module 5 discusses interventions that may be necessary to protect patients from intentionally harming themselves, up to and including making arrangements for involuntary hospitalization. Additional educational resources can be found in the Patient Education Tools/Other Resources section of this Toolkit.

In This Section

Module 1 – Prevalence and Comorbidity

This two-page learning module summarizes the magnitude of the suicide problem in the U.S. and Colorado and describes how the vast majority of those cases are associated with one or more mental health or substance abuse problems.

Module 2 – Epidemiology

This three-page learning module summarizes the epidemiology of suicide attempts and suicide deaths in various demographic groups.

Module 3 – Effective Prevention Strategies

This five-page learning module discusses general practices that can be incorporated into primary care settings to lower the risk of suicide across their entire patient population.

Module 4 – Suicide Risk Assessment

This six-page learning module presents a methodology for gathering information about a patient's suicidal thoughts and plans and an approach for assessing the level of suicidal intent. It concludes with pointers for clinical decision making regarding the assessment of risk.

Module 5 – Intervention

This eight-page learning module discusses a range of patient management approaches that can be implemented in the primary care setting according to the level of risk.

A GUIDE FOR PRIMARY CARE PROVIDERS AND MEDICAL PRACTICE MANAGERS

SUICIDE PREVENTION PRIMER

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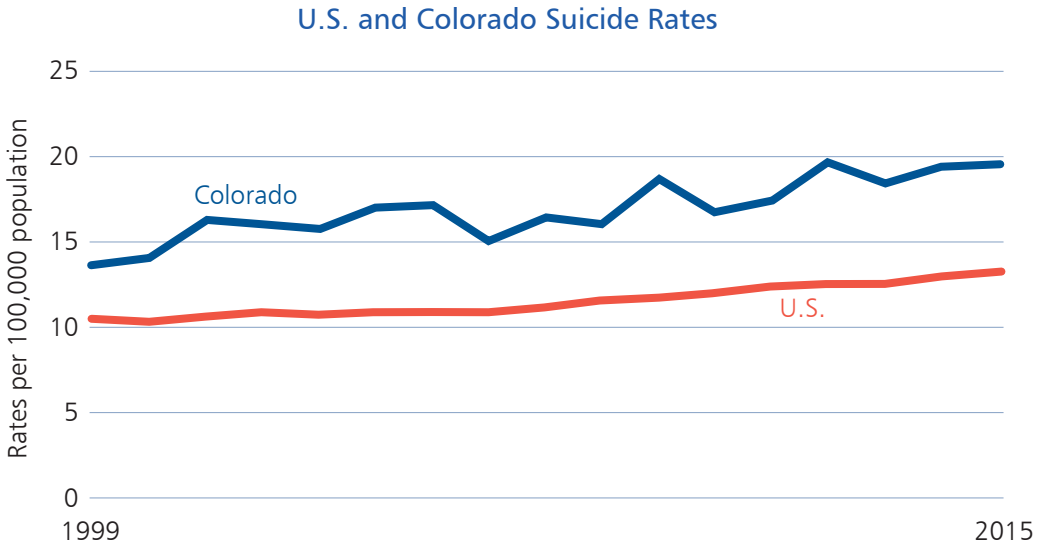
List of Modules

Module 1 – Prevalence and Comorbidity

Prevalence of Suicide

More than 44,000 U.S. individuals and approximately 1,000 Coloradans died by suicide in 2015.[1,2]

Colorado's suicide rate is higher than the U.S. rate, and increased by 44% from 1999 to 2015, while the U.S. suicide rate increased by 27%.[1,2]



Suicide impacts people of all ages in the U.S. and Colorado:

- Overall, suicide is the tenth leading cause of death in the U.S. and the seventh leading cause of death in Colorado.[3,4]
- Nationally, suicide is the third leading cause of death for children ages 10-14 and the second leading cause of death for children ages 15-34.[3]
- In Colorado, suicide is the second leading cause of death for ages 10-44.[5]

In 2015, 9.8 million U.S. adults (4.0%) considered suicide in the past year, of those approximately, 28% (2.7 million) made a suicide plan, and 14% (1.4 million) attempted suicide.[6] Some of these people will seek your care.

In Colorado, although the state rate is higher than the U.S., suicide rates vary widely by county and region. Rural and Frontier regions in Colorado experience higher rates of suicide, while more populated urban counties have higher numbers of suicide deaths.[7]

In Primary Care:

Individuals often use health services prior to death by suicide.

83% of individuals who died by suicide had a health care visit in the year prior to their death and contact with a primary care provider (PCP) was the most common visit type (64%)[8].

Comorbidity

Mental illness is neither a necessary nor sufficient condition for suicide, but is strongly associated with suicide.

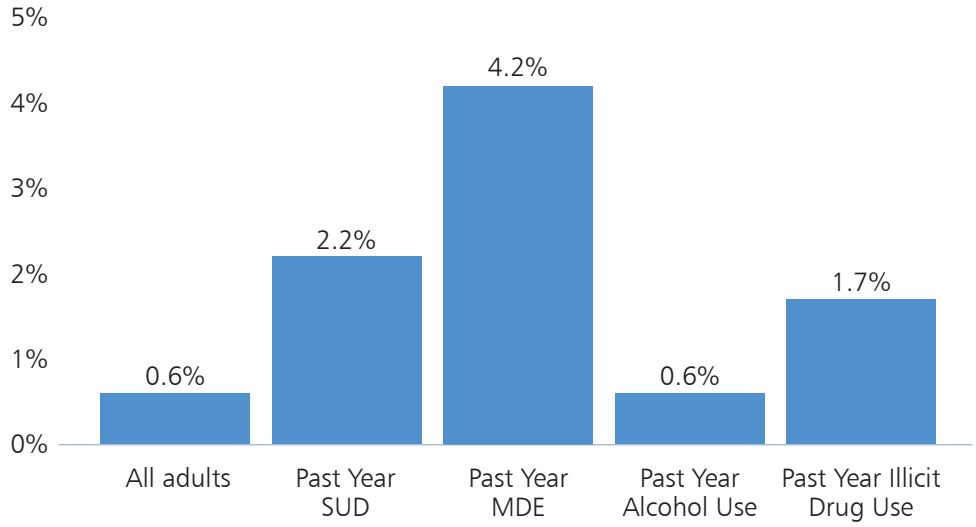
Adults with a mental illness are at increased risk for attempting and completing suicide, and those with multiple (comorbid) disorders have at least a two-fold risk of suicide attempts, increasing with the number of comorbid disorders.[9,10]

- Approximately 66% of adults who consider suicide and nearly 80% of those who attempt suicide had a prior mental health disorder.[9]
- More than 70% of adults who have attempted suicide have an anxiety disorder.[10]
- Adults with mood, anxiety, or substance use disorders have been shown to be at greater risk of contemplating or attempting suicide.[9,11]

Adults who had a Substance Use Disorder (SUD) or Major Depressive Episode (MDE) within the past year are significantly more likely to have suicidal thoughts, make suicide plans, and attempt suicide.[6]

Adults who use alcohol or drugs are more likely to have suicidal thoughts, make suicide plans, and attempt suicide.[6]

Past Year Suicide Attempts Among Adults 18 or Older – 2015 NSDUH



Similar patterns have been found for youth, with mood disorders being strongly associated with suicidal thoughts, plans, and attempts. Substance use, anxiety, and disruptive behavior disorders are associated with suicidal thoughts and attempts, and eating disorders are associated with suicide attempts.[12]

Proactive support and treatment of psychiatric and substance use disorders is an important part of a comprehensive, primary-care based approach to suicide prevention.

High Risk Populations

All demographic groups have some level of risk. It is important not to dismiss any individual as being free of risk because they belong to a particular demographic group. There are some demographic groups, however, that are at relatively greater risk than others.

- See Module Four, Suicide Risk Assessment, for information on individual, social/environmental, and societal risk factors.

Gender

Males, both nationally and in Colorado, are about three times more likely to die by suicide than females.[1,2] However, the U.S. and Colorado rates for females have increased by approximately 50% since 1999.[13,2] Therefore, both should be supported with suicide preventative care.

Age

While adolescents and young adults are more likely to consider suicide, adults have higher rates of death by suicide.[13,14]

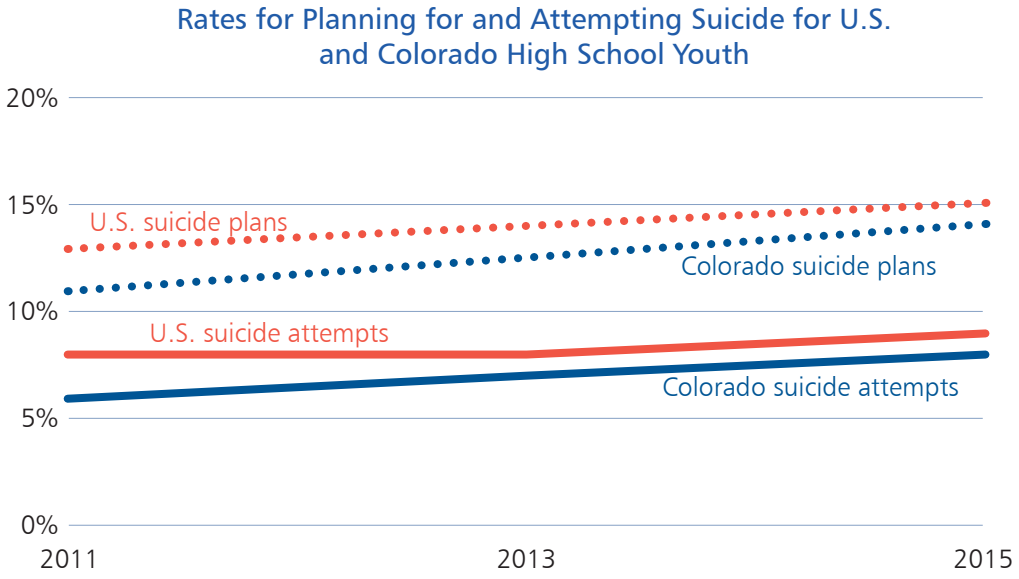
Nationally, adults aged 18-25 are more likely to consider suicide, plan for suicide, and attempt suicide than adults aged 26 or older.[6] **Yet adults 45 years, especially men, or older have the highest suicide rates.**[14]

In Colorado, adults aged 35-54 have the highest suicide rates.[2]

For U.S. children and adolescents, the death rate for suicide doubled from 2007 (0.9) to 2014 (2.1).[15]

From 2011 to 2015, reported rates of considering suicide, planning for suicide, and attempting suicide for U.S. high school youth have slightly increased.[16] Trends for Colorado's high school youth are similar, yet slightly lower than U.S. rates.[17]

Both nationally and in Colorado, high school females have higher reported rates of making a suicide plan and attempting suicide than high school males.[16,17] In Colorado, youth who have an adult they can go to for help and who feel safe at school are more than three times *less* likely to attempt suicide.[17]



Race/Ethnicity

Patterns of suicide rates do emerge among the various races both nationally and in Colorado. Nationally, American Indians and Alaskan Natives have high suicide rates. In Colorado, White individuals have the highest suicide rates.[1,18]

In 2015, the U.S. suicide rate was highest for American Indians and Alaskan Natives, followed by White individuals, Asian and Pacific Islander individuals, Black individuals, and Hispanic individuals.[1] In Colorado, White individuals have had the highest trends in suicide rates, while trends for other races and ethnicities have varied somewhat; typically American Indians and Alaskan Natives have had the second highest suicide rate, followed by Hispanic, Black, and Asian and Pacific Islander individuals.[18]

For American Indian and Alaskan Native adolescents and young adults ages 15-34, the suicide rate is especially high, 1.5 times that of the national average.[19]

In 2015, both nationally and in Colorado, multi-racial high school students had the highest reported rates of planning for and attempting suicide, followed by American Indian or Alaskan Native students.[16,17]

Note: White, Asian and Pacific Islander, and Black individuals' statistics reported are non-Hispanic.

Lesbian, Gay, Bisexual, Transgendered, Queer Individuals

These groups have disproportionately high rates of reported suicide attempts.[20]

Overall, lesbian, gay, and bisexual (LGB) individuals are more than twice as likely as heterosexual persons to attempt suicide.[20] This community is also more likely to be at risk for depression, anxiety disorders, and substance dependence.[20,21] Potential reasons for these elevated rates include the prejudice, discrimination, and social stigma faced by these groups.[22]

Rates of reported attempted suicide for LGB youth have been shown to range from 20% to 53%, and in one small focused study, transgender youth had a 25% lifetime rate of attempted suicide.[23,24] Parental support also appears to play a significant role, as LGB young adults who reported high levels of rejection by their families were 8.4 times more likely to report having attempted suicide.[21] Similarly, Colorado LGBTQ high school students have higher reported rates for making a suicide plan and attempting suicide than heterosexual and non-transgendered students.[17] Colorado LGBTQ students who have an adult they can go to for help are more than two times *less* likely to attempt suicide.[25,26]

Veterans

Veterans of the armed forces carry an alarmingly and disproportionately higher risk for suicide than the civilian population, and are often not utilizing the Veterans Health Administration (VHA) for their healthcare. It is always helpful for practices to ascertain Veteran status, as they are likely to see Veterans who may not know that they are entitled to services from the VHA, and knowing Veteran status provides indications of the need for other screenings, such as trauma and traumatic brain injury.

On average, 20 U.S. Veterans die by suicide each day.[27] Veterans' risk of suicide is 21% higher than that of U.S. adult civilians and, while Veterens made up 8.5% of the U.S. adult population in 2014, they accounted for 18% of suicide deaths.[27] Male Veterans have an 18% higher suicide risk than U.S. civilians and female Veterans' risk is twice as high as U.S. civilians. More than half of all Veterans who die by suicide are age 50 or older.[27]

Only 28% of Veterans receive at least one healthcare service or benefit from the VHA.[28] From 2001 to 2014, the suicide rate for Veterans who did not receive services from the VHA had a greater increase than Veterans who used VHA services.[27] However, the difference between suicide rates for Veterans who did not receive VHA services and those who did has decreased since 2001.

Veterans who die by suicide are more likely to use a firearm. Approximately two-thirds of Veterans that died by suicide used a firearm, while about half of U.S. adults aged 17 and older used a firearm in their suicide.[27,1]

About 24% of all U.S. Veterans reside in rural communities, which may be far from military or Veterans services.[29] Approximately 17% of Colorado Veterans live in rural areas.[29]

Module 3 – Effective Prevention Strategies

Primary care providers can implement some of the most effective strategies for suicide prevention. Ideally, a primary care clinic would plan a comprehensive suicide prevention approach such as the Zero Suicide framework (see information on Zero Suicide in Section 6: Patients Education Tools/Other Resources of this Toolkit) that includes all the strategies in the box below. We will discuss the strategies in five sections: staff training, screening and management of depression, screening for suicide risk, patient education, and restricting means for lethal self-harm. Assessing and managing patients at risk for suicide are discussed in Modules 4 and 5 of this Primer.

Suicide Prevention Strategies in Primary Care

1. Train staff to recognize and respond to warning signs of suicide
2. Screen for and manage depression
3. Screen all patients for suicide risk
4. Educate patients about warning signs for suicide
5. Safety Plan/Temporarily restrict means for lethal self-harm

1. Train Staff to Recognize Warning Signs of Suicide

As workers in primary care settings interact with their patients, they may able to observe and respond to many of the common warning signs for suicide, but only if they know what to look for.

All staff should be trained in suicide prevention, relative to their role in the clinic. In addition to the information provided below, suicide prevention trainings or individual online learning can teach recognition and response to suicide warning signs. Trainers are available in most areas to teach these important skills. Training is also available online. See the Resource List for some of the national vendors of these programs; contact the authors or the Suicide Prevention Resource Center (www.sprc.org/states) for your state's suicide prevention coordinator, or the Colorado Department of Public Health and Environment Office of Suicide Prevention at www.coosp.org. After even minimal training, staff can observe and respond to warning signs of suicide in patients while talking with them on the phone or in the office. When they detect a warning sign, staff can immediately alert office clinicians who are prepared to ask the patient about suicidal ideation. Though these trainings require a modest investment of time and money, they may save lives.

Identify Warning Signs

People who are in danger of harming themselves may reach out to their primary care providers – sometimes directly, sometimes indirectly. **Rarely will patients immediately volunteer the information that they are thinking of harming themselves or ending their lives.** Be alert for warning signs that a patient may be at risk of imminent suicide. Warning signs include:[30]

Strongest Warning Signs – Take Immediate Action to Protect Person – Full Risk Assessment Warranted

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking about feeling hopeless or having no reason to live

Other warning signs of suicide

- Anxiety
- Agitation, aggression
- Acting reckless
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Withdrawing or feeling isolated
- Talking about being a burden to others
- Rage or seeking revenge
- Dramatic mood swings
- Feeling trapped – like there's no way out
- Talking about being in unbearable pain

2. Screen For and Manage Depression

Training providers to recognize and treat depression increases prescription rates for antidepressants and decreases suicidal ideation and completed suicides in their patients.[31]

A key factor in reducing suicides and suicidal behaviors is the effective diagnosis and management of major depression. Tools for screening and managing depression within a primary care setting have been developed by The MacArthur Initiative on Depression and Primary Care and are available free of charge online. **A downloadable Toolkit can be found at:** http://otgateway.com/articles/13macarthurtoolkit.pdf

Keep in mind that the best approach to treating major depressive disorder (as well as many other mental illnesses) uses **a combination of medication and psychotherapy whenever possible.**[32,33,34] This is why it is so important to have reliable and trusted mental health treatment partners to refer to.

3. Screen all patients for Suicide Risk

Screening all patients for suicidal thinking is an important part of suicide prevention and is recommended by The Joint Commission.[35] Patients with warning signs or other risk factors should routinely be asked about suicidal thoughts as well. It is also helpful for practices to ascertain Veteran status, as they are likely to see Veterans who may not know that they are entitled to services from the VHA, and knowing Veteran status provides indications of the need for other screenings, such as trauma and traumatic brain injury.

Using simple screening tools such as the **9-item Depression Scale of the Patient Health Questionnaire (PHQ-9)** can be an effective, matter-of-fact, and time-efficient way to screen patients. The PHQ-9 is

included as part of the MacArthur Initiative Toolkit discussed above and English and Spanish versions, as well as a modified version for adolescents are available at: http://www.integration.samhsa.gov/clinical-practice/screening-tools

The Columbia Suicide Severity Rating Scale (C-SSRS) is another, more specialized tool for assessing suicidality. If screening tools such as the PHQ-9 are used, providers must be diligent about reviewing patient responses and specifically monitoring whether patients endorse items related to suicidality. The C-SSRS is available at: http://cssrs.columbia.edu/

Suicidal ideation can vary greatly. Some experience chronic suicidal ideation over the course of their lifetime, some have thoughts of suicide in situations of acute stress, trauma, or loss. It is important to fully understand the context of someone's thoughts of suicide and how it may impact their safety in the immediate future by doing a complete assessment as laid out in Module 4 of this Primer.

The Joint Commission Sentinel Event Alert (SEA) Number 56, Detecting and Treating Suicide Ideation in All Settings, outlines 8 guidelines for effectively addressing suicidal ideation in all care settings, including the recommendation that providers "Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool." All SEA 56 recommendations can be found at: https://www.jointcommission.org/sea_issue_56/

Some or all of the Sample Questions in Module 4 for inquiring about thoughts of suicide can be used for informal screening of patients. **The key is to ask directly about thoughts of suicide or ending one's life as part of the screening. Practice asking the question(s) several times before trying it in a clinical situation.**

Never ask leading questions such as "You're not thinking of hurting or killing yourself, are you?"

Sample screening question:

"We ask every one of our patients about whether they have felt suicidal or have been considering hurting themselves. Have you had thoughts of hurting yourself or killing yourself?"

"Sometimes people with your condition (or in your situation) feel like they don't want to live anymore, or sometimes they think about killing themselves. Have you been having any thoughts like these?"

A positive response to this screening question requires additional assessment (assessments can be found in Module 4). These instruments should always be used as an augment to a thorough clinical interview.

In addition to routine screening for all patients, certain conditions, situations or life events may warrant inquiry into whether the patient is experiencing suicidal thoughts, these **RISK FACTORS** include:

Key Risk Factors[36]

- Prior suicide attempt(s)
- History of depression or other mental Illness
- Alcohol or drug abuse
- Family history of suicide or violence

- Exposure to suicide in community, social circles, or the media
- Physical illness or recent serious diagnosis
- Feeling alone
- Irritability, agitation, aggression

Other Risk Factors

- Other mental health or emotional problems
- Chronic pain
- Insomnia
- Post-Traumatic Stress Disorder (PTSD)
- Traumatic Brain Injury (TBI)
- Events or recent losses leading to humiliation, shame or despair

This Decision Support Tool, from the Suicide Prevention Resource Center's Caring for Patients with Suicide Risk: A Consensus Guide for Emergency Departments, may be a helpful tool to screen for suicide risk:[37]

TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (NOTE: the transitional question above is not part of scoring.)

1. **THOUGHTS OF CARRYING OUT A PLAN** Recently, have you been thinking about how you might kill yourself? If yes, consider the immediate safety needs of the patient.
2. **SUICIDE INTENT** Do you have any intention of killing yourself?
3. **PAST SUICIDE ATTEMPT** Have you ever tried to kill yourself?
4. **SIGNIFICANT MENTAL HEALTH CONDITION** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?
5. **SUBSTANCE USE DISORDER** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
6. **IRRITABILITY/AGITATION/AGGRESSION** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the answer to the Transition Question and any of the other six items is "Yes," further intervention, including assessment by a mental health professional, is needed.

4. Educate patients and their loved ones about Suicide Warning Signs

Just as we educate the public on the warning signs of strokes and heart attacks, we should provide basic information to the public on the warning signs of suicide. For severe suicide warning signs, the appropriate response may be to:

- call the 24-hour hotline at Colorado Crisis Services (CCS), Colorado's statewide behavioral health crisis response system, 1-844-493-TALK (8255)
- arrange for the patient to be transported to one of CCS's 11 regional walk-in crisis centers (a link to these centers is located in Section 5: State Resources, Policy, and Billing of this Toolkit)
- call 911
- or go to a hospital emergency department.

For less emergent situations, it may be appropriate to call the Colorado Crisis Services statewide behavioral health crisis hotline 1-844-493-TALK (8255), or the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). Calls to both numbers are routed to a nearby certified crisis center with trained counselors. Counselors are available 24/7 and provide services in English, Spanish and many other languages. The Colorado Crisis Services hotline also has a "warmline" option, where patients or their families can call and get support from trained peer specialists (individuals with lived experience). Veterans calling the National Lifeline may press "1" to be directed to a crisis center run by the Department of Veterans Affairs. The service is free anywhere in the United States. The most effective and expedient response will depend on the resources in your area.

This Toolkit contains a wallet card (pg 66) for everyone that list the most recognizable warning signs and the number of the national crisis line. These cards are available free and can be provided to all primary care patients and their loved ones through the office. For information on ordering the wallet cards, see the SAMHSA Store or the "National Suicide Prevention Lifeline Resources" web address in the Resource List of the Toolkit.

5. Safety Plan and Temporarily Restrict Means of Lethal Self-Harm

As primary care providers, you and your staff can and should work with suicidal or potentially suicidal patients and their loved ones to temporarily restrict means of lethal self-harm in their homes. Involuntary commitment and hospitalization should be utilized only as last resorts, when safety planning has been unsuccessful and the patient is assessed to be at imminent risk of harming themselves.

Safety Planning: A safety plan (also referred to as a "crisis response plan") is developed *collaboratively* with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. **A simple and structured safety planning process is reviewed in detail in Primer Module 5: Intervention.**[38]

Temporarily Restricting Means of Lethal Self Harm: This step can be the hardest step for many patients, and perhaps the most critical. The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will agree to solutions to temporarily restrict his or her access to lethal means. **Lethal means restriction for patients of all ages is reviewed in detail in Primer Module 5: Intervention.**

Module 4 – Suicide Risk Assessment

While there is no way to predict with complete certainty who will attempt suicide, understanding certain imminent warning signs as well as statistically related risk factors will help providers know when to actively intervene and further assess for imminent suicide risk.

Key components of a suicide risk assessment[39,40]

1. Assess warning signs and risk factors
2. Assess protective factors
3. Suicide Inquiry: thoughts/plan/intent/access to means
4. Clinical judgment

1. Warning Signs and Risk Factors

Warning signs are changes in behavior or new behaviors that may indicate that a person is suicidal, while risk factors are characteristics or conditions that increase the chance that a person may try to take their life.

Identify Warning Signs

People who are in danger of harming themselves may reach out to their primary care providers– sometimes directly, sometimes indirectly. **Rarely will patients immediately volunteer the information that they are thinking of harming themselves or ending their lives**. Be alert for warning signs that a patient may be at risk of imminent suicide. Warning signs include:[30]

Strongest Warning Signs – Take Immediate Action to Protect Person – Full Risk Assessment Warranted

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
  - This includes statements such as: "My family would be better off without me"; "I won't be around for xxx"
  - Among the elderly, these statements may sound more like "I don't want to be a burden" or "I don't belong anywhere anymore"
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person

Other warning signs of suicide

- Anxiety, agitation, irritability
- Insomnia or sleep disturbance
- Increased alcohol or drug use
- Purposelessness – no reason for living
- Hopelessness
- Withdrawing from friends, family and society

- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes
- Feeling trapped – like there's no way out

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.[41]

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt. A prior suicide attempt does not always mean that a person will go on to complete suicide; over 90% of individuals who have survived an attempt will not go on to later die by suicide. It is important to take all attempts seriously, however, and not interpret a patient who has had multiple attempts as solely "attention seeking". Help, hope, and recovery are possible.[42]

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.[43]

Individual Risk Factors

- Previous suicide attempt, especially within the past year
- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including TBI
- Mental illnesses, particularly:
  - Mood disorders
  - Schizophrenia
  - Anxiety disorders (including, PTSD)
  - Certain alcohol and other substance use disorders
  - Personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD)
  - In youths: Attention-deficit/hyperactivity disorder (ADHD) and conduct disorders (antisocial behavior, aggression, impulsivity)
- Psychiatric symptoms/states of mind: anhedonia (diminished or inability to gain pleasure from normally pleasurable experiences or activities), severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
- Impulsive and/or aggressive behavior
- History of trauma or abuse
- Family history of suicide or exposure to suicide in social network, community, media
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated)

Social/Environmental Risk Factors

- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- Lack of social support and increasing sense of isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Local clusters of suicide that can have a contagious influence

- Legal difficulties/contact with law enforcement/incarceration
- Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)[43]
- Exposure to, including through the media, and influence of others who have died by suicide

2. Protective Factors

While protective factors provide only a limited counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment) and vary greatly from one individual to another, **protective factors may mitigate risk in a person with moderate to low suicide risk**. Strengthening protective factors can be a part of safety planning, which will be discussed in Module 5.

Some important protective factors are:[44]

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness
- Coping skills
- Problem-solving skills
- Strong therapeutic relationship with a trusted provider
- Reality testing ability
- Religious faith

3. Suicide Inquiry

If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted. Patients will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. **Ask patients directly about suicide and seek collateral information** from other clinicians, family members, friends, EMS personnel, police, and others.[45]

Asking about suicide and suicidal thoughts can be very uncomfortable for some providers – it is important for providers to assess their own level of comfort with suicide inquiry and rehearse or role-pay to increase their level of comfort. Read on for a variety of tools and sample questions that you can use to assess suicide risk. How you ask the questions affects the likelihood of getting a truthful response. **Use a non-judgmental, non-condescending, matter-of-fact approach.**

NEVER ask leading questions like:

"You're not thinking of suicide, are you?"

"I hope that you aren't thinking about hurting yourself."

PRACTICE the questions below several times prior to a clinical encounter; again, asking about suicide for the first time may be harder than you think!

Thoughts of Suicide

Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Questions to uncover suicidal thinking:[45]

"Sometimes, people in your situation (describe the situation) lose hope; I'm wondering if you may have lost hope, too?"

"Have you ever thought things would be better if you were dead?"

"With this much stress (or hopelessness) in your life, have you thought of hurting yourself?"

"Have you ever thought about killing yourself?"

Prior Attempts

A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Questions to assess prior attempt:

"Have you ever tried to kill yourself or attempt suicide?"

"Have things ever been so bad for you in the past that you thought about killing yourself or actually tried to hurt yourself or kill yourself?"

If your questioning reveals no evidence of suicidal ideation AND you do not otherwise suspect that the patient is minimizing or being less than truthful about their suicidal ideation, you may end the inquiry here and document the finding.

If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you are seeing and what the patient is saying.

"You seem very upset to me, and I'm still concerned about you, are you sure that you haven't been thinking about hurting yourself or thinking that your loved ones would be better off without you?"

You can also ask to speak with a family member or friend if you remain concerned.

If your patient is having suicidal thoughts, ask specifically about frequency, duration, and intensity.

Questions to assess suicidal ideation:

"When did you begin having suicidal thoughts?"

"Did any event (stressor) precipitate the suicidal thoughts?"

"How often do you have thoughts of suicide? How long do they last? How strong are they?"

"What is the worst they have ever been?"

"What do you do when you have suicidal thoughts? Do you find that you have them more frequently or more intensely at different times of the day or of the week?"

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.[45] **Ask whether the patient has a plan and, if so, get the specifics.**

Questions to assess suicidal planning:

"Do you have a plan or have you been planning to end your life? If so, how would you do it? "Where would you do it?"

"Do you have the (drugs, gun, rope) that you would use? Where is it right now?"

"Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?"

Intent

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient's reasons to die vs. reasons to live. Many patients are very ambivalent about suicide – see Module 5: Intervention – of this Primer to learn more about ways to capitalize on this ambivalence and get them focused on reasons for living. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan.[45]

Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Questions to assess intent:

"What would it accomplish if you were to end your life?"

"Do you feel as if you're a burden to others?"

"How confident are you that this plan would actually end your life?"

"What have you done to begin to carry out the plan?"

"For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?"

"Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?"

"What makes you feel better (e.g., contact with family, use of substances)?"

"What makes you feel worse (e.g., being alone, thinking about a situation)?"

"How likely do you think you are to carry out your plan?"

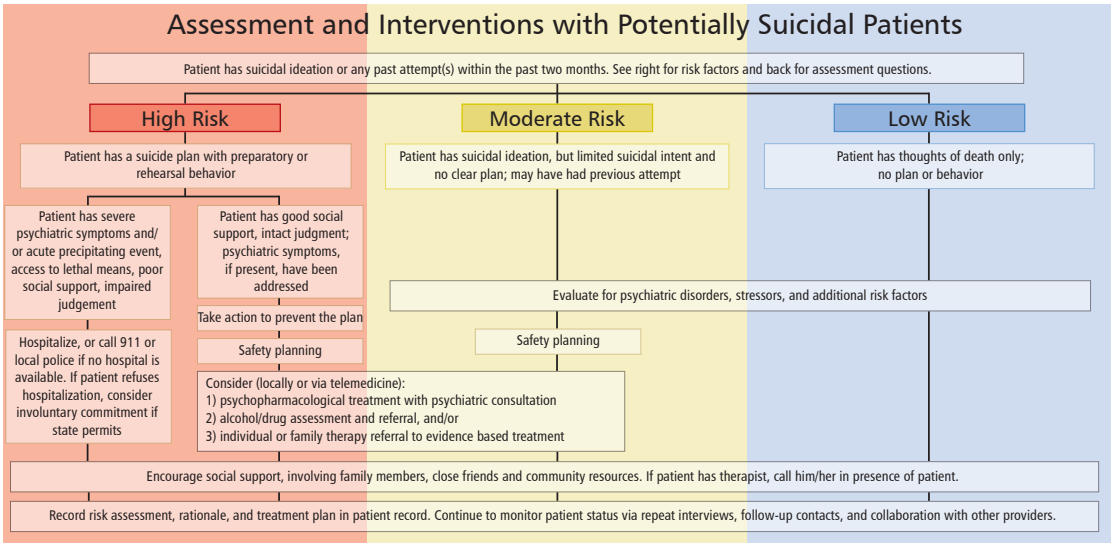
"What stops you from killing yourself?"

Look for any disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with youth, seek to confirm the patient's reports with information from a family member, spouse, or close friend. **Patients are more likely to tell a family member than a PCP that they are suicidal**.[46]

It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.[40]

4. Clinical Judgment of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients without thoughts of death or wanting to die, and without intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end of the risk spectrum. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can predict with complete accuracy which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for use by primary care professionals in assessing suicide risk and determining appropriate interventions (covered in Module 5). The copy of the pocket guide is also available as a separate document/tool for reference .



Suicide Risk and Protective Factors[1]

RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- Current/past psychiatric disorders: especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
  Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication.
  For children and adolescents: oppositionality and conduct problems.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- Chronic medical illness (esp. CNS disorders, pain).
- History of or current abuse or neglect.

PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk.

- Internal: ability to cope with stress, religious beliefs, frustration tolerance.
- External: responsibility to children or pets, positive therapeutic relationships, social supports.

Module 5 – Intervention

Taking appropriate action following a suicide risk assessment is critical and may save lives. The decision tree presented in the previous module will help determine appropriate interventions with potentially suicidal patients. You can make a difference in your patients' lives by addressing suicidality with the following steps:

1. PCP Treatment
2. Collaborative Safety Planning
3. Referral to Evidence Based Treatment
4. Documentation and Follow-up Care

1. PCP Treatment

Primary care providers are invaluable in the treatment and support of potentially suicidal patients. Important interventions that can be carried out in a primary care office include treatment of psychiatric symptoms, including depression and severe anxiety.

Depression treatment- medication

Most antidepressant prescriptions in the United States are written by primary care providers. Prescribing providers should monitor patients to ensure their symptoms are responding to treatment as expected. Medication adherence may be improved by addressing concerns regarding medication side effects when they are initially prescribed and as needed thereafter. Patients should also be informed that many antidepressant medications take 4-6 weeks before their onset of action; this information will help patients manage expectations and to continue taking the medication even if they do not initially notice any benefit. If the patient has been referred to a mental health provider, obtain a release of information from the patient and seek ongoing collaboration with that provider to coordinate care and to share information about the patient's mental health status. Follow-up care should be documented carefully to ensure that the patient continues to receive recommended services.

Always monitor frequently for efficacy and side effects.

Encourage a support network

Encouraging depressed, anxious, or otherwise at-risk patients to identify and utilize a support network is a key component of suicide prevention. Patients may need assistance with identifying the supportive individuals in their lives. Having a predetermined list of supportive individuals and their contact information will increase the likelihood that the patient will seek help before or during a crisis. This information should always be included in the patient's safety plan.

The support network may include:

- friends
- family members
- a therapist
- co-workers
- a suicide prevention hotline
- clergy/minister
- peer support

Encouraging the patient to utilize their support network even when they are not feeling suicidal can help reduce the number of suicidal crises they experience.

2. Safety Planning

A safety plan (also referred to as a "crisis response plan") is developed *collaboratively* with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The plan is developed in six steps,[38] and providers can help patients fill out the simple safety plan template included in Section 4: Patient Management Tools, section of this Toolkit.

The plan is to be provided to the patient to serve as a reference and support if thoughts of suicide occur.

1. Recognizing warning signs that a suicide crisis may be approaching
2. Identifying internal coping strategies that can be used by the patient to soothe emotions and avert the crisis
3. Utilizing friends and family members that can be contacted in order to distract from suicidal thoughts and urges without discussing suicidal thoughts
4. Contacting friends and family members who may help to resolve a crisis and with whom suicidal thoughts can be discussed directly
5. Contacting health professionals or agencies, including dialing the Colorado Crisis Services Hotline (1-844-493-TALK [8255]), the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to a local hospital emergency room
6. Making the environment safe—reducing access to lethal means

Step 1. Warning signs and triggers

The first step in safety planning is to help patients become aware of their own triggers and the cues that signal that a suicidal crisis may be developing for them. For example, a patient might start to feel very angry, anxious, or alienated before a suicidal crisis. Patients who are familiar with their own personal triggers and cues can utilize coping strategies and may be able to prevent themselves from reaching a point where they feel out of control.

To help patients determine their own unique triggers and cues you can ask patients such questions as:

"How do you feel in the hours or days before you first notice that you are feeling suicidal?"

"What do you notice in your thoughts and feelings, or in your body?"

"What are your triggers? What happens just before you start feeling or thinking this way?"

If the patient is unable to answer these questions, family members and friends have likely noticed changes that occur before the patient enters into a crisis. With permission from the patient, you may be able to involve people close to the patient (their support network) in answering these questions.

Step 2. Coping Strategies

The second step in safety planning is to help patients identify and practice coping strategies to help prevent or avert the development of a suicidal crisis. Coping techniques have different effects on different people; therefore, the provider should help the patient think through what really helps him or her feel better. Some examples of coping techniques are relaxation techniques, physical activity, moving away from a stressor or stressful person, and distraction techniques.

> **Some sample questions to get patients thinking about effective coping techniques are:**
>
> *"What relaxes you?"*
>
> *"When was the last time you felt relaxed or peaceful? What were you doing?"*
>
> *"Are there any things that you do that help you take your mind off thinking about death and dying?"*
>
> *"Who do you spend time with that makes you feel good?"*

Once coping strategies are identified, encourage patients to practice them before a crisis arises. Practicing these strategies when the patient is calm helps make them more automatic for the patient and thus easier to employ when the patient is distressed. Refer at-risk patients to the website resource below for help to identify techniques for self-soothing: http://www.nowmattersnow.org/skill/mindfulness

Step 3. Distracting from the crisis

Ask your patient about reaching out to family or friends, or going to specific social settings, such as a park or a coffee shop, or activities to distract them from their feelings or thoughts.

> Ask:
>
> *"Where could you go or who could you call to take your mind off the crisis or off of how you are feeling?"*
>
> *"Who helps you feel better when you socialize with them?"*
>
> *"Is there anything you do that helps you feel better?"*

Assess how likely it is that the patients will actually take these steps, if you suspect resistance, ask about it.

> Ask:
>
> *"You've come up with some good options, but I'm worried that you might not follow through when you are in crisis – what steps could we take now to help make sure that you will be able to follow through?*

Step 4. Family, friends, and other supports who can help

While similar to Step 3, this step involves working with the patient to identify individuals in her/his life that s/he can turn to in a crisis who will be able to help resolve a crisis.

> Ask:
>
> *"Among your family or friends, who do you think you could contact for help during a crisis?" or*
>
> *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*
>
> *"Who do you feel comfortable with discussing your thoughts of suicide?"*

Encourage the use of peer supports if the patient experiences chronic struggles with any mental illness and/or suicidal thoughts. Individuals with lived experience can help patients in ways that health care providers can't. To find peer support specialists near you, contact your local Community Mental Health Center or call the Colorado Crisis Services hotline 1-844-493-TALK (8255).

Ask the patient to list more than one person, in case one contact is unreachable. They can then prioritize their list, realizing that they may be more comfortable with different people at various times.

As in Step 3, assess how well you think the patient will follow through with this in a crisis, and discuss with them any barriers that might come up.

Step 5. Professionals to contact for help

Add any mental health, substance abuse, health care or other types of counselors and providers such as clergy or specialty providers that may be of support or assistance to the patient. If the client has no current connections to a professional they could ask for help, see Item 3: Referral, above.

Step 6. Temporarily restricting access to lethal means of self harm

The last step in safety planning addresses the issue of access to lethal means. This step is left for last because it may be the most delicate step for many patients, and perhaps the most critical. The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will relinquish his or her access to lethal means. **If the patient has expressed *any* suicidal ideation, described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting, loading a gun) it is *essential* to inquire about whether those specific means are available and to eliminate access to them while they are at risk.** Lethal means may include guns (ask about all guns in the home or that a patient may have access to elsewhere), ammunition, medications (prescription as well as over-the-counter), knives, razors, etc. It is important to help the patient identify whom they will entrust with these items until they can be safely returned. **With the patient's permission, contact family members or other persons within the patient's support system in order to assist with temporarily limiting access.**[47] Discussing lethal means with your patient is not a time for debating social issues around firearm ownership. Counseling on access to lethal means is a time to work with the patient to identify strategies to temporarily make their environment safe during periods of crisis.

The Harvard Means Matter Campaign and website asserts: "Means reduction" (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. It is based on the following understandings:

- Many suicide attempts occur with little planning during a short-term crisis.
- Intent isn't all that determines whether someone who attempts suicide lives or dies; means also matter.
- 90% of attempters who survive do NOT go on to die by suicide later.
- Access to firearms is a risk factor for suicide.
- Firearms used in youth suicide usually belong to a parent.
- Reducing access to lethal means saves lives.

Learn more about lethal means safety for patients of all ages: https://www.hsph.harvard.edu/means-matter/ or http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0

You can alert all your patients that gun locks can be obtained free of charge at: http://www.projectchildsafe.org/safety/safety-kit/Colorado

Direct patients, parents and other concerned family members to the website below for tips on temporarily removing lethal means from the home: www.suicideproof.org

As the plan is developed write each step on a paper the patient can take home. Use the handy form included on Section 4: Patient Management Tools of this Toolkit, or create one of your own. When it is clear the patient understands the plan, the patient should be able to commit to their clinician they will follow the plan, in sequence.

Rehearse with the patient how he/she will use the plan:

Where will the plan be kept?

How will he/she know when to take the first step?

What comes next?

When implementing the plan, the patient builds coping skills and develops confidence that they can manage future crises when they occur. Both the patient and their support person(s) should know the number for the National Suicide Prevention Lifeline 1-800-273-TALK (8255) and the Colorado Crisis Services 24-hour crisis line 1-844-493-TALK (8255).

Lethal Means Planning Among Specific Patient Groups:

Youth. Firearms remain the number one way by which young people die by suicide, although intentional deaths by prescription pain killers are on the rise among youth.[48] It is important to find out about a youth's specific plan for suicide, if it exists, and work with family members or guardians to restrict access to means of any kind, including access to firearms, potentially lethal prescription and over the counter (OTC) medications (including containers of more than 25 acetaminophen tablets), alcohol, and even rope. Anecdotal evidence suggests young people frequently know where guns and keys to gun cabinets are kept, even though parents may think that they do

not. Primary care providers should counsel parents or guardians of children and adolescents to either temporarily remove firearms from the home entirely or securely lock guns and ammunition – in separate locations. When primary care providers recommend that parents restrict access of their children to guns and medications in the home, most of them do.[22] The websites listed above, for the Means Matter and Suicideproof.org programs, provide valuable insight on restricting and temporarily removing access to lethal means around the home.

Elderly. Along with assessing for access to firearms, providers should pay close attention to the number and nature of medication prescriptions written for older adult patients from all of their providers, and assess for any possible stockpiling. If elderly patients are not able or willing to return or destroy excess medication, family members or other friends or loved ones can hold on to excess medication until such time that the patient is not at risk of harming themselves. Providers should also be aware that smaller doses of medications can have a higher lethality when mixed with alcohol, so access to alcohol should be discussed and potentially restricted as well. Providers can access the Colorado Prescription Drug Monitoring Program to get information on patients' prescriptions from other providers: https://copdm-ph.hidinc.com

Veterans. Lethal means restriction is often more complex with patients who are Veterans, service members, National Guard members, and other Reservists. Veteran patients are more likely to have firearms in their possession, more comfortable with firearms, and more likely to use a firearm in a suicide attempt, thus making the lethality of their attempts very high. Veterans are also typically more likely to resist relinquishing their firearms. It is crucial, therefore, when a Veteran patient is expressing or exhibiting any level of suicidality, to:

1. Discuss gun storage safety with Veterans – ask your Veteran patients to commit to one or all of the following temporary measure until such time as they are no longer at risk of harming themselves (important to stress this last part to Veteran patients):
   - Storing guns away from their homes temporarily, potentially with a friend, family member, or trusted battle buddy
   - Storing guns and ammunition separately, both under lock and key
   - Storing guns with a gun lock
2. Discuss whether the patient has a trusted friend or family member that would be willing to store the patient's firearm(s), lock box keys, or gun lock key(s) until such time as the patient no longer is at risk of harming themselves.
   - Have the patient commit to a plan of action for safe gun storage and follow-up with the patient or a friend or family member to ensure that they have followed through.
3. Assess the number and nature of medication prescriptions written for the patient from all of their providers, and assess for any possible stockpiling.

Find a pocket card developed by the Veterans Administration to guide the development of a safety plan provided with this Toolkit and downloadable from the Department of Veterans Affairs: http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf

Additionally, find an excellent free video training for safety planning at: http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm

NOTE: **"No-suicide contracts" have been found to be ineffective in preventing suicidal behavior and are often done solely to alleviate anxiety on the part of the provider. It is more effective to make a plan with your suicidal patients concerning what they will do in the event that they feel suicidal and are worried about their safety, rather than what they won't do.**

3. Referral to Evidence-Based Treatment

For patients in the moderate and high risk categories and who have symptoms of a psychiatric disorder, consider a referral to a **psychiatrist for a medication evaluation** and to a mental health professional for evidence-based psychotherapy. (Telemedicine is increasingly becoming an option for accessing psychiatric services in rural locations. See the Resource List in the Patient Education Tools section of this Toolkit for more information about establishing telemedicine services in your area.) For patients with **alcohol or substance use issues, consider a referral for alcohol/drug assessment and treatment.**

For patients in any risk category who are having significant thoughts of death or suicide, consider a referral for evidence-based individual **or family therapy**. When in doubt about whether a behavioral healthcare provider provides evidence-based treatment, ask! For all patients at increased risk, be sure to provide information about Colorado Crisis Services, Colorado's statewide behavioral health crisis response system, including their 24-hour hotline, 1-844-493-TALK (8255). When you call Colorado Crisis Services, you will be connected to a crisis counselor or trained professional with a master's or doctoral degree. They offer translation services for non-English speakers, and engage in immediate problem solving, and make follow-up calls to ensure callers receive continued care. The hotline offers texting services as well, which can be accessed by texting "TALK" to 38255, and online chat that can be accessed at www.coloradocrisisservices.org. Colorado Crisis Services contractors operate regional walk-in crisis centers at well as Crisis Stabilization units that are accessed via referral, a map of walk-in crisis centers is included in Section 3: Developing Mental Health Partnerships. Patients can also access the **National Suicide Prevention Lifeline**, 1-800-273-TALK (8255). By calling the Lifeline, patients are connected to the nearest certified crisis center, usually within the state. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 rescue when indicated.

For patients who are an imminent danger to themselves despite intervention efforts and attempts at safety planning, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily. A call to the Colorado Crisis Services hotline will inform providers whether there are resources in the area to send a mobile clinician directly to your office to perform a mental health evaluation and place a patient on a mental health hold, if necessary.

Locate specific information about Colorado's involuntary treatment laws and have this in the office as well as contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area. In Colorado, Revised Statute 27-65-105 addresses holds for mental health evaluation and treatment (and can be found at https://www.colorado.gov/pacific/cdhs/behavioral-health-laws-rules).

Criteria for involuntary commitment for up to 72 hours:

- Imminent danger to self or others and/or
- Grave disability - Inability to provide for his/her own basic needs

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Developing Mental Health Partnerships

The strong association between behavioral health problems and suicide suggests that the majority, though not all, of the patients you evaluate for suicide risk may also be in need of mental health care. In many rural areas, accessibility to specialized mental health treatments is limited. Regardless of how far away the nearest mental health care may be, ongoing communication between the primary care provider and mental health clinicians is a key to achieving treatment success. When comprehensive treatment is delivered to patients, recovery becomes an achievable goal in most situations.

Additional resources related to developing these partnerships are available in the Patient Education Tools/ Other Resources section of this Toolkit.

In This Section

Mental Health Outreach Letter

To help build strong, collaborative partnerships between primary care and mental health practices, this Toolkit includes a draft Outreach Letter. This letter may be modified to fit your personal style and circumstances and then sent to providers of mental health services to whom you expect to refer patients.

Date

Name

Address

Address

Dear (Mental Health Professional Name):

We at (Name of practice) are implementing changes in our practice to help us better identify and support patients who are at elevated risk for suicide. We are training our staff to better recognize the common warning signs of suicide and to screen patients for suicidal ideation when they present with known risk factors. As we step up our vigilance for suicide risk, we may be reaching out to you for help in assessing and/or treating behavioral health problems, including suicidal thoughts and behaviors.

A Toolkit developed by the National Suicide Prevention Resource Center (www.sprc.org) and the Western Interstate Commission for Higher Education Mental Health Program (http://www.wiche.edu/Mentalhealth) is assisting us with this practice enhancement. The Toolkit suggests we share with you a newly revised pocket card developed by mental health professionals for assessing suicide risk. It was developed by the nation's leading mental health experts in the field. Although you may already know the information on the card, having it concisely presented in an organized way may be useful. (We will also be using a pocket card from the Toolkit developed specifically for primary care professionals.)

We would like to work with you to assure the best access for our patients to your specialized knowledge and expertise. Since collaborative care requires strong communication, I propose that we set up a meeting to share perspectives and develop a model for collaboration. I will be contacting your office in the near future to explore this possibility.

Sincerely yours,

P.S. As you may know, The National Strategy for Suicide Prevention recommends that health professionals across the board receive specialized training in assessing and managing people at risk for suicide. We are pleased to be engaged in this education and training. In case you or any of your mental health colleagues are interested in trainings tailored especially for them, we are including some sources of such trainings on the attachment which we received as part of the Toolkit.

Nationally Disseminated Information and Trainings on Suicide Prevention Models and Suicide Assessment and Management for Mental Health Professionals

Zero Suicide. The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems as well as a specific set of tools and strategies. It is both a concept and a practice. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. It is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). For more information on the initiative go to: http://zerosuicide.sprc.org. For information on training options go to: http://zerosuicide.sprc.org/resources/suicide-care-training-options. (Offered by SPRC.)

Applied Suicide Intervention Skills Training (ASIST). A workshop designed for caregivers of individuals at risk of suicide. Training dates and locations are provided on the website. Also online are a text and audiovisual overview of the workshop, research and evaluations on the program, and suicide awareness facts. For more information go to: http://www.livingworks.net/programs/asist. (Offered by LivingWorks.)

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. A one-day workshop for mental health professionals and employee assistance professionals that focuses on competencies that are core to assessing and managing suicide risk. For more information go to http://www.sprc.org/training-events/amsr or contact the AMSR staff at amsr@edc.org. (Offered by SPRC.)

Collaborative Assessment and Management of Suicidality (CAMS). CAMS is a therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk. It is a flexible approach that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities. Online training, practical role-play training, presentations, and consultation services are available. For more information go to: https://cams-care.com. (Offered by CAMS-care.)

QPRT: Suicide Risk Assessment and Management Training. (QPRT stands for Question/Persuade/Refer/Treat.) A 10-hour course available either online or face-to-face for professionals who may evaluate, assist, counsel or treat potentially suicidal persons - a tool that is uniquely designed to gather critical information about a person's status at intake and to establish a safety and intervention plan. For more information to go http://www.qprinstitute.com. (Offered by QPR Institute.)

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians. A two-day advanced interactive training augmented by pre-workshop, web-based assessment and post workshop mentoring. For more information go to www.suicidology.org/training-accreditation/rrsr or contact Paul at the American Association of Suicidology, prothenberg@suicidology.org. (Offered by American Association of Suicidology.)

SafeTALK. SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. For more information go to: http://www.livingworks.net/programs/safetalk/ (Offered by LivingWorks.)

Patient Management Tools

Many concrete and easy-to-use tools are available to assist you and your staff in preventing suicide. This section includes pocket-sized tools to facilitate assessment and intervention with at-risk patients in the office, as well as templates for helping to ensure the patients' safety outside of your office. Also included in this section is one strategy for carefully tracking the status of patients at heightened risk for suicide, an important component of effective suicide prevention.

In This Section

Primary Care Pocket Guide

The Pocket Guide for Primary Care Professionals provides a summary of important risk and protective factors for suicide, questions you can use in a suicide assessment, and a decision tree for managing the patient at risk for a suicide attempt. The card is designed to be printed on both sides and folded in quarters to fit easily in the pocket. Hard copies are available for purchase through the WICHE Mental Health Program at mentalhealthemail@wiche.edu or by calling 303-541-0311.

SAFE-T Pocket Card

http://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card

This pocket card, designed by mental health experts for mental health professionals, provides a brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The website above will direct you to the SAMHSA Publications Ordering website where the card can be downloaded or ordered free of charge https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/SMA09-4432. SAMHSA's free suicide prevention app, Suicide Safe, was based on the SAFE-T card and can be downloaded for iOS and Android devices. More information about Suicide Safe is available at: https://store.samhsa.gov/apps/suicidesafe/index.html.

Safety Planning Guide

http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians

The pocket-sized safety planning guide reminds clinicians of the most important points to cover in collaboratively developing a safety plan with a patient. The guide was adapted from content developed by the Department of Veterans Affairs.

Patient Safety Plan Template

http://www.sprc.org/resources-programs/patient-safety-plan-template

The Patient Safety Plan Template is filled out collaboratively by the clinician and the patient and then used independently by the patient to help ensure their safety in their day-to-day lives. The Safety Planning Guide (listed above) can be used as a source of questions to ask to facilitate development of the Safety Plan.

Crisis Support Plan

The Crisis Support Plan is used by the patient and the clinician to enlist social support from a trusted friend or relative should a suicide crisis recur. It explains roles that supportive individuals can take to help protect the person at risk for suicide and serves as an informal contract that the designated support person will fulfill these roles. Active support of a friend or loved one is among the strongest protective factors against suicide.

Screening: uncovering suicidality[2]

Transition Question: Confirm Suicidal Ideation
Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? **(Note: the transitional question is not part of scoring.)**

1. **Thoughts of carrying out a plan.** Recently, have you been thinking about how you might kill yourself? **If yes, consider the immediate safety needs of the patient.**
2. **Suicide intent.** Do you have any intention of killing yourself?
3. **Past suicide attempt.** Have you ever tried to kill yourself?
4. **Significant mental health condition.** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?
5. **Substance use disorder.** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
6. **Irritability/agitation/aggression.** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression.

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the answer to the transition question and any of the other six items is "Yes", further intervention, including assessment by a mental health professional, is needed.

Assess suicide ideation and plans[3]

- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?

Endnotes:

[1] SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).

[2] *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.* Suicide Prevention Resource Center. Newton, MA. http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf.

[3] Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. American Family Physician, 59 (1999), 1500-1506.

Call the Colorado Crisis Services 24/7 Hotline at 1-844-493-TALK (8255) for mental health crisis services including mobile crisis response.

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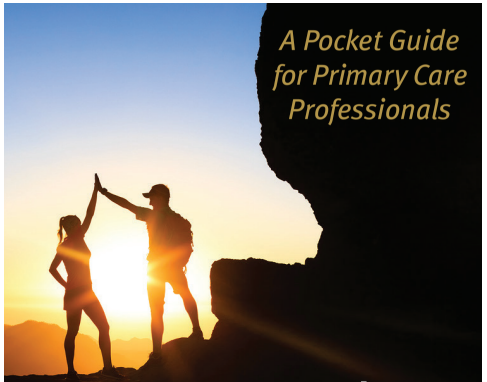
WICHE

Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/



A Pocket Guide for Primary Care Professionals

Assessment and Interventions with Potentially Suicidal Patients

SPRC

WICHE Western Interstate Commission for Higher Education

Assessment and Interventions with Potentially Suicidal Patients

Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

High Risk

Patient has a suicide plan with preparatory or rehearsal behavior

Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement

Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits

Patient has good social support, intact judgment; psychiatric symptoms, if present, have been addressed

Take action to prevent the plan

Safety planning

Moderate Risk

Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt

Evaluate for psychiatric disorders, stressors, and additional risk factors

Safety planning

Consider (locally or via telemedicine):
1) psychopharmacological treatment with psychiatric consultation
2) alcohol/drug assessment and referral, and/or
3) individual or family therapy referral to evidence based treatment

Low Risk

Patient has thoughts of death only; no plan or behavior

Encourage social support, involving family members, close friends and community resources. If patient has therapist, call him/her in presence of patient.

Record risk assessment, rationale, and treatment plan in patient record. Continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers.

Suicide Risk and Protective Factors[1]

RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- Current/past psychiatric disorders: especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
  Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication.
  For children and adolescents: oppositionality and conduct problems.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- Chronic medical illness (esp. CNS disorders, pain).
- History of or current abuse or neglect.

PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk.

- Internal: ability to cope with stress, religious beliefs, frustration tolerance.
- External: responsibility to children or pets, positive therapeutic relationships, social supports.

RESOURCES

- Download this card and additional resources at **http://www.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

- For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

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WICHE

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3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/

Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

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Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

Patient Safety Plan Template

Step 1. Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2. Internal coping strategies – things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3. People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4. People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5. Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
2. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
3. Local Urgent Care services _____
   Urgent Care services address _____
   Urgent Care services phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6. Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

Crisis Support Plan

For: _____ Date: _____

I understand that suicidal risk is to be taken very seriously. I want to help _____ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases, inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - _____
  - _____
- Help _____ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms and ammunition
  2. Remove or lock up:
     - knives, razors, and other sharp objects
     - prescriptions and over-the-counter drugs (including vitamins and aspirin)
     - alcohol, illegal drugs, and related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict access to vehicle, ropes, inflammables, etc. as appropriate.
  5. Limit or restrict access to vehicle/car keys as appropriate.
  6. Identify people who might escalate risk for the client and minimize their contact with the client.
  7. Provide access to things client identifies as helpful and encourage healthful behaviors such as good nutrition and adequate rest.
- Other _____

If I am unable to continue to provide these supports, or if I believe that the Crisis Action Plan is not helpful or sufficient, I will contact [name of therapist or therapy practice] immediately and express my concerns.

If I believe _____ is a danger to self or others, I agree to:

- Call [name of therapist or therapy practice and phone number]
- *or* call 911
- *or* help _____ get to a hospital.

I agree to follow by this plan until _____. Support signature: _____

Client signature: _____ Therapist signature: _____

SPRC

WICHE Mental Health Program

State Resources, Policy, and Reimbursement Information

Policies, billing procedures, and referral procedures related to suicide prevention in primary care vary significantly across states. Understanding how to bill for mental health services in primary care, how to obtain higher levels of care for individuals at risk for suicide, and where to find information relevant to your state is critical. Learning to successfully navigate these processes will reduce the barriers to mental health service provision within your setting and will enhance your ability to partner with mental health treatment centers when crisis services are needed.

In This Section

Tips and Strategies for Reimbursement

This brief module provides strategies that billing personnel within primary care practices may use to increase their success in obtaining reimbursement for mental health services.

State-Specific Resources and Policy Information

This is a guide to direct providers and staff to state-specific behavioral health resources and policies. It includes suggestions for locating information regarding crisis services and inpatient mental health care.

Tips and Strategies for Reimbursement for Behavioral Health Services in a Primary Care Setting

Overview

Reimbursement to primary care providers who deliver behavioral health services is available from a variety of payer sources, including Medicaid, Medicare, and private insurers. Growing support for integrated physical and behavioral health care has led to improvements in reimbursement to primary care providers for behavioral health services. For example, Medicare now reimburses primary care providers for certain behavioral health services provided to Medicare beneficiaries. **This module provides you with a basic understanding of the behavioral health diagnoses and services eligible for reimbursement and includes links to a variety of resources, including tools to develop an integrated medical and behavioral health practice.**

Private Insurers

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care. The Affordable Care Act (ACA) further expands the MHPAEA's requirements by ensuring that qualified plans offered on the health insurance marketplaces cover many behavioral health treatments and services. The ACA also requires coverage for rehabilitative and habilitative services that can help support people with behavioral health challenges.

The ACA requires plans to cover depression screening for adults and adolescents; alcohol misuse screening and counseling for adults; and alcohol and drug use assessments for adolescents. So, the service codes for the screening and counseling services provided in the Medicare section of this Chapter should be reimbursed by private insurers, in addition to other behavioral health services. Check with your patient's insurance provider for detailed information.

Medicare and Medicaid

Medicare and Medicaid are the payers most frequently billed for behavioral health services in a primary care setting. An important first step is determining services eligible for reimbursement and credentialing for providers who deliver these services.

Medicare. Medicare Part B pays for reasonable and necessary medical and behavioral health care services when they are furnished on the same day, to the same patient, by the same professional or a different professional. This is regardless of whether the professionals are in the same or different locations. **Key services reimbursed by Medicare include:**

- **Annual Depression Screening** (HCPCS/CPT Codes G0444) furnished in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. All Medicare beneficiaries are eligible. (Copayment/coinsurance and deductible waived.)
- **Alcohol Misuse Screening and Counseling**
  - Annual alcohol misuse screening (G0442 - annually)
  - Quarterly brief face-to-face behavioral counseling for alcohol misuse (G0443 – four times per year for those who screen positive)

  All Medicare beneficiaries are eligible. Medicare beneficiaries who screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol

dependence) are eligible for counseling under certain conditions. (Copayment/coinsurance and deductible waived.)

- **Screening, Brief Intervention, and Referral to Treatment** (SBIRT) services are an evidence- and community-based practice designed to identify, reduce, and prevent problematic substance use disorders. Medicare pays for medically reasonable and necessary SBIRT services when furnished in physicians' offices and outpatient hospitals. In these settings, you assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment. There are specific qualifications for suppliers authorized under Medicare to furnish SBIRT services; however, SBIRT services may be provided by physicians, physician assistants, clinical nurse specialists, clinical psychologists, clinical social workers, and certified nurse midwifes.

  Colorado participates in the SBIRT program at 20 different locations within the state. For more information contact SBIRT Colorado at http://improvinghealthcolorado.org/

Medicaid. Medicaid reimbursement and provider requirements vary from state to state (e.g., where one state may allow billing for two services in one day, another may not.) Currently, 28 state Medicaid programs allow reimbursement for two services by one provider organization. To assist providers with billing solutions, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions provides customized Billing and Financial Worksheets for each state to help identify existing opportunities. The worksheets include information related to Medicare services as well. http://www.integration.samhsa.gov/resource/billing-financial-worksheets#Billing

Colorado Medicaid benefits. Colorado will reimburse providers enrolled in the Medicaid program for most screening and assessment procedures, including alcohol or drug assessment (H0001); screening for possible admission to a treatment program (H0002); behavioral health counseling and therapy (H0004). Also, primary care practices with integrated behavioral health services are eligible for Medicaid reimbursement for several services. Coordination with the state's Behavioral Health Organizations (BHO) may be necessary for individuals enrolled with a BHO.

Integrating Behavioral Health Services into a Primary Care Practice

Primary care settings are increasingly serving as the gateway for individuals with behavioral health needs to address those needs. Many primary care providers are integrating behavioral health care services into their practices. Several modes for integrated care exists. The SAMHSA Center for Integrated Health Solutions provides technical assistance and training for integration of primary and behavioral health care and related workforce development. More information about the Center may be found at: http://www.integration.samhsa.gov/about-us/about-cihs. Tools and supports are also available for providers through the Colorado State Innovation Model (SIM), Colorado's federally funded behavioral health and primary care integration grant project:

https://www.colorado.gov/healthinnovation
http://www.ucdenver.edu/anschutz/about/practicetransformation/Pages/default.aspx
http://www.practiceinnovationco.org/sim/

Suggested Reading

The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization, 1992.
http://www.who.int/classifications/icd/en/bluebook.pdf

Mental Health Services; Department of Health and Human Services, Centers for Medicare & Medicaid Services Mental Health Services. January 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf

Reimbursement of Mental Health Services in Primary Care Settings; (Mauch, Danna, Ph.D; Kautz, Cori. MA and Smith, Shelagh, MPH; US Department of Health and Human Services; SAMHSA) February 2008. http://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf

Resources:

ICD-10-CM (Diagnosis coding): https://www.aapc.com/icd-10/

CPT Codes (Service coding): https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology

HCPCS Codes (Service coding): https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

State-Specific Resources and Policy Information

This section is intended to assist primary care providers and staff within the practice setting to identify Colorado behavioral health resources and policies that may direct where and how patients with higher level treatment needs access care. It would be ideal if someone in the practice had information on local and state crisis numbers, involuntary psychiatric hospitalization laws, and how to access psychiatric crisis beds throughout the state.

- Colorado Crisis Services statewide behavioral health crisis response system hotline line number: 1-844-493-TALK (8255) or text "TALK" to 38255.
- National Suicide Hotline: Lifeline 800-273-TALK (8255). This number will connect you to a local certified crisis line.
- Visit www.coloradocrisisservices.org to identify your nearest walk-in location, access crisis chat features or download printable wallet cards.
- Visit the Zero Suicide initiative (http://zerosuicide.sprc.org/) for information and resources related to suicide prevention.
- Other local hotline numbers _____

Information regarding procedures for admission to an inpatient psychiatric treatment bed or facility

Involuntary Commitment

For patients who are an imminent danger to themselves despite intervention efforts and attempts at safety planning, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily, depending upon the severity of their symptoms and their ability to commit to inpatient treatment. A call to the Colorado Crisis Services hotline, 1-844-493- TALK (8255) will inform providers whether there are resources in the area to send a mobile clinician directly to your office to perform a mental health evaluation and place a patient on a mental health hold, if necessary, and about how to inquire about available psychiatric beds.

Locate specific information about Colorado's involuntary treatment laws and have this in the office as well as contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area. In **Colorado, Revised Statute 27-65-105** addresses holds for mental health evaluation and treatment and can be found at: https://www.colorado.gov/pacific/cdhs/behavioral-health-laws-rules

Criteria for involuntary commitment for up to 72 hours (a "mental health hold"):

- Imminent danger to self or others and/or
- Grave disability - Inability to provide for his/her own basic needs

RS 27-65-105 states "…When any person appears to have a mental illness and, as a result of such mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled, then a person specified in subparagraph (II) of this paragraph (a), each of whom is referred to in this section as the "intervening professional", upon probable cause and with such assistance as may be

required, may take the person into custody, or cause the person to be taken into custody, and placed in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation."

The legal form required to place someone on a "mental health hold" is known as the M-1 form. A copy can be found and at the website: https://www.colorado.gov/pacific/cdhs/mental-health-emergency-holdinvoluntary-commitment

Primary contacts and information for local or state psychiatric hospital/facility/ crisis beds for psychiatric emergencies.

A call to the Colorado Crisis Services hotline listed above or to your local Community Mental Health Center (CMHC) will provide information about state psychiatric hospital/s, local crisis stabilization units, and transportation options.

A list of **Colorado Community Mental Health Centers** (CMHCs) can be found at: https://www.cbhc.org/.

A list of **Colorado Crisis Services Walk-In Centers** can be found at: http://coloradocrisisservices.org/.

Healthcare Provider Self-care

Healthcare providers have higher rates of depression and suicide and are less likely to seek help compared to the general population. It is therefore important for healthcare providers to regularly engage in self-care and ensure that their mental health needs do not go untreated.

In This Section

Physician Suicide

Provides an overview of suicide rates and related risk factors among healthcare providers and links to additional information on physician depression and suicide.

Tips and Resources for Healthcare Provider Self-care

This section provides tips for practicing self-care and resources for self-care.

Physician Suicide

There is one more high-risk group for suicide that must be highlighted, and that is YOU and your staff!

Physicians have higher rates of suicide, suicide risk, and symptoms of depression than the general population, and at the same time are less likely to seek mental health treatment.[1] For male physicians, the suicide rate is 1.41 times higher than the general male population, and for female physicians, this risk is even higher, at 2.27 times greater than the general female population.[1] Physicians are even more prone to the stigma surrounding mental health care, and report time constraints and concerns about reputation and confidentiality as additional barriers to seeking treatment.[1]

From 2004 to 2014, Healthcare Providers and Social Assistance workers have had the fifth highest number of suicides in Colorado (638 suicides within this 10 year time frame), with health diagnosing and treating practitioners having by far the highest number of suicides within that group (317 suicides within this ten year time frame).[2] Healthcare support and Office and Administrative Support workers have had the second and third highest number of suicides, respectively, within the Healthcare Provider group.[2]

Risk for suicide increases among physicians when mental health conditions go untreated; self-medicating, even with prescription medications, may temporarily reduce some symptoms of depression and anxiety, but the underlying issue remains untreated. "Practice what you preach" and model good self-care and attention to your mental health.

Other Healthcare Professions

Veterinarians have also been found to have a substantially higher rate of suicide and suicidal thoughts, up to three times the national average, than the general public.

Find more facts about physician depression and suicide here: http://afsp.org/wp-content/uploads/2016/11/ten-facts-about-physician-suicide.pdf or listen to a podcast from Emergency Medicine Reviews and Perspectives (EMRAP) on the subject: https://www.emrap.org/episode/suicideriskin/suicideriskin

[1] Physician and Medical Student Depression and Suicide Prevention. American Foundation for Suicide Prevention. https://afsp.org/our-work education/physician-medical-student-depression-suicide-prevention/.

[2] *Suicides in Colorado: Industry and Occupation, age 15 years and over*. Colorado Violent Death Reporting System (CoVDRS), Colorado Suicide Data Dashboard. Colorado Department of Public Health & Environment. Retrieved from https://www.colorado.gov/pacific/cdphe/colorado-violent-death-reporting-system.

Tips and Resources for Healthcare Provider Self-Care

How do you take care of yourself?:

Physicians and other healthcare providers must routinely and intentionally engage in self-care to be at their best for their patients, their families, and themselves.

The Healthcare Toolbox provides excellent and concise advice on physician self-care. The authors stress the importance of:

- **Awareness** of one's own emotional reactions and distress when confronting others' difficult and traumatic experiences
- **Connecting** with others by talking about reactions with trusted colleagues or others who will listen
- Maintaining a **balance** between one's professional and personal life, with a focus on self-care such as exercise, relaxation, and stress management

Additionally, **seek professional help** when symptoms of depression, anxiety or other mental health or substance use issues impact your daily personal or professional functioning.

Find other great tips on caring for yourself at:
https://healthcaretoolbox.org/self-care-for-providers.html

or go to the National Academy of Medicine website:

Patient Education Tools/Other Resources

This section contains a list of additional tools to educate providers and help increase awareness in patients, families, and communities about suicide. The Public Awareness Materials include items that may be ordered for posting in your clinic as well as items that may be disseminated to patients and families. Increasing awareness is an important component of addressing the problem of stigma associated with suicidality.

Also included in this section is a list of Suicide Prevention Resources. This list includes additional resources for providers as well as for patients, families, and community members. Samples of several of the tools included in this list are provided in the front pocket of the Toolkit, along with samples of the pocket guides described in the Developing Mental Health Partnerships and Patient Management Tools sections of the Toolkit.

In This Section

Public Awareness Materials

This section lists materials you may find useful for posting in your office to promote suicide prevention awareness or for making available to patients in need of information about suicide.

Suicide Prevention Resource List

This is a guide to direct providers and staff to state-specific behavioral health resources and policies. It includes suggestions for locating information regarding crisis services and inpatient mental health care.

Public Awareness Materials

The materials below represent a sample of those that may be helpful for your clinic. Posting these materials in your waiting room, exam rooms, or office hallways will provide your patients with the suicide hotline number, an important resource for potentially suicidal patients, and may help to address the problem of stigma associated with suicidality.

SAMHSA/National Suicide Prevention Lifeline materials:

The National Suicide Prevention Lifeline (NSPL) website contains free downloadable Warning Signs Lifeline wallet cards in English and Spanish, Risk Assessment Lifeline wallet cards, and a NSPL one-page Impact Sheet that contains information about the NSPL.

https://suicidepreventionlifeline.org/media-resources/

https://store.samhsa.gov/product/SVP13-0126

Spanish Version:
https://store.samhsa.gov/product/SVP11-0126SP

SAMHSA suicide prevention materials:

The Substance Abuse and Mental Health Services Administration (SAMHSA) Store has a variety of free sucide prevention materials that can be ordered or downloaded, and used in health care office.

https://store.samhsa.gov/facet/Issues-Conditions-Disorders/term/Suicide?pageNumber=1

SAMHSA's Wellness Initiative:

SAMHSA's Wellness Initiative raises awareness of health disparities among people with serious mental and/or substance use disorders and the general population. It encourages people to improve their mental and physical health through positive lifestyle changes. This initiative includes the Eight Dimensions of Wellness and National Wellness Week.

https://www.samhsa.gov/wellness-initiative

Additional state resources:

Additional suicide prevention posters and other resources may be available through the suicide prevention coordinator in your home state. State coordinator contact information is available through the Suicide Prevention Resource Center website.

http://www.sprc.org/states

Practitioners can also request posters and other materials from Man Therapy (http://mantherapy.org/) from the Office of Suicide Prevention (www.coosp.org) and from Colorado Crisis Services (www.coloradocrisisservices.org) from the Colorado Office of Behavioral Health (abrassa@state.co.us).

Suicide Prevention Resource List

The following is a resource guide for suicide prevention in Primary Care settings. The resources are presented in the categories below; however, many of these resources could fit appropriately in more than one category.

1. Resources for Providers:
   - Depression
   - Improving access to health care
   - Means restriction
   - Substance abuse
   - Suicide fact sheets
   - Trainings and guides

2. Resources for Patients, Families, and Community Members:
   - General resources
   - Population specific resources
   - American Indians and Alaska Natives
   - Gay, lesbian, bisexual, transgender
   - Veterans
   - Trainings and guides

3. General Information on Suicide Prevention and Related Topics

1. Resources for Providers

General

Zero Suicide
http://zerosuicide.sprc.org/

The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems as well as a specific set of tools and strategies. It is both a concept and a practice. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. It is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Quick Guide to Getting Started with Zero Suicide (http://zerosuicide.sprc.org/resources/quick-guide-getting-started-zero-suicide) provides tips and strategies for how to quickly implement the initiative and has been included at the end of the Suicide Prevention Resource List.

Colorado Suicide Prevention Commission
https://www.colorado.gov/pacific/cdphe/suicide-prevention-commission

The Suicide Prevention Commission serves as the interface between the public and private sectors in establishing statewide suicide prevention priorities that are data-driven and evidence-based. By focusing on current resources and expanding the network of partnerships across the state, the commission boosts the efforts of Colorado's Office of Suicide Prevention and makes annual reports to the governor as well as the General Assembly. The public is welcome to attend commission meetings and contact the coordinator for opportunities to be involved in commission efforts.

Depression

The Columbia Suicide Severity Rating Scale (C-SSRS)
http://cssrs.columbia.edu/

A specialized tool for assessing suicidality that uses simple, plain-language questions to assess suicide risk that anyone can ask. The tool helps identify if someone is at risk for suicide, assesses the severity and immediacy of that risk, and gauges the level of support that the person needs. It is available free of charge.

Macarthur Depression Toolkit
http://otgateway.com/articles/13macarthurtoolkit.pdf

The Toolkit is provided free of charge and contains detailed, evidence-based information about treating depression as well as numerous tools for primary care providers.

Patient Health Questionnaire Depression Scale (PHQ-9)
http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

The PHQ-9 is the 9-item depression scale of the Patient Health Questionnaire. The final item screens for the presence of suicidal ideation. May be downloaded free of charge.

Improving Access to Health Care

Behavioral Health Treatment Services Locator

https://findtreatment.samhsa.gov/locator/home

1-800-662-HELP (4357)

1-800-487-4889 (TDD)

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal government provides a confidential, anonymous online service to locate treatment facilities in the U.S. and U.S. Territories for substance abuse/addiction and/or mental health problems.

Federally Funded Community Health Center Locator

http://findahealthcenter.hrsa.gov/Search_HCC.aspx

A locator for federally funded health centers – search by zip code. These Health Centers work in communities, providing access to high quality, family oriented, comprehensive primary and preventive health care, regardless of patients' ability to pay.

Means Restriction

Lock It Up Campaign

http://www.kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOK-IT-UP.aspx

LOK-IT-UP raises awareness about the importance of safe firearm storage, informs the public about safe storage options, and promotes the availability of safe storage devices. The Public Health Seattle King County website contains information for healthcare providers, including brochures and answers to important questions regarding gun storage.

Means Matter

http://www.hsph.harvard.edu/means-matter/

The Means Matter website, created by the Harvard Injury Control Research Center at the Harvard School of Public Health, contains information on means reduction and why it is important. Means reduction statistics and programs are provided by state.

Safe Use of Prescription Pain Medication Brochure

http://here.doh.wa.gov/materials/safe-use-of-prescription-pain-medication/33_PainMeds_E15L.pdf

A 3.5 x 8.5 informational brochure describing how to use prescription pain medication safely, dangers of not following the directions, possible signs of overdose, and how to safely dispose of unwanted or expired medication. May be downloaded free of charge in English and Spanish.

Substance Abuse

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. A Treatment Improvement Protocol (TIP) 50

https://store.samhsa.gov/product/SMA15-4381

A manual developed by SAMHSA that offers guidelines for working with suicidal adults living with substance use disorders. It covers risk factors and warning signs for suicide, core competencies, and clinical vignettes. A PDF copy can be downloaded and printed copies can be ordered at the URL above.

Alcohol Screening and Brief Intervention

http://www.integration.samhsa.gov/clinical-practice/Alcohol_screening_and_brief_interventions_a_guide_for_public_health_practitioners.pdf

A printable guide for public health practitioners produced by the American Public Health Association.

Helping Patients Who Drink Too Much: A Clinician's Guide and Related Professional Support Resources

http://www.niaaa.nih.gov/guide

A guide for clinicians produced by the National Institute on Alcohol Abuse and Alcoholism. Includes the downloadable guide, a medications update, a PowerPoint presentation, and a 10-minute interactive video course. The downloadable and video courses include free CME/CE credits.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

https://www.samhsa.gov/sbirt

SBIRT services are an evidence-and community-based practice designed to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Colorado participates in the SBIRT program at 20 different locations within the state. For more information contact SBIRT Colorado at http://improvinghealthcolorado.org/.

Screening for Tobacco, Alcohol and Other Drug Use

http://www.drugabuse.gov/nmassist/

A Web-based interactive tool produced by the National Institute on Drug Abuse to guide clinicians through a short series of screening questions and, based on the patient's responses, generate a substance involvement score that suggests the level of intervention needed. Also provides links to resources for conducting a brief intervention and treatment referral, if warranted.

Suicide Fact Sheets

Risk and Protective Factors for Suicide

http://www.sprc.org/resources-programs/understanding-risk-and-protective-factors-suicide-primer-preventing-suicide

This primer provides a brief overview of the importance of risk and protective factors as they relate to suicide and offers guidance about how communities can best use them to decrease suicide risk.

U.S. Suicide Fact Sheet

https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

This 2-page fact sheet provides a basic overview of suicide, developed by the Centers for Disease Control and Prevention.

Trainings and Guides

After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors

http://store.samhsa.gov/product/A-Guide-for-Medical-Providers-in-the-Emergency-Department-Taking- Care-of-Suicide-Attempt-Survivors/SMA08-4359

Brochure intended to provide medical professionals with tips on how to enhance care in the emergency department for people who have attempted suicide. The guide also contains information on HIPAA, patient discharge, and resources about suicide for medical professionals, patients and their families.

At-Risk in Primary Care
https://kognito.com/products/at-risk-in-primary-care/

An online, interactive, self-paced, role-play simulation offered by Kognito that prepares primary care professionals to screen patients for substance use and mental health conditions, conduct brief interventions using motivational interviewing techniques, and coordinate referrals or follow-up care. It is listed in the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry for Evidence -based Programs and Practices (http://nrepp.samhsa.gov/ProgramProfile.aspx?id=212).

Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments
http://www.sprc.org/resources-programs/caring-adult-patients-suicide-risk-consensus-guide-emergency-departments

Full Guide: http://www.sprc.org/sites/default/files/EDGuide_full.pdf
Quick Guide: http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf

A manual designed to assist Emergency Department (ED) health care professionals with decisions about the care and discharge of patients with suicide risk. It helps ED caregivers intervene effectively while the patient is in the ED, decide if the patient can be discharged or if further evaluation is needed, and ensure that the patient will be safe after leaving the ED.

Continuity of Care for Suicide Prevention: The Role of Emergency Departments
http://www.sprc.org/resources-programs/continuity-care-suicide-prevention-role-emergency-departments

A six-page paper highlighting key steps emergency department (ED) providers can take to establish continuity of care for patients at risk for suicide. Includes recommendations to help organizations implement national standards and goals relevant to ED care for patients with suicide risk.

Counseling on Access to Lethal Means (CALM)
http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

A free online course, designed for providers who counsel people at risk for suicide, that aims to reduce access to lethal means, particularly (but not exclusively) firearms. An in-person training is also available. For more information see: http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0.

Detecting and Treating Suicide Ideation in all Settings-Sentinel Event Alert 56
https://www.jointcommission.org/sea_issue_56/

Sentinel Event Alerts identify specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences. Event Alerts are published by The Joint Commission for Joint Commission-accredited organizations and interested health care professionals. The goal of this alert is to help health care organizations that provide inpatient and outpatient care to better identify and treat individuals with suicide ideation.

Is Your Patient Suicidal?
http://www.sprc.org/resources-programs/your-patient-suicidal

A four-color poster that provides Emergency Department practitioners with information on recognizing and responding to acute suicide risk. It is designed to be hung in staff-only areas. The poster features the most common and noticeable warning signs of acute risk for suicide as well as simple questions clinical staff can ask to uncover suicide risk when warning signs are noticed or suspected. The poster and Clinical Guide can be ordered as a kit from SPRC at http://www.sprc.org/webform/emergency-department-poster-kit-request. Online versions of the poster and guide can also be downloaded and printed from the SPRC website at: http://www.sprc.org/for-providers/emergency-department-resources#general.

Preventing Suicide in Emergency Department Patients

http://www.sprc.org/resources-programs/preventing-suicide-emergency-department-patients

This interactive online course, developed by SPRC, teaches healthcare professionals who work in an ED how to conduct screening, assessment, and brief interventions. It also covers patient-centered care, patient safety, and including suicide prevention in discharge planning.

Recognizing and Responding to Suicide Risk in Primary Care

http://www.suicidology.org/training-accreditation/rrsr-pc

A training developed by the American Association of Suicidology in collaboration with primary care practitioners specifically for primary care physicians and staff.

SAFE-T Pocket Card

http://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card

The SAFE-T Card guides mental health clinicians through five steps which address the patient's level of suicide risk and suggest appropriate interventions. It is intended to provide an accessible and portable resource to the professional whose clinical practice includes suicide assessment. The card lists key risk and protective factors that should be considered in the course of completing the five-steps. The link above will direct you to the SAMHSA Publications Ordering website where a PDF of the card can be downloaded. The PDF image of the card prints out in the center of 8.5 X 11 paper because the original is a 6x7 2-sided, folded pocket card. Quantities of the SAFE-T cards are available for order through Screening for Mental Health, Inc at https://shop.mentalhealthscreening.org/products/safe-t-cards or through the SAMHSA Store at https://store.samhsa.gov/product/SMA09-4432.

Safety Planning Guide

http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians

The pocket-sized safety planning guide reminds clinicians of the most important points to cover in collaboratively developing a safety plan with a patient. The guide was adapted from content developed by the Department of Veterans Affairs. Note this content is included in Tab 4 of this Toolkit.

Safety Planning Intervention for Suicide Prevention

http://zerosuicide.sprc.org/resources/safety-planning-intervention-suicide-prevention

A free online training from the New York State Office of Mental Health and Columbia University that describes the Safety Planning Intervention and how it can help individuals, explains when to work with individuals to create a safety plan, and describes the steps in creating a safety plan.

State Suicide Prevention Coordinators

http://www.sprc.org/states

Contact your state suicide prevention coordinator to determine whether there are additional suicide prevention posters and other materials available in your state.

Suicide Safe

https://store.samhsa.gov/apps/suicidesafe/index.html

A free suicide prevention app developed by SAMHSA for mobile devices and optimized for tablets that helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients. It was based on the SAFE-T card. It is available for iOS® and Android™ devices.

Talking with Your Adult Patients About Alcohol, Drug, and/or Mental Health Problems: A Discussion Guide for Primary Health Care Providers

http://store.samhsa.gov/shin/content//SMA15-4584/SMA15-4584.pdf

An online guide to equip primary health care providers with questions to begin discussions with their patients about alcohol, illicit drug, and mental health problems, as well as co-occurring disorders. This brief guide also includes resources for patients who need an evaluation based on positive screening results.

Telebehavioral Health Training and Technical Assistance

http://www.integration.samhsa.gov/operations-administration/telebehavioral-health

The Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions Telebehavioral Health Training and Technical Assistance Series helps safety net providers and rural health clinics understand and adopt telebehavioral health services. It is divided into six sessions and provides tools and resources necessary to identify and implement a telebehavioral health program.

2. Resources for Patients, Families, and Community Members

General Resources

American Foundation for Suicide Prevention (AFSP)

http://www.afsp.org

AFSP raises awareness, funds scientific research, provides resources and aid to those affected by suicide, trains clinicians in suicide prevention, and advocates for policy that will save lives. AFSP has local chapters in all 50 states with programs and events nationwide.

Find your Words

https://findyourwords.org/welcome

A public health awareness campaign designed to encourage conversations about mental health and decrease the sigma of mental illness. The website contains spots for TV, theater, digital, and radio featuring lyrics that talk about depression in an honest and inspiring way. The campaign is a joint effort of Kaiser Permanente, the National Alliance on Mental Illness, National Suicide Prevention Lifeline, Crisis Text Line and Mental Health America.

Make it Ok

http://makeitok.org/

A website that aims to help reduce the reduce stigma of mental illness. Contains a variety of information related to mental illnesses, what stigma is, tips for having conversations about mental illness, and a variety of resources and tools, such as posters, flyers, PowerPoints, fact sheets, newsletter templates, and links to the podcast, The Hilarious World of Depression, which uses humor as a way to start a conversation about mental illness.

Man Therapy

https://mantherapy.org/

A web-based campaign designed to show working age men that discussing their problems, seeking help, and fixing themselves is masculine. It is designed to help men cope with issues like depression, anxiety, and suicidal thoughts, with the goal of helping men at risk for suicide get the help they need. Users can interact with fictional "therapist", Dr. Rich Mahogany, who lets men know talking honestly and openly about their problems is how they will start to solve them. Men with high levels of distress and referred to the National Suicide Prevention Lifeline or "the Pros" (a vetted list of professional mental health service providers. The website also has a section, that provides tips for individuals who are worried about the mental health of a man in their life. Practitioners can also request posters and other materials from Man Therapy (http://mantherapy.org/) from the Office of Suicide Prevention (www.coosp.org).

National Alliance on Mental Illness (NAMI)

http://www.nami.org

An association of hundreds of local affiliates, state organizations and volunteers who work to raise awareness about mental illness and provide support and education that was not previously available to those in need. NAMI advocates for public policy, provides education programs, and public awareness events, including Mental Illness Awareness Week and NAMIWalks, and has a toll-free NAMI HelpLine (1-800-950-NAMI [6262] or info@nami.org) that provides information, support, and referrals.

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org

1-800-273-TALK (8255)

1-800-799-4889 (TTY)

The National Suicide Prevention Lifeline offers a free 24-hour hotline available to anyone in suicidal crisis or emotional distress. Calls are routed to the caller's nearest crisis center.

National Suicide Prevention Lifeline Resources
http://www.suicidepreventionlifeline.org/GetInvolved/Promote

The National Suicide Prevention Lifeline offers free resources and online materials. Materials are available in Spanish and English and all materials contain the Lifeline's phone number.

National Behavioral Health Treatment Services Locator
https://findtreatment.samhsa.gov/locator/home

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal government provides a confidential, anonymous online service to locate treatment facilities in the U.S. and U.S. Territories for substance abuse/addiction and/or mental health problems.

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline

1-800-662-HELP (4357)

1-800-487-4889 (TTY)

SAMHSA provides free and confidential treatment and referral information about mental health and/or substance use disorders, prevention, and recovery, in English and Spanish, 24 hours a day, 7 days a week.

Suicide Proof
http://www.suicideproof.org/suicide-proof.html

The Suicide-Proofing Initiative aims to educate parents about simple steps they can take to reduce the risk of suicide in their homes. The Initiative is the result of a partnership between the Rhode Island Department of Health and Brady Center to Prevent Gun Violence and is based in part on research conducted by the Harvard School of Public Health.

Colorado Resources

Colorado Crisis Services
http://coloradocrisisservices.org/

1-844-493-TALK (8255)

Text TALK to 38255

Provides confidential and immediate support, 24/7/365 for people who are in crisis or need help dealing with one. Trained professionals can be reached via the toll-free number or text. The website also has an online chat feature as well as a list and map of 24/7 walk-in crisis services which offer confidential, in-person crisis support, information and referrals.

Colorado Mental Wellness Network
http://www.coloradomentalwellnessnetwork.org/

A state-wide, grassroots, peer-run organization that seeks to provide opportunities for individuals to improve the quality of their lives, give back to their communities, and change public perceptions of mental illness. The Network provides whole-person wellness education to people in recovery, advocates for person-centered care in traditional healthcare settings and trains individuals in recovery to become Peer Support Specialists and wellness planning workshop facilitators.

Colorado Office of Suicide Prevention
www.coosp.org

Pursuant to Colorado Revised Statute Section 25-1.5-101(1)(w)(III)(A), the Office of Suicide Prevention at the Colorado Department of Public Health and Environment is required to report annually on the status of program efforts to coordinate statewide suicide prevention services. It also funds various community suicide prevention efforts and has a variety of resources related to preventing suicide.

Let's Talk CO
http://letstalkco.org/

A state media campaign with the goal of reducing the stigma around mental illness so that people who need treatment are more likely to seek it. Contains a variety of informational materials, tips for having conversations about mental illness, resources, and media tools.

Mental Health Colorado
http://www.mentalhealthcolorado.org/

A nonprofit, nonpartisan organization and an affiliate of Mental Health America that advocates for the prevention, diagnosis, and treatment of mental health and substance use disorders in Colorado.

Mental Health First Aid Colorado
http://www.mhfaco.org/

A state resource for promoting and supporting mental health education and wellness through offering Mental Health First Aid (MHFA), an evidence-based training program that empowers individuals to identify, understand, and respond to others who might experience a mental health or substance abuse crisis. The website lists and allows users to sign up for upcoming MHFA and Youth Mental Health First Aid classes.

National Alliance on Mental Illness-Colorado
http://www.namicolorado.org/

NAMI Colorado is located in Metro Denver and has 15 local affiliate organizations across the state. NAMI's focus is to connect, educate, and support the mental health issues and needs of Coloradans.

Pregnancy-related depression
https://www.colorado.gov/pacific/cdphe/pregnancy-related-depression/

The Colorado Department of Public Health and Environment (CDPHE) provides resources related to pregnancy-related depression including a pregnancy-related depression and anxiety public awareness campaign (https://www.colorado.gov/pacific/cdphe/2016-2017-pregnancy-related-depression-anxiety-public-awareness-campaign), which includes a Community partner Toolkit that provides promotional materials for outreach extension and includes a best practice guide and technical assistance guide.

Speak Now-Colorado
https://www.speaknowcolorado.org/

Speak Now is an effort of the Colorado Department of Human Services, Office of Behavioral Health focused on providing evidence-based information and resources to parents and caregivers regarding youth substance abuse prevention in Colorado. Speak Now addresses the use of alcohol and marijuana, and the misuse of prescription drugs and other drugs among Colorado's youth. It's an educational resource

for parents and caregivers on how to start conversations and keep them going about the risks of alcohol, marijuana, prescription drugs and other drugs among youth.

Population Specific Resources

American Indians and Native Alaskans

American Indian and Alaska Native Suicide Prevention Website

https://www.ihs.gov/suicideprevention/

The Indian Health Services provides information about suicide prevention programs and resources for providers and American Indian and Alaska Native community members.

Gay, Lesbian, Bisexual, Transgender

The Trevor Project

www.thetrevorproject.org

The Trevor Project operates the nation's only 24-hour toll-free suicide prevention helpline for gay, lesbian, transgender and questioning youth (1-866-488-7386).

Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth

http://www.sprc.org/sites/sprc.org/files/library/SPRC_LGBT_Youth.pdf

This publication addresses the special concerns related to suicide prevention among lesbian, gay, bisexual, and transgender (LGBT) youth. It summarizes the current state of knowledge about suicidality in this population, and outlines twenty-one recommendations for helping to reduce suicidal behavior among LGBT youth. Includes a resource appendix and an extensive bibliography.

Veterans

RESPECT-Mil Primary Care Clinician's Manual

http://www.usafp.org/wp-content/uploads/2013/12/PTSD-in-primary-care-RESPECT-mil.pdf

Designed for primary care providers, this manual describes the RESPECT-Mil program for soldiers using a systematic primary care approach to the management of depression and PTSD.

Veterans Administration Suicide Prevention Coordinators

http://www.veteranscrisisline.net/GetHelp/ResourceLocator.aspx

Suicide prevention coordinators are licensed mental health professionals who ensure that veterans at high risk for suicide get the care they need. This website contains information about the VA's suicide prevention coordinators and how to locate the coordinator nearest you.

Veterans Crisis Line/ Military Crisis Line

https://www.veteranscrisisline.net/

1-800-273-TALK (8255), Veterans Press 1

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) founded a national suicide prevention hotline to ensure veterans in emotional crisis have free, 24/7 access to trained counselors. To operate the Veterans Hotline, the VA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and press "1" to be routed to the Veterans Suicide Prevention Hotline. Veterans an also send a text message to 838255 or chat online.

Trainings and Guides

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department

http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in- the-Emergency-Department/SMA08-4357

Brochure intended as a guide for families of suicide attempt survivors on what to expect in the emergency department and after release from the hospital. Includes information on national resources and organizations and contains advice for safety planning, ongoing support and learning about mental illness. (Also available in the Spanish Language Materials category).

After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department

http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355

Brochure intended as a guide for individuals on how to move forward after being treated in an emergency department for attempting suicide. Includes information on national resources and organizations and contains advice for safety planning, ongoing support and learning about mental illness. (Also available in Spanish in the Spanish Language Materials Category).

Applied Suicide Intervention Skills Training (ASIST)

http://www.livingworks.net/programs/asist/

A workshop designed for caregivers of individuals at risk of suicide. Training dates and locations are provided on the website. Also online are a text and audiovisual overview of the workshop, research and evaluations on the program, and suicide awareness facts.

At-a-Glance: Safe Reporting on Suicide

http://www.sprc.org/resources-programs/recommendations-reporting-suicide

The research-based recommendations include suggestions for online media, message boards, bloggers, and "citizen journalists." Released in 2011.

Question, Persuade, Refer (QPR)

http://www.qprinstitute.com/

A gatekeeper training program for suicide prevention based upon three basic steps. The website also includes literature, evidence for QPR, helpful links, and a QPR Gatekeeper Trainer Certification Course to certify individuals to become QPR instructors.

Mindfulness Training

http://www.nowmattersnow.org/skill/mindfulness

A free online training that provides skills and support for coping with suicide. Mindfulness skills taught in the training are part of Dialectical Behavior Therapy (DBT), which research has shown to help individuals who are considering suicide.

SafeTALK

http://www.livingworks.net/programs/safetalk/

SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide.

3. General Information on Suicide Prevention and Related Topics

American Association on Suicidology (AAS)
http://www.suicidology.org

American Foundation for Suicide Prevention (AFSP)
http://www.afsp.org

Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/injury/

Bureau of Health Workforce
https://bhw.hrsa.gov/

National Alliance on Mental Illness (NAMI)
http://www.nami.org

National Rural Health Association (NRHA)
http://www.ruralhealthweb.org

National Institutes of Health (NIH), National Institute on Mental Health (NIMH)
http://www.nimh.nih.gov/

National Rural Recruitment and Retention Network
http://www.3rnet.org

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
http://www.suicidepreventionlifeline.org/

Rural Health Information Hub (RHIH)
https://www.ruralhealthinfo.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

Suicide Prevention Resource Center (SPRC)
http://www.sprc.org

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

- » LEAD
- » TRAIN
- » IDENTIFY
- » ENGAGE
- » TREAT
- » TRANSITION
- » IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

SPRC

National Action Alliance for Suicide Prevention

2.10.15

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.

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