SUICIDE SAFER CARE

A Toolkit for Pediatric Primary Care Providers and School-Based Health Centers

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Suicide prevention has been named a national priority and much work has been done to review existing evidence and identify gaps in how our nation's mental health and healthcare systems address this public health challenge. A national task force that was part of the effort to update the national suicide prevention strategy reviewed research and best practices from the field and concluded that suicide prevention could be improved in primary healthcare. The task force found three common characteristics among successful suicide prevention programs in healthcare settings. Healthcare staff in these organizations:

- Believed that suicide can be prevented in the population they serve through improvements in service access and quality, and through systems of continuous improvement;
- Created a culture that finds suicide unacceptable and sets and monitors ambitious goals to prevent suicide; and
- Employed evidence-based clinical care practice, including standardized risk stratification, evidence-based interventions, and patient engagement approaches.[1]

This Guide Focuses on Four Core Components:

1. Screening and identifying patients of all ages at risk for suicide starting at school age
2. Assessing patients at risk
3. Restricting access to lethal means and safety planning
4. Caring for patients at risk for suicide

The final section contains some additional information on administrative and legal issues providers and leaders may find helpful to support integration of Suicide Safer Care in practice. Many providers and clinical leaders erroneously assume if they discuss suicide with a patient that they open themselves up to liability. Utilizing a patient safety approach, primary care organizations can establish Suicide Safer Care practices that deliver high quality care to patients of all ages and reduce risk to the organization.

In each section of this guide you will find:

- Information summarized for providers, including some helpful provider communication tips.
- A list of recommended trainings and resources to learn more.
- Leadership actions organizations may take to help providers reduce suicide in their organization's patient population, and
- Relevant tools, templates, and case studies.

This toolkit begins with a brief background on the impact of suicide. The toolkit offers practical tools and tips for pediatric primary care providers and school-based health centers to use during a primary care visit.

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[1] Hogan,M.F. ,Goldstein Grumet,J.(2016).Suicide Prevention: An Emerging Priority for Health Care. Health Aff.Jun1;35(6):1084-90.doi: 10.1377/hlthaff.2015.1672.

BACKGROUND: WHY PRIMARY CARE SHOULD MAKE SUICIDE CARE A PRIORITY

Pediatric Suicide - The Problem and the Opportunity

The Rate of Suicide Deaths Is Increasing

Suicide is a leading cause of death in the United States, cited as the cause of death for more than 47,000 Americans in 2019. [2] The total age-adjusted suicide rate in the U.S. increased by 35% from 1999 through 2019. [3] According to the Centers for Disease Control and Prevention, suicide rates increased in all but one state between 1999 and 2016.[4]

Pediatric Suicide

According to the CDC, suicide is the second leading cause of death for children, adolescents, and young adults aged 10-24, only after unintentional injury.[5] In 2019, this accounted for 6,488 total deaths—18 every day—more than 20% of all deaths for youth of those ages.[6] There are a number of unique suicide risk factors among youth and adolescents, including previous suicide attempts, isolation and withdrawal, mental health conditions (i.e. anxiety, depression, conduct disorders, etc.), childhood maltreatment, bullying, mood changes, losses (i.e. breakups, lost friendships, academic failure, etc.), and self-injury. The time between childhood and adulthood is one of major changes in an individual's body, thoughts, and feelings.

The Youth Risk Behavior Surveillance Survey found that 19% of high-school-aged youth seriously considered suicide in 2019, and 9% made one or more attempts within the same time period.[4] Similarly, among 10 to 12-year-olds, 29% of youths presenting to emergency rooms screened positive for suicide risk,[7] and 5 to 11-year-olds accounted for 43% of visits to ERs for suicide attempts or suicidal ideation in youths younger than 18.[8] Rural youth are at particularly high risk of suicide, with suicide rates approximately double those in urban areas.[9] Firearms are the most common means of death for youth aged 15-25, representing almost half of all deaths by suicide in

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[2] CDC. (2019). WISQARS. 10 Leading Causes of Death, U.S. Retrieved from www.cdc.gov/injury/wisqars/LeadingCauses.html.

[3] Hedegaard, H., et al. Suicide mortality in the United States, 1999-2019 (2021). *NCHS Data Brief* 398: February 2021. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db398-H.pdf.

[4] Stone, D. M., et al. (2018). Vital Signs: Trends in State Suicide Rates — United States, 1999-2016 and Circumstances Contributing to Suicide — 27 States, 2015. *CDC Morbidity and Mortality Weekly Report* 2018;67(22):617-624.

[5] Ivey-Stephenson, A. Z., et al. (2020). Suicidal ideation and behaviors among high school students - Youth Risk Behavior Survey, United States, 2019. *CDC Morbidity and Mortality Weekly Report* 2020;69(1): 47-55.

[6] CDC. (2019). WISQARS. 10 Leading Causes of Death, U.S. Retrieved from www.cdc.gov/injury/wisqars/LeadingCauses.html.

[7] Lanzillo, E., et al. (2019). The importance of screening preteens for suicide risk in the emergency department. *Hosp. Pediatr.* 2019;9(4):305-307.

[8] Burstein, B. (2019). Suicidal attempts and ideation among children and adolescents in US emergency departments, 2007-2015. *JAMA Pediatr.* 2019;173(6):598-600.

[9] Fontanella. C. et al. (2015). Widening rural-urban disparities in youth suicides, United States, 1996-2010. *JAMA Pediatr.* 2015;169(5):466-473.

that age category. [3],[4]Death by suffocation, particularly hanging, is also common and is the leading cause of death by suicide in children aged 10-14, representing nearly 60% of all deaths.[10]

In general, youth with frequent and severe suicidal ideation (i.e. high levels of intent and/or planning) have about a 60% chance of making a suicide attempt within 1 year of ideation onset.[11] Furthermore, significant racial disparities exist in youth suicidality: for children younger than 13, for example, suicide rates are approximately twice as high for African American children than white children,[12] and for high-school students, Latinx and African American youths are more likely than white youths to have attempted suicide.[13]

It is also important to consider significant gender disparities in suicide rates:

· **From 1999 through 2018 ,the suicide rate for males was 3.5-4.5 times the rate for females in the U.S., and suicide rates for both males and females increased.[14]**
· **Suicide was the 8th leading cause of death among all males in the U.S. and the 2nd leading cause of death for males aged 10-34 andfemalesaged10-24 in 2019.[15]**
· **Although males are at higher risk for suicide, the suicide rate for females increased 55% from 1999 to 2018,comparedtoa28%increase for males.[16]**

Pediatric Primary Care and School-Based Health Center Teams Are Uniquely Positioned to Identify Risk and Intervene

Primary care providers have a unique opportunity to incorporate suicide prevention into established health risk assessment and patient safety practices.[17] Approximately 45 percent of individuals who died by suicide visited a primary care provider in the month before their death[18],[19]. Many had appointments within 30 days of their death. Suicide is a public health problem, and suicide prevention can be integrated into routine primary care services, along with other preventive screenings and interventions. Suicide can be prevented, and primary care can play a pivotal role. Although primary care clinicians do play a critical role in addressing suicide risk with patients, all members of the care team participate in preventing suicide and providing care to those at risk.

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[10] CDC. (2019). WISQARS. 10 Leading Causes of Death, U.S. Retrieved from www.cdc.gov/injury/wisqars/LeadingCauses.html.

[11] Goldstein, T. (2009). Suicidality in pediatric bipolar disorder. Child and adolescent psychiatric clinics of North America, 18(2), 339 viii. https://doi.org/10.1016/j.chc.2008.11.005

[12] Bridge, J. A., et al. (2018). Age-related racial disparity in suicide rates among US youths from 2001 through 2015. JAMA Pediatr. 2018;172(7):697-699.

[13] Ivey-Stephenson, A. Z., et al. (2020). Suicidal ideation and behaviors among high school students – youth risk behavior survey, United States, 2019. CDC Morbidity & Mortality Weekly Report 2020;69(1): 47-55.

[14] NCHS Vital Statistics System for Numbers of Deaths. Bureau of Census for Population Estimates. Accessed at wisqars-viz.cdc.gov/.

[15] Centers for Disease Control and Prevention. Leading Causes of Death in Males, 2019. Retrieved from https://webappa.cdc.gov/sasweb/ncipc/leadcause.html.

[16] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1

[17] National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc.

[18] Ahemdani, B.K., Simon, G.E., Steward, C., Beck C., Waitzfelder, B.E., Rossom, B....Solberg, L.I. (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, 29(6), 870-877.

[19] Luoma JB, Martin CE, Pearson JL. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002 Jun;159(6).

Providing Suicide Safer Care is now a nationwide effort, involving primary care providers, professional associations, and state government agencies.

> *"For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care; and to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients."*
>
> – Mike Hogan, PhD, Former Commissioner for Mental Health Services, New York State

How Teams Can Take Action

No single strategy or approach will prevent suicide within a primary care organization's patient population. Rather, a comprehensive approach that embeds evidence-based practices during a primary care visit can reduce suicide deaths.

Getting Started with Key Action Steps:

- **Establish protocols for routine suicide screening, assessment, intervention, and referral**
- **Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling**
- **Work with your local healthcare delivery system partners to enhance continuity of care by sharing patient health information with emergency care and behavioral care providers to create seamless care transitions**
- **Provide information on the National Suicide Prevention Lifeline crisis line and services**

COMMON RISK FACTORS & WARNING SIGNS

In addition to integrating routine suicide screening into primary care, it is important for primary care teams to understand the risk factors, warning signs, and the difference between the two. Knowing the risk factors can help primary care teams identify patients that may require further assessment for suicide and responsive care through brief interventions.

Primary care clinicians and leaders must also work to dispel myths that suicide is directly linked to mental illness. Suicide is rarely caused by any single factor, rather determined by multiple factors. Diagnosed depression or other mental health conditions are only one of many risk factors for suicide[20,21] (see a complete list of risk factors at the end of this section). These risk factors are likely common among patients served in primary care practices and integrating routine screening can help identify patients at greater risk. Routine screening is not intended to predict suicide but rather to plan effective suicide care.

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of the most significant concern if the new or changed behavior is related to a painful event, loss, or change.

If a person talks about:
- Feeling hopeless
- Feeling trapped
- Having no reason to live
- Being a burden to others
- Experiencing unbearable pain
- Suicide

If any of the following behaviors/conditions are present:
- Increased use of alcohol or drugs
- Looking for a way to end their lives, such as searching online for methods
- Isolating from family and friends
- Visiting or calling people to say goodbye
- Aggression
- Displaying severe/overwhelming emotional pain or distress.
- Withdrawing from activities
- Sleeping too much or too little
- Giving away prized possessions
- Fatigue
- Family history of suicide
- Local suicide epidemic
- Previous suicide attempts

If a patient describes or evidences feelings of:
- Depression
- Rage
- Humiliation
- Impulsivity
- Sudden sense of peacefulness
- Loss of interest
- Irritability
- Agitated
- Anxiety
- Despair

Scott M, et al. The Columbia suicide screen: Does screening identify new teens at risk? Presented at the American Academy of Child and Adolescent Psychiatry; October 21, 2004; Washington, D.C. 31. Simon GE, et al: Does response on the PHQ-9 depression questionnaire predict subsequent suicide attempt or suicide death? Psychiatric Services, December 2013;64(12):1195-1201.

[20] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates United States,1999–2016 and Circumstances Contributing to Suicide —27States,2015.MMWRMorbMortalWklyRep2018;67:617–624.DOI:http://dx.doi.org/10.15585/mmwr.mm6722a1

[21] Ibid

Routine Screening and Assessment in Pediatric Settings

Screening for suicide improves patient safety and represents a huge opportunity for primary care providers and care teams to improve patient safety, but there are still many unknowns and the evidence and recommendations continue to evolve.[22]

In 2016 when it issued its Sentinel Event alert, the Joint Commission, an independent agency that accredits and certifies healthcare organizations in the United States, urged that all primary, emergency, and behavioral health clinicians take eight steps to prevent suicide, including steps 1-3 related to screening:[23]

1. **Review each patient's personal and family medical history for suicide risk factors.**
2. **Screen all patients for suicide ideation,[24] using a brief, standardized, evidence-based screening tool.**
3. **Review screening questionnaires before the patient leaves the appointment or is discharged.**

Linking Suicide and Depression Screening Health Settings

Primary care clinicians are making great strides in integrating behavioral health and primary care to better address the needs of patients. In 2016, 60.3 percent of patients over the age of 12 received a routine screening for depression and had a follow-up care plan as appropriate.[25] Primary care clinicians can use these routine screening practices as a foundation and include within these processes a specific focus on suicide screening. Many organizations are just now implementing screening for ages under 12, given the prevalence of suicide.

In a 2011 study of U.S. primary care providers, suicide was discussed in only 11 percent of encounters with patients who had screened positive for suicidal ideation, unbeknownst to their providers.[26] A significant body of research shows that a brief screening tool can identify individuals at risk for suicide more reliably than leaving the identification up to a clinician's personal judgment.[27]

Screening Best Practices
· **Most practices screen yearly—it is best to use PHQ-9 to directly ask about suicide.**
· **Rescreen patients who are pregnant/post-partum.**
· **Screen patients experiencing transitions in care.**
· **Move routine screening for patients with HIV, substance, or alcohol use.**

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[22] In 2014, the U.S. Preventive Services Task Force reviewed current evidence and concluded, "Limited evidence suggests that primary care-feasible screening instruments may be able to identify adults at increased risk of suicide, and psychotherapy targeting suicide prevention can be an effective treatment in adults . Evidence was more limited in older adults and adolescents… research is needed."

[23] https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

[24] Suicidal thoughts , or suicidal ideation, means thinking about or planning suicide.

[25] Health Resources and Services Administration. National Uniform Data System (UDS) reporting. Accessed online: https://bphc.hrsa.gov/uds/datacenter.aspx

[26] Vannoy SD , Robins L S . Suicide-related discussions with depressed primary care patients in the U SA : gender and quality gaps A mixed methods analysis. BM J. 2011;1(2):e000198.

[27] 26. Simon GE , et al: Do PHQ depression questionnaires completed during outpatient visits predict subsequent suicide attempt or suicide death?
Psychiatric Services , December 1, 2013;64(12):1195–1202. 27. Shaffer D , et al. The Columbia Suicide Screen: Validity and reliability of a screen for youth suicide and depression. Journal of the American Academy of Child and Adolescent Psychiatry, 2004;43:71-79.

[28] Cauffman E . A statewide screening of mental health symptoms among juvenile offenders in detention. Journal of the American Academy of Child and Adolescent Psychiatry, 2004;43:430-439. 29. Joiner T E Jr, et al. A brief screening tool for suicidal symptoms in adolescents and young adults in general health settings: Reliability and validity data from the Australian National General Practice Youth Suicide Prevention Project. Behaviour Research and Therapy, 2002;40:471-481. 30.

Review of Screening Protocols and Tools

The Suicide Prevention Resource Center and the Joint Commission have studied best practices in screening for suicide and make the following recommendations.

1. Screen all patientsages18andupusingabasicPatient Health Questionnaire (PHQ-9).

Many primary care settings rely on the PHQ-9[28] for screening all patients over age 12 for depression. This screening tool includes item 9, which asks specifically about suicidal thoughts, "Over the past two weeks, have you been bothered by... thoughts that you would be better off dead or of hurting yourself in some way?" The PHQ-A is a modified version of the PHQ-9 utilized for adolescents.

2. ThePHQ-9ModifiedforAdolescents(PHQ-A)

The PHQ-A is a depression screening tool for children and adolescents aged 11 to 17. The 2019 US Preventive Services Task Force (USPSTF) Recommendation Statement *Depression in Children and Adolescents: Screening Guidelines* recommends depression screening of teens 12 to 18 years. The AAP *Guidelines for Adolescent Depression in Primary Care* recommend annual universal screening of adolescents 12 and over at health maintenance visits and at more frequent screening intervals.[29] Given its frequent use in primary care, utilization of the PHQ-A is widely accepted and endorsed as one of several tools that can be used for identifying depression and may identify thoughts of self-harm via item #9. PCPs must be prepared to assess for suicide risk if the answer to question # 9 is positive.

3. If the PHQ-2isusedfor routine screening,consider adding in question 9.

The PHQ-2screens for depression but does not ask specifically about suicide. Some clinicians start with the PHQ-2and move on to the PHQ-9if the patient responds "yes" to questions about depression. One concern about this approach is that a patient could answer"no"to the questions and still be having suicidal thoughts that go undetected. Organizations may consider adding a question specific to suicide to the brief screening tool.

Resources

Establish a policy to screen all patients over the age of 12 using a standardized screening tool.	· Patient Health Questionnaire–9(PHQ-9) · Patient Health Questionnaire – Modified for Adolescents (PHQ-A) · Columbia Suicide Severity Rating Scale (see Appendix)

Screening and Assessment

- ASQ NIMH Toolkit
- PHQ-A
- Columbia Suicide Severity Rating Scale
- Safety Plan Intervention
- Children's Hospital of Philadelphia Risk Assessment and Care Pathway

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[28] Spitzer, R.L.,Williams, J.B.W., Kroenke, K.,et al. (2001)Patient health questionnaire-9(PHQ-9).Retrieved from http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9 English.pdf

[29] Zuckerbrot RA, Cheung A, Jensen PS, Stein REK, Laraque D. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. *Pediatrics*. 2018;141(3).

Patient Health Questionnaire - 9 (PHQ-9)

Over the **last 2 weeks** how often have you been bothered by any of the following problems? (Use a ✔ to Indicate your answer)

	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in someway	0	1	2	3

For office coding _____ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all   **Somewhat difficult**   **Very difficult**   **Extremely difficult**

○   ○   ○   ○

Developed by Dis. Robert L Spitzer, Janet B.W. Williams. Kurt Kroenke and colleagues, with an education grant from Pfizer Inc.
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PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐Yes   ☐No
If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐Not difficult at all   ☐Somewhat difficult   ☐Very difficult   ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
☐Yes   ☐No
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
☐Yes   ☐No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way. please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Office use only: Severity score: _____

Modified with permission from the PHQ (Spitzer. Williams & Kroenke. 1999) by J. Johnson (Johnson. 2002)

Screening Tools for Children Under 12

1) The Ask Suicide-Screening Questions (ASQ) Tool:

- The ASQ is a brief, 4-item suicide risk screening tool which was initially developed in a sample of youth ages 10-21 presenting to the emergency department (ED).[30]
- Screening with the ASQ is recommended for medical patients starting at age 10-24, and behavioral health patients 8 years and over. Younger children can also be screened when there is concern.
- The ASQ contains four yes/no questions and a prompted fifth question that assesses acuity.
- The ASQ has been successfully implemented in busy EDs, inpatient medical/surgical units, and primary care settings across the country.[31]

Interpreting ASQ Screening Results

- If the patient responds "no" to all 4 of the ASQ questions, the <u>screen is a negative</u>.
- If the patient responds "yes" to any of the 4 ASQ questions, or refuses to answer any question, and answers "no" to the 5th acuity questions, the <u>screen is a non-acute positive</u>.
- If the patient responds "yes" to any of the 4 ASQ questions, or refuses to answer any question, and answers "yes" to the 5th acuity questions, the <u>screen is an acute positive</u>.

Advantages to using the ASQ:

- Excellent true positive sensitivity (97%) while minimizing false positives (88%) specificity36
- Can be used in young children
- Brief and easy to administer
- Scripting and management plan provided

Considerations:

- An ASQ toolkit supported by the National Institutes of Mental Health (NIMH) available in the public domain includes flyers to alert parents of standardized screening procedures, scripts for staff and suggested resources for patients at risk. Research supports that most parents/guardians are comfortable with youth being screened independently.[32]
- Many practices already use the PHQ-A for depression screening, which includes item #9, a question on self-harm. Recent data reveals that depression screening alone may be inadequate for identifying all youth at risk for suicide.[33] However, depression screening is also important. Rather than replacing the PHQ-A, adding the ASQ questions at the end of the PHQ-A is an option for more suicide risk specific screening (see appendix).

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[30] Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. *Arch Pediatr Adolesc Med*. 2012;166(12):1170-1176.

[31] Horowitz LM, Ballard ED, Pao M. Suicide screening in schools, primary care and emergency departments. Current opinion in pediatrics. 2009;21(5):620-627.

[32] Horowitz LM, Snyder D, Ludi E, et al. Ask suicide-screening questions to everyone in medical settings: the as Q'em Quality Improvement Project. Psychosomatics. 2013;54(3):239-247.

[33] Brahmbhatt K, Kurtz BP, Afzal KI, et al. Suicide Risk Screening in Pediatric Hospitals: Clinical Pathways to Address a Global Health Crisis. Psychosomatics. 2019;60(1):1-9.

Ask-Suicide Screening Questions (ASQ)

asQ
Ask Suicide-Screening Questions

Suicide Risk **Screening Tool**

Ask the patient:

1. In the past few weeks, have you wished you were dead? ○ Yes ○ No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ○ Yes ○ No

3. In the past week, have you been having thoughts about killing yourself? ○ Yes ○ No

4. Have you ever tried to kill yourself? ○ Yes ○ No

If yes, how? _____

_____

_____

When? _____

_____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ○ Yes ○ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary ('Note: Clinical judgment can always override a negative screen).

- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question# 5; to assess acuity:**
  - ☐ "Yes" to question #5 = acute positive screen (Imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question#5; = non-acute positive screen (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454

- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit **NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)** NIH 6/13/2017

Script for nursing staff

Ask Suicide-Screening Questions

Say to parent/guardian:

"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:

"Now I'm going to ask you a few more questions." Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:

"I'm so glad you spoke up about this. I'm going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you."

If patient screens positive, say to parent/guardian:

"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child."

Script for nursing staff

Ask Suicide-Screening Questions

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

asQ Suicide Risk Screening Toolkit   **NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)**   NIH 6/13/2017

Help from Your EHR

One tool that for each of the steps described above can help clinicians and staff to adhere to the protocol and elevate the standard of care for patients at risk of suicide.

- EHR systems that have built in templates may allow entry of the patient's overall score. Some systems allow entry of the patient's answer to question 9 on the PHQ-9. Entry of a "yes" answer then prompts an assessment protocol. Suicide risk should be put on the problem list.

- Some EHR systems can be configured to record safety and contingency plans, a list of referrals made and why, and a plan for follow-up with the patient and other care givers. If your EHR doesn't have a place for safety plans, consider scanning them into the patient record.

- An alert should be added on the record of patients who are being monitored and treated for suicide risk so that each time a patient is seen EHR alerts or banner scan serve as a reminder that the patient's suicide status must be addressed.

Add Suicide to Your EHR Problem List:

Suicide, suicidal (attempted) (by) X83.8
   blunt object X79
   burning, burns X76
       fluid NEC X77.2
       specified NEC X77.8
       cold, extreme X83.2
   collision of motor vehicle w/
       motor vehicle X82.0
       specified NEC X82.8
       train X82.1
       tree X82.2

Instrument X78.9
       Knife X78.1
       Specified NEC X78.8
Drowning (in) X71.9
       Bathtub X71.0
electrocution X83.1
explosive X75 (s) (material)
       fire, flames X76
       firearm X74.9
           handgun X72
           hunting rifle X73.1
           specific NEC X73.8
           shotgun X73.0

hanging X83.8
jumping before moving object X81.8
   motor vehicle X81.0
       subway train X81.1
       train X81.1
from high place X80 lying before moving object, train, vehicle X81.8

Suicide Risk Assessment

Once screening shows some risk for suicide, additional instruments can then be deployed to get more detail and a better assessment of risk.

If the patient answers yes to any of these questions in the PHQ-9 (item 9 and or additional questions on the ASQ) or the provider has other reasons to suspect suicide may be a concern, a complete assessment of thinking, behavior, and risk should be done immediately. There are a few tools available to further assess suicide risk. The Columbia-Suicide Severity Rating Scale (C-SSRS) is one example of an assessment tool primary care practices could use for this purpose. The C-SSRS guides the provider through a series of questions, including whether the patient has been thinking about a method, whether there is some intent behind their thoughts of suicide, whether they have a plan, and any suicidal behavior.

Provider Communication Tip

- Be sure to orient your patients before moving into the C-SSRS.
- Ask matter of fact questions.
- Orient ahead of time that you are going to follow up on these questions but you have to ask the most important questions first.
- Sample introduction to the assessment: "At our organization we feel that it is really important we ask you about suicide. As a provider, I know that suicidal thoughts are not unusual, and at the same time they are a good measure of how much people are suffering"
- Review the PHQ-9 responses, reviewing each one working to question 9

"I see that you are having trouble sleeping, and you report that most days. I also see you are having trouble concentrating some days. These are likely related. I also see you are having thoughts of being better off dead, some days. Thank you for sharing you are thinking about suicide. Your life matters to me, and I would like to ask you a few more questions about suicide."

Caring and Clear Provider–Patient Communication

During a primary care visit focused on suicide risk assessment, providers can offer some information and resources to help patients cope with their suicidal thoughts. Providers and care team members can use effective communication approaches to increase the likelihood that the patient will recall and use the information presented in the encounter.

PROVIDER COMMUNICATION TIP: BRIEF INTERVENTIONS

- **Thank you for sharing your suicidal thoughts.**
- **I won't be asking for the detail snow, but they are important.**
- **Suicidal thoughts are not unusual,but they area good indication of how bad things are.**
- **It is hard to think clearly when our brains are so overwhelmed with emotions – and others don't understand this.**
- **Some people in despair imagine suicide because their brain wants away out of the intense pain.**
- **It would really help me out if you removed the gun from your home,at least temporarily.**
- **What you do with the suicidal thought makes all the difference: Acknowledge them but direct your attention away from them by focusing your attention on something else.**

Columbia-Suicide Severity Rating Scale: Primary Care Screen with Triage Points

Ask questions that are in bold.

Ask Questions 1 and 2	YES	NO
1. Have you wished you were dead or wished you could go to sleep and not wake up? **2. Have you had any actual thoughts of killing yourself?**		
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had some intention of acting on them? *As opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Response Protocol to C-SSRS Screening

☐ Item 1 and Item 2:Lethal Means Restriction & Safety

☐ Item 3:Behavioral Health Consult(Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

☐ Item 4 and Item 5:Patient Safety Precautions

☐ Item 6:Behavioral Health Consult(Psychiatric Nurse/Social Worker) and consider Patient Safety Precaution

☐ Item 6:3 months ago or less:Behavioral Health Consultation and Patient Safety Precautions

Columbia Suicide Severity Rating Scale (C-SSRS) — Pediatric (≤11 years) Quick Screen

Some questions include options for different wording. Ask one question for each, and use the alternate wording to probe further if appropriate.

Suicidal Ideation			
Questions	**Past month**		**What a positive response indicates**
Ask questions 1 and 2.			
1. *Have you thought about being dead or what it would be like to be dead?* *Have you wished you were dead or wished you could go to sleep and never wake up?* *Do you ever wish you weren't alive anymore?*	Yes ☐	No ☐	**Wish to be dead.** Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. Example: *"I've wished I wasn't alive anymore."*
2. *Have you thought about doing something to make yourself not alive anymore?* *Have you had any thoughts about killing yourself?*	Yes ☐	No ☐	**Non-specific active suicidal thoughts.** General non-specific thoughts of wanting to end one's life or commit suicide. Example: *"I've thought about killing myself."*
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3. *Have you thought about how you would do that or how you would make yourself not alive anymore (or kill yourself)?*	Yes ☐	No ☐	**Active suicidal ideation with any methods (not plan) without intent to act.** Person endorses thoughts of suicide and has thought of at least one method. Example: *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."*
4. *When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?* *This is different from having thoughts but knowing you wouldn't do anything about them.*	Yes ☐	No ☐	**Active suicidal ideation with some intent to act.** Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts Example: *"I have had the thoughts, and I have considered acting on them."* Not: *"I have the thoughts but I definitely will not do anything about them."*
5. *Have you ever decided how or when you would make yourself not alive anymore (or kill yourself)?* *Have you ever planned out how you would do it?* *What was your plan?* *When you made this plan (or worked out these details), was any of part you thinking about doing it?*	Yes ☐	No ☐	**Active suicidal ideation with specific plan.** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: *"Next Thursday when my parents are sleeping, I am going to take the sleeping pills in the upstairs medicine cabinet."*
Suicidal Behavior			
6. *Did you ever do anything to try to make yourself not alive anymore (or kill yourself)?* *Did you ever hurt yourself on purpose?*	Yes ☐	No ☐	**Actual attempt.** A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt.
In the past 3 months?	Yes ☐	No ☐	**Aborted or self-interrupted attempt.** When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior.
In the past 4 weeks?	Yes ☐	No ☐	**Interrupted attempt.** When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. (If not for that, an actual attempt would have occurred.)
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.			**Preparatory acts or behavior.** Acts or preparation toward imminently making a suicide attempt.

Clinician Signature: _____ **Date:** _____ **Time:** _____

Advantages to Using the C-SSRS

- Well scripted for use by non-mental health professionals
- [Online training available](#)
- Includes triage guidelines
- Can double as both a screening tool and a risk assessment tool

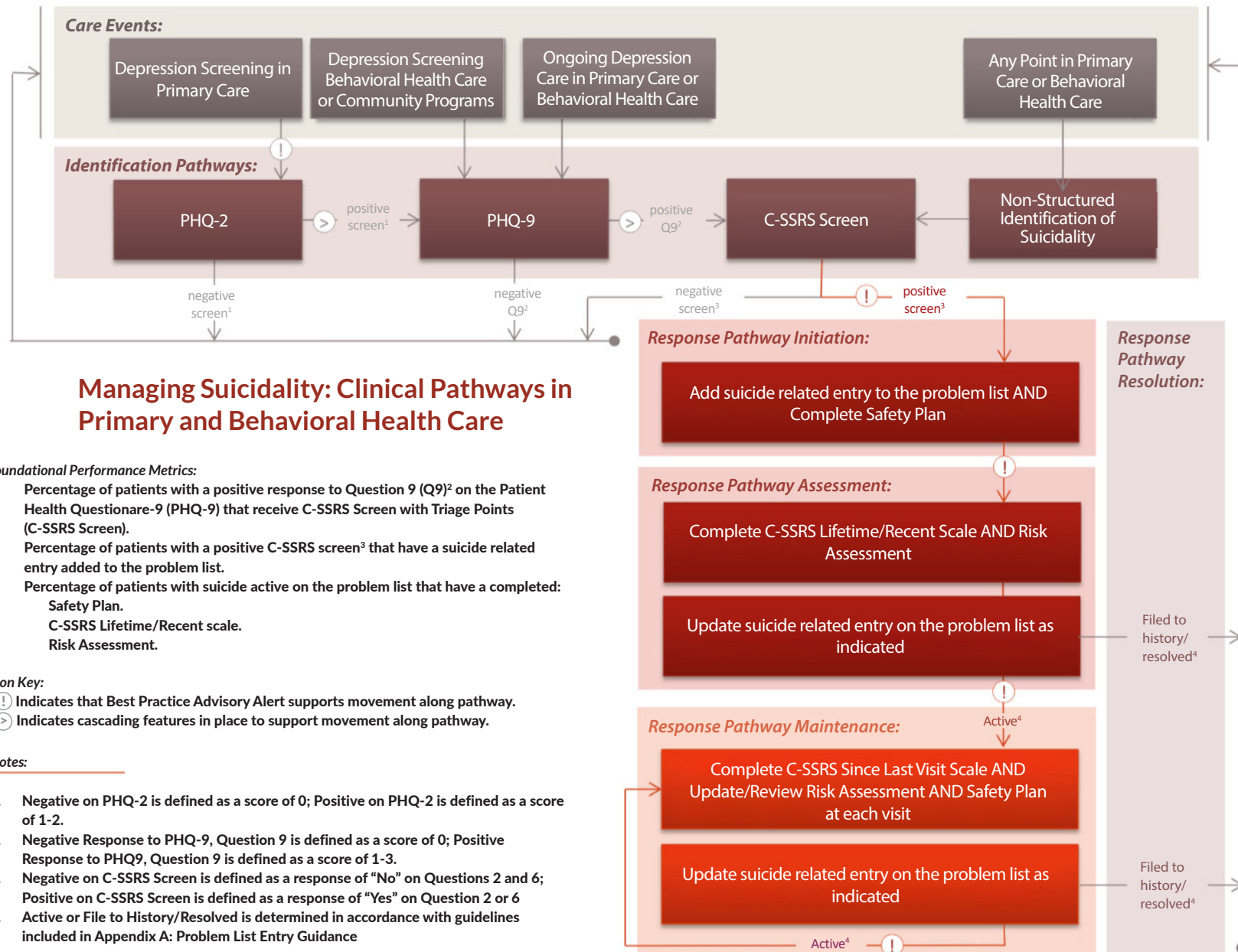## Resources: Routine Screening and Assessment in Primary Care

Action Steps	Trainings and Resources
Training for Nonclinical Team Members	• SafeTALK curriculum • Mental Health First Aid
Regulatory	• Joint Commission Alert with Eight Steps on How to Prevent Suicide: Mental Health First Aid

Every patient who is identified as being at risk for suicide must be closely followed through a Suicide Care Management Plan. It is essential to continuously assess risk, engage patients in their treatment and safety plan, and re-engage patients at every encounter, no matter the reason for the visit. These steps cannot just fall on one provider—they are the responsibility of a whole care team and organization committed to reducing suicide.

The Suicide Care Management Plan includes a package of evidence-based protocols and interventions to mitigate the risk of suicide. Key components include:

- **The screening tool and criteria to indicate that the patient should be engaged in Suicide Safer Care**
- **Completion of CSSRS to assess for risk and intent**
- **Requirements and protocols for safety planning, crisis support planning, and, when needed, lethal means reduction(see additional details in the Part Three below)**
- **Frequency of visits for a patient with a Suicide Care Management Plan and actions to be taken when the patient misses appointments or drops out of care**
- **Process for communicating with a patient about diagnosis, treatment expectations, and what it means to have a Suicide Care Management Plan**
- **Requirements for continued contact with and support for the patient, especially during transitions in care**
- **Referral process to suicide-specific, evidence-based treatment**
- **How documentation of progress and symptom reduction will take place**
- **Criteria and protocols for closing out a patient's Suicide Care Management Plan**

Example Suicide Safer Care Pathway

Care Events:

| Depression Screening in Primary Care | Depression Screening Behavioral Health Care or Community Programs | Ongoing Depression Care in Primary Care or Behavioral Health Care | Any Point in Primary Care or Behavioral Health Care |

Identification Pathways:

PHQ-2 → positive screen[1] → PHQ-9 → positive Q9[2] → C-SSRS Screen ← Non-Structured Identification of Suicidality

negative screen[1]

negative Q9[2]

negative screen[3]

positive screen[3]

Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Response Pathway Initiation:

Add suicide related entry to the problem list AND Complete Safety Plan

Response Pathway Assessment:

Complete C-SSRS Lifetime/Recent Scale AND Risk Assessment

Update suicide related entry on the problem list as indicated

Response Pathway Maintenance:

Complete C-SSRS Since Last Visit Scale AND Update/Review Risk Assessment AND Safety Plan at each visit

Update suicide related entry on the problem list as indicated

Active[4]

Response Pathway Resolution:

Filed to history/resolved[4]

Filed to history/resolved[4]

Active[4]

Foundational Performance Metrics:

✓ **Percentage of patients with a positive response to Question 9 (Q9)[2] on the Patient Health Questionare-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).**

✓ **Percentage of patients with a positive C-SSRS screen[3] that have a suicide related entry added to the problem list.**

✓ **Percentage of patients with suicide active on the problem list that have a completed:**
   Safety Plan.
   C-SSRS Lifetime/Recent scale.
   Risk Assessment.

Icon Key:
(!) Indicates that Best Practice Advisory Alert supports movement along pathway.
(>) Indicates cascading features in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of "No" on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of "Yes" on Question 2 or 6
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance

BRIEF EVIDENCE-BASED INTERVENTIONS

Ages 12 and Up

Primary care providers can help support patients at risk for suicide using brief interventions. These can be utilized during the period between assessment and referral to follow-up behavioral healthcare. These brief interventions may also assist care teams to begin offering Suicide Safer Care in areas where access to behavioral health care is limited. Brief interventions include:

1. **Creating a safety plan with the patient**
2. **Reducing access to lethal means**
3. **Using clear and caring provider-patient communications**
4. **Implementing Caring Contacts**

Treating suicidal ideation specifically and directly, independent of any diagnosed mental health or substance abuse problem, in the least restrictive setting demonstrates promising results in reducing suicide attempts.[34] Primary care clinicians and care team members can use these brief interventions as part of a care management plan.

1. Make a Safety Plan

Complete a safety plan:

- Engage Patients at Risk for Suicide in a Care Plan: Using the Electronic Health Record

Train staff and providers on helping patients at risk to make a Safety Plan:

- Safety Plan Template,
- Brown-Stanley
- Safety Planning Intervention for Suicide Prevention

The Minimum WHAT (to do)

BEFORE THEY LEAVE YOUR OFFICE
- Suicide Prevention Lifeline or Crisis Text Line in their phone
  —1-800-273-8255 and text the word "Hello" to 741741
- Address guns in the home and preferred method of suicide
- Give them a caring message (NowMattersNow.org ⤴ "More")

NowMattersNow.org ©2018 All Rights Reserved

> **"I didn't realize how do-able and important doing safety plans are. Like asthma action plans, they are really helpful resources for patients at risk."**
> — **PCP, Maine**

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[34] Brown G.K., & Jager-Hyman S.(2014).Evidence-based psycho therapies for suicide prevention: Future directions. American Journal of Preventive Medicine,47(3Suppl2),S186–194.Retrievedfrom
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Evidence-Based%20Psychotherapies%20for.pdf

Apart from those needing emergency hospitalization, most patients at risk of suicide will benefit from establishing a Safety Plan with their primary care provider. Establishing a safety plan is an evidence-based best practice.[35]

The Safety Plan should:

- **Be brief, in the patient's own words, and easy to read**
- **Involve family members as full partners in the collaborative process, especially to establish their role in responding to patient crises**
- **Include a plan to restrict access to lethal means, which is also balanced with respect to legal and ethical requirements under federal and state laws**
- **Be updated whenever warranted**
- **Be in the patient's possession when she or he is released from care**

> **TIP**: Program Lifeline into your phone, and have patients program it into their phone during visits.

Provide the local crisis center phone number or the 988 suicide and crisis lifeline (formerly the National Suicide Prevention Lifeline at 1-800-273-8255) number to every patient as part of the safety plan. Patients may call or text 988.

A Suicide Safer Care approach requires primary care organizations to put systems in place to address both identifying patients at risk **AND** providing routine primary care to patients at risk.

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[35]Stanley, B, Brown GK.(2011).*Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice.* 19(2):256-264.

NowMattersNow.org Safety Plan

NowMattersNow.org Emotional Fire Safety Plan

Select those that fit you, cross out those that don't, add your own. Based on research, and advice from those who've been there.
Visit nowmattersnow.org/get-involved for most recent version, last updated 18.09.11 © 2018

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— Shut it down —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— No Important Decisions —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— Make Eye Contact —
A difficult but powerful pain reliever. Look In their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

☐ Visit NowMattersNow.org (guided strategies)	☐ Opposite Action (act exactly opposite to an urge)
☐ Ice-Water and Paced Breathing (exhale longer)	☐ Mindfulness (choose what to pay attention to)
☐ Call/Text Crisis Line or A-Team Member (see below)	☐ Mindfulness of Current Emotion (feel emotions in body)
☐ "It makes sense I'm stressed and/or in pain"	☐ "I can manage this pain for this moment"
☐ "I want to feel better, not suicide or use opioids"	☐ Notice thoughts, but don't get in bed with them
☐ Distraction:	☐

FIRE PREVENTION

Put Crisis Resources in Phone (take photo of this safety plan with phone and practice calling/texting)

☐ Suicide Prevention Lifeline 1-800-273-8255, Press 1 for Veteran and 2 for Spanish	
☐ Crisis Text Line 741741 Help	☐ Trevor Lifeline (LGBT youth) 1-866-488-7386
☐ See nowmattersnow.org/help-line	☐ Trans Lifeline (transgender) 1-877-565 8860
☐ My3 safety plan app	☐ 911, ask for mobile crisis unit
☐ WarmLine.org	☐

Keeping Myself Safe (address if relevant, as best as possible, as part of collaborative conversation)

☐ Guns locked up w/out key or combo (__NA)	☐ Suffocation and overdose thoughts addressed (__NA)
☐ Guns stored separately from ammunition (__NA)	☐ Preferred suicide methods reviewed and addressed
☐ Guns stored outside of home (__NA)	☐ Remove opioids from home (__NA)
☐ A-Team supports these safety steps (__NA)	☐ No one with or using opioids allowed in home
☐ Confirm steps with another person	☐ Remove or store prescription medications safely

The reason(s) I want to live or not use drugs_____

☐ Visible reminder (e.g., note to self or photo of loved one: phone background, gun case, med cabinet, car dashboard, wallet even after suicidal crisis has passed)

The #1 thing leading to suicidal thoughts or urges to use_____

Create an A-Team (people I can talk to about suicide, drug or alcohol or mental health struggles)
Can be healthcare provider, peer support, friend, family member or other

☐ Choose A-Team member(s)_____

☐ Message or call A-Team members, individually or as a group to let them know they are A-Team

☐ Discuss in advance what would be helpful in crisis ("I believe in you", support this plan, just listen, hospitalization or not)

☐ Decide how to ask for help effectively (be willing to take help, try to communicate before a crisis)

Watch Out for These	Things I'd Be Willing to Try
☐ Not sleeping	☐ Regular sleep for a week (8 hours nightly)
☐ Feeling really anxious or irritable	☐ Validate yourself, "my emotions make sense"
☐ Increased alcohol or drug use or relapse	☐ Talk to someone in recovery
☐ Being in frustrating and painful situations	☐ Make plans to get out of these situations
☐ Stop taking medication without support	☐ Go to scheduled appointments or schedule one
☐ Avoiding calls or messages	☐ Message an A-Team member a caring message
☐ Suicidal thoughts or images	

NowMattersNow.org Emotional Fire Safety Plan (Additional Notes)

Select those that fit you, cross out those that don't, add your own. Based on research, and advice from those who've been there.
Visit nowmattersnow.org/get-involved for most recent version, last updated 18.09.11 © 2018

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Direct advice for overwhelming urges to kill self or use opioids

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— Make Eye Contact —
A difficult but powerful pain reliever. Look In their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use

Visit NowMattersNow.org	

FIRE PREVENTION

Put Crisis Resources in Phone

☐ Suicide Prevention Lifeline 1-800-273-8255, Press 1 for veterans and 2 for Spanish	
☐ Crisis Text Line 741741 Help	

The reason(s) I want to live and not use drugs_____

The #1 thing leading to suicidal thoughts or urges to use_____

Keeping Myself Safe

Create an A-Team (healthcare provider, peer support, friend, family member or other)

Possible A-Team members_____

Watch Out for These	Things I'd Be Willing to Try

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 techniques, physical activity): |

1. _____
2. _____
3. _____

| Step 3: | People and social settings that provide distraction: |

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 3. 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 Emergency Contact # _____

2. Clinician Name _____ Phone _____

   Clinician Emergency Contact # _____

3. Local Urgent Care Services _____

   Urgent Care Services Address _____

   Urgent Care Services Phone _____

4. Suicide Prevention Lifetime 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:

Basic Sections Can Include:

- **What are your warning signs?**
- **What are your coping strategies?**
- **People and social settings that provide distraction (remember, are they accessible all times of day and year?)**
- **People I can ask for help and contact info (are they always available?)**
- **Professionals I can contact during a crisis and their contact info**
- **Steps to make my environment safe**
- **Reasons for living**

Reduce Access to Lethal Means

Every safety plan should address specific steps for reducing access to any lethal means that are available to the patient. This may include limiting access to medications and chemicals and removing or locking up firearms. Studies have demonstrated that the overall rate of suicide drops when access to commonly used, highly lethal suicide methods is reduced.[36]

Reducing access to possible methods of suicide may be one of the most challenging tasks a clinician faces with a patient. Zero Suicide recommends all clinical and, in some cases, non-clinical staff take the Counseling on Access to Lethal Means (CALM) online training. This training is offered online free of charge by the Suicide Prevention Resource Center.[37]

Online Training

- CALM – Counseling Access to Lethal Means
- CSSRS

Access to Lethal Means Handouts

- Information for Families
- Guidelines for Clinicians

Action Steps	Trainings and Resources
Develop organizational policies that clearly state what clinicians and care teams can do to counsel patients on lethal means, including the protocol to follow. In the event a patient brings a weapon or other lethal means to the clinical setting.	• Reducing Access to Lethal Means (CALM) • Sample Policies and Procedures for Securing Weapons for Suicidal/Homicidal Clients • Recommendations from the Harvard T. H. Chan School of Public Health, Means Matter Campaign for clinicians regarding guns and medications

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[36] HarvardT.H.ChanSchool of Public Health. (2016). Means Matter. Retrieved from https://www.hsph.harvard.edu/means-matter/

[37] Suicide Prevention Resource Center. Counseling on Access to Lethal M e ans C(ALM). http://training.sprc.org/enrol/index.php?id=3

Medication and drug overdose are the most common means of suicide attempts. Because medications may be needed by the patient or other family members, large quantities should be secured in a locked box such as a steel toolbox with a padlock. Parents should dispense medication prescribed to the patient. Over the counter medications should be secured as well and replaced with small quantities if needed in the home. Special attention should be paid to high-risk medications such as antidepressants, sedatives and opiates. Pharmacists can also dispense smaller quantities of high-risk medications.

Center SPR. 2018. CALM: Counseling on Access to Lethal Means. Educational Development Center. https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means.

A Helpful Resource for Parents, Caregivers, Friends, and Family

SuicideIsDifferent.org provides suicide caregivers
with interactive tools and support to:

| Learn About Suicide | Process Your Feelings | Adapt to Change | Set Safe Boundaries | Talk About Suicide |

"I'm a Suicide caregiver and this is exactly what I didn't know I needed! Thanks For reminding me to take care of myself," - Suicide Is Different User


SUICIDEISDIFFERENT.ORG

It is essential that patients have access to a crisis line, such as 988 (formerly the National Suicide Prevention Lifeline). This should be noted in the Safety Plan as well. Providers and care team members can help make the crisis line readily available to patients.

Provider Communication Tip: Connecting Patients to Crisis Support Services

- Do you have a phone? I'd like you to enter 988 in your phone right now.
- You may never need it, but you want to have it in case someone you care about is suicidal.
- Next, let's open a website called NowMattersNow.org and look at a 40-second video by Marsha on suicidal thoughts. I want you to go to the website after our visit.

Examples of resources that providers can share with patients include NowMattersNow. This website can be given to patients or even pulled up during your primary care visit. The website offers resources and tips for providers.
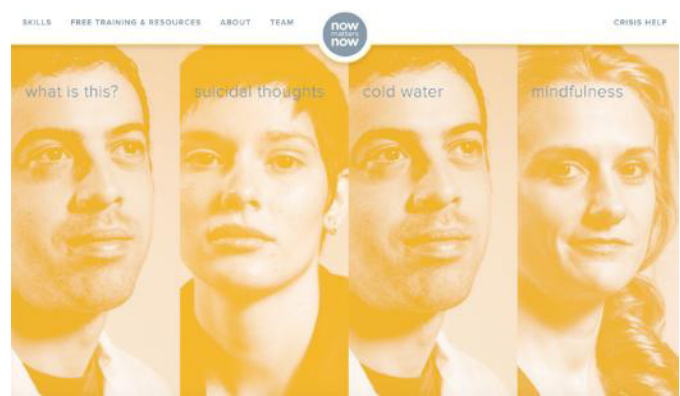

Other Resources to Consider

- **988 Lifeline**
  - **988**
  - **https://988lifeline.org/**
  - **Spanish/Español: https://988lifeline.org/es/inicio/**
- **Crisis Text Line**
  - **Text HOME to 741-741**
- **Suicide Prevention Resource Center**
- **National Institute of Mental Health**
- **Substance Abuse and Mental Health Services Administration**

Follow Up with Caring Contacts

Caring contacts are brief communications with patients during care transitions such as discharge from treatment or when patients miss appointments or drop out of care. Healthcare professionals' contact with patients at risk of suicide have been found effective in suicide prevention.[38,39] Through these contacts care teams continue to show support for a patient, promote a patient's feeling connection to treatment, and increase patient engagement in care. Caring contacts may be especially helpful for patients who have barriers to accessing outpatient care or are less likely to access care.

Examples of caring contacts include:

- Postcards, letters,patient portal emails, and text messages.
- Some EHR systems may have automated patient engagement systems that can be used.
- Phone calls made by care management staff, patient navigators,or peer providers.
- Home visits.
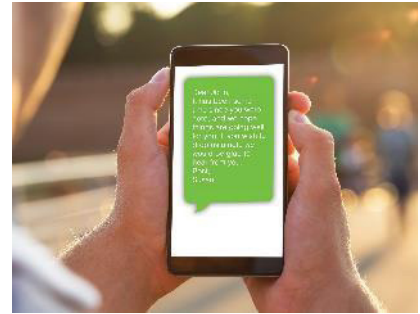
Organizations can explore developing partnerships with local crisis centers that can provide follow-up caring contacts with patients during transitions in care.

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38 Motto J.A., Bostrom A.G. (2001). A randomized controlled trial of post crisis suicide prevention. Psychiatr Serv.52(6):823-33.

39 Berrouiguet S., Gravey M., Le Galudec M., Alavi Z, Walter M.(2014).Post-acute crisis text messaging out reach for suicide prevention: a pilot study. PsychiatryRes.217(3):154-7.

Alternative Levels of Care

The process of making safety plans in collaboration with the patients can help the provider determine what kind of referral may be appropriate. The patient's level of engagement in creating these plans will also be a factor in determining the level of ongoing follow-up the patient will need. While risk stratification for patients at risk for suicide is not yet well developed, new models of care suggest that treatment and care for patients at risk for suicide should be provided in the least restrictive setting.
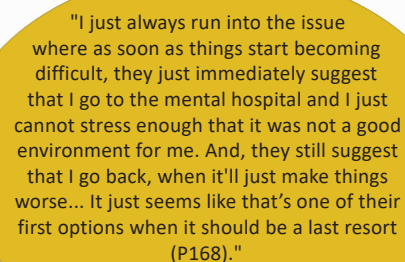
Multi-disciplinary or integrated care teams can deliver care management focused on patient engagement in care plans, care coordination, risk monitoring, and evidence-based clinical interventions to address medical and behavioral health conditions. Increased patient engagement and effective care management supports may help reduce suicide risk. Patients with a moderate-to-high risk score on assessments and who have symptoms of mental illness may require referral to a behavioral health provider for evaluation and treatment. Patients who continue to be an imminent danger to themselves even after intervention efforts may require hospitalization; however, emerging evidence suggests that hospitalization should be avoided if at all possible. An article in the *American Journal of Preventive Medicine* (2014) recommends a "stepped care treatment pathway" for intervention[40].

The Stepped Care Model Includes Six Levels of Care for Suicide Risk:

1. **Crisis center hot line support and follow-up – have the patient put the lifeline number in their phone**
2. **Brief intervention and follow-up (see more detail in Part Three below)**
3. **Suicide-specific out patient care**
4. **Emergency respite care**
5. **Partial hospitalization,with suicide-specific treatment**
6. **Inpatient psychiatric hospitalization, with suicide-specific treatment**

A Reminder About HIPAA

When suicidal ideation (SI) is present, contact family or friends when possible. According to the Joint Commission, "For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others."[41]

"I just always run into the issue where as soon as things start becoming difficult, they just immediately suggest that I go to the mental hospital and I just cannot stress enough that it was not a good environment for me. And, they still suggest that I go back, when it'll just make things worse... It just seems like that's one of their first options when it should be a last resort (P168)."

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[40] Ahmedani, B.K., & Vannoy, S.(2014). National pathways for suicide prevention and health services research. American Journal of Preventive Medicine,47(3 Suppl2),S222–S228.Retrieved from http://actionallianceforsuicideprevention.org.

[41] Sentinel E vent Alert, The Joint Commission, Issue 56, F ebruary 24, 2016

Care Transitions

Effective care coordination and care transition services are an important component of Suicide Safer Care. Care transitions are a time of great vulnerability for individuals at risk for suicide. [42] Caregivers and clinicians must address suicide risk at every visit, including when transitioning a patient within an organization between the primary care provider and behavioral health staff in integrated care settings. Healthcare teams must also support care transitions between care settings such as inpatient, emergency department, or primary care, and behavioral health care. Examples of care transition supports include:

- **For patients who are admitted for inpatient care, make a follow-up appointment for a patient before discharge. Ideallyfollow-upcareshouldbescheduledwithin48hoursof discharge, for both medical and psychiatric admissions.**
- **Involve family, friends, and other loved ones in the plan for care transition.**
- **Make follow-up contacts(e.g., by email,text or phone) with patients after inpatient hospitalizations.**
- **Patients transitioning from incarceration.**
- **Patient sending substance use treatment.**

Organizations can establish policies that provide guidance for successful care transitions and specify the contacts and supports needed throughout the process to manage any care transition.

Providers and care team members should follow organization policies on obtaining patient consent to share patient health information.

Again, a Little Help from the EHR:

The electronic health record (EHR)plays a key role in assuring the following:

- **Patient appointments inside or outside an organization a rerecorded.**
- **No-shows are flagged and actions are taken to locate the person, ensure their safety, and reschedule the appointment or link them to a higher level of care if necessary.**
- **Patient information—especially information about suicide risk and previous care—is transmitted to the receiving provider, including referrals for specialty care such as cardiology.**

Action Steps	Trainings and Resources
Monitor to ensure that care transitions are documented and flagged for action in an electronic health record or a paper record.	• **Structured Follow-up and Monitoring for Suicidal Individuals**

Does your organization use CPT codes 99495/99496 to help track transition of care?

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[42] Bickley,H.,Hunt, I.M., Windfuhr, K., Shaw, J., Apple by,L.,& Kapur, N.(2013).Suicide within two weeks of discharge from psychiatric inpatient care: A case-control study. Psychiatric Services,6 (7),653–659.Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201200026

Recommendation for Monitoring Through the Quality Improvement Program

Incorporating all aspects of Suicide Safer Care into clinical workflow and quality assurance processes will support primary care teams in delivering high quality care. A data-driven quality improvement approach can help to monitor the systems, care strategies, and patient care outcomes.

Primary care leaders can establish processes that work to implement suicide care in practice and evaluates performance towards patient care goals. The team can create a plan to collect and review data regularly. The team can also present feedback to senior leadership and staff on progress of the organization. The Zero Suicide Toolkit offers a Data Elements Worksheet that defines key measures that organizations may want to consider.[43]

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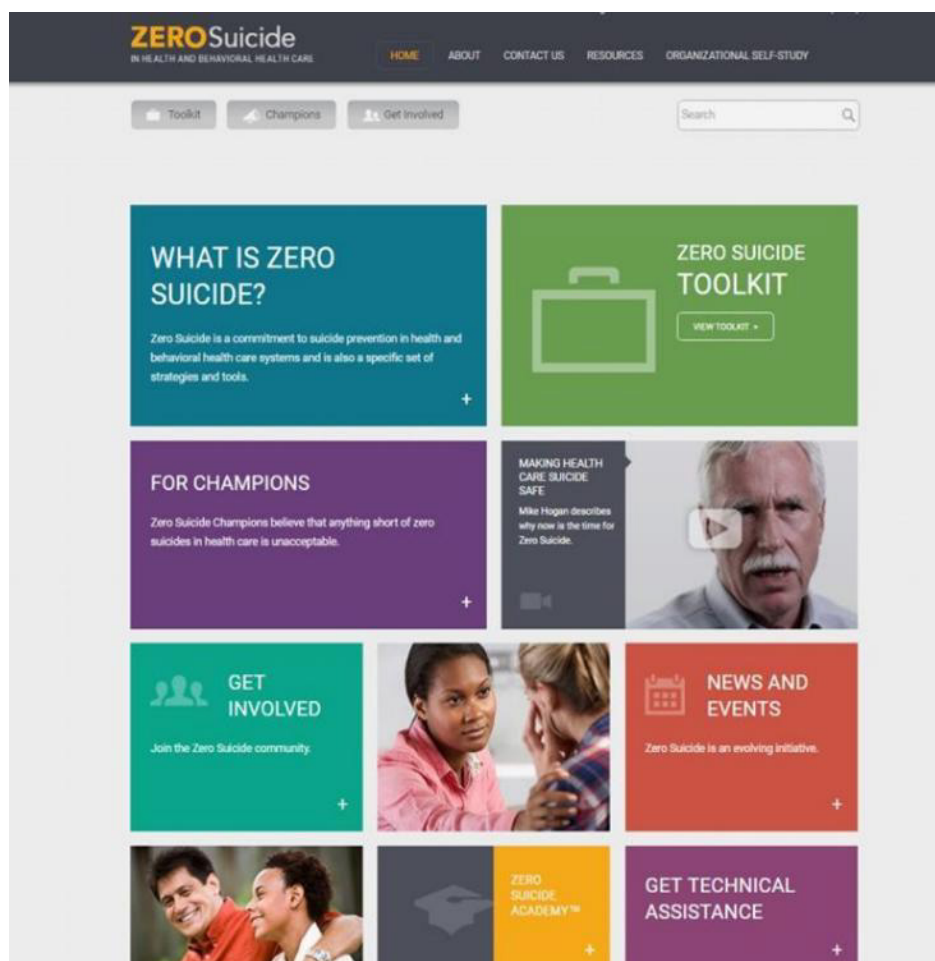
[43] Zero Suicide Toolkit, Zero Suicide Data Elements Worksheet. Retrieved from: http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS%20Data%2Elements%20Worksheet.TS_.pdf.

Don't Let Liability Concerns Deter Your Organization from Addressing Suicide

Primary care organizations and providers implementing suicide prevention practices often have concerns about liability and legal issues. Patients at risk for suicide present a special challenge. Providers want to provide quality care without putting themselves or their practices at risk. By following some basic guidelines, providers can reduce risk in situations where the worst-case scenario happens. Universal screening and adequate documentation are critical.

The following list was developed based on actual court cases [44] and offers strategies for proper documentation:

- **Get a good medical history and document clinical/family history, if relevant, when making notes about concerns about suicide and when formulating a diagnosis.**
- **Be knowledge able on the necessary conditions for involuntary hospitalization. Be aware of the rule of the "least restrictive environment."**
- **Take greater precautions if patient demonstrates an active suicide plan.**
- **Make arrangements for follow-up appointments and care continuity, especially if you plan to be absent.**
- **Use the care management plan to record care team action plan and follow-up.**
- **Inform/involve the family. Be knowledgeable on the standard of care (provide a translator to inform both the patient and the family of important information). Take appropriate action to inform the family of patient's status.**

Proper documentation of all conversations and contact with the patient, as well as reasons for the provider's decisions is key.

Action Steps	Trainings and Resources
Get a brief sense of case law and successful malpractice and negligence cases involving suicide.	• **Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines**
Review best practices in documentation.	• **Legal and Liability Issues in Suicide Care**

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[44] Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines. https://www.researchgate.net/publication/240314951

Resources: Other Considerations

Action Steps	Trainings and Resources
Assess what core elements of Suicide Safer Care your organization has in place.	Zero Suicide Organizational Self-Study
Assess staff skills and training needs related to suicide care on a routine basis.	Zero Suicide Workforce Survey
Establish a suicide care training plan for all staff in the organization.	Suicide Care Training Options

Resources and Tools for Workforce Development

When a primary care organization makes a commitment to preventing suicide through adoption of a comprehensive approach, it is essential that all staff members have the necessary skills to provide high-quality care and feel confident in their ability to deliver effective care to patients with suicide risk. Primary care leaders can assess staff for the beliefs, training and skills needed to care for individuals at risk of suicide. Based on needs identified, a training plan can be established.

There are many training workshops currently available online and through live training offerings. The Zero Suicide Toolkit offers a comprehensive list of Suicide Care Training Options.[45] Primary care organizations can reassess staff training needs throughout the implementation of the suicide care approach.

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[45] Zero Suicide Toolkit, Suicide Care Training Options. Retrieved from: http://zerosuicide.sprc.org/

Example Training Grids

Action Steps	Lenght	Trainings and Resources
Assessment of Suicidal Risk Using C-SSRS	45 min. (online)	https://zerosuicide.edc.org/resources/resource-database/assessment-suicidal-risk-using-columbia-suicide-severity-rating-scale
Safety Planning Intervention for Suicide Prevention	45 min. (online)	https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention
Counseling on Access to Lethal Means (CALM)	2 hrs. (online)	https://zerosuicidetraining.edc.org/enrol/index.php?id=20
Assessing and Managing Suicide Risk (AMSR)	1 day (in-person)	http://zerosuicideinstitute.com/amsr
Structured Follow-up and Monitoring	45 min. (online)	http://zerosuicideinstitute.com
SafeTALK	3 hrs. (in-person)	https://www.livingworks.net/
Suicide Care at the Institute for Family Health	4 hrs (in-person)	https://institute.org/

Job Title	Required Suicide Prevention Trainings
• Associate Director • Associate Director of Psychiatry • Associate Regional Director • Behavioral Health Faculty • Care Management Coordinator • Care Manager • Director Clincial Quality & Compliance • Director Of Technology Implementation • Director Of Psychiatry • Mental Health Clinician • Nurse Care Manager • Program Director • Director Of Family Programs • Psychiatric Provider • Rn Care Coordinator • Social Worker • Substance Abuse Director	• **Assessment of Suicidal Risk Using C-SSRS** • **Safety Planning Intervention for Suicide Prevention** • **Counseling on Access to Lethal Means** • **Assessing and Managing Suicide Risk** • **Structured Follow-up and Monitoring** • **Suicide Care at the Institute for Family Health**
• Care Coordinator • Case Manager • Community Health Worker • Family Assessment Worker • Medical Assistant • Outreach And Assessment Coordinator • Patient Navigator • Retention & Adherence Specialist - Bachelors • Director, Process Improvement & Analytics • Health Education & Access Coordinator • Lead Patient Services Rep • Billing + Referral Coordinator • Mental Health Billing Director • Nutritionist • Outreach Worker • Patient Service Representative • Practice Administrator	• **Safety Planning Intervention for Suicide Prevention** • **Counseling on Access to Lethal Means** • **Structured Follow-up and Monitoring** • **safeTALK**