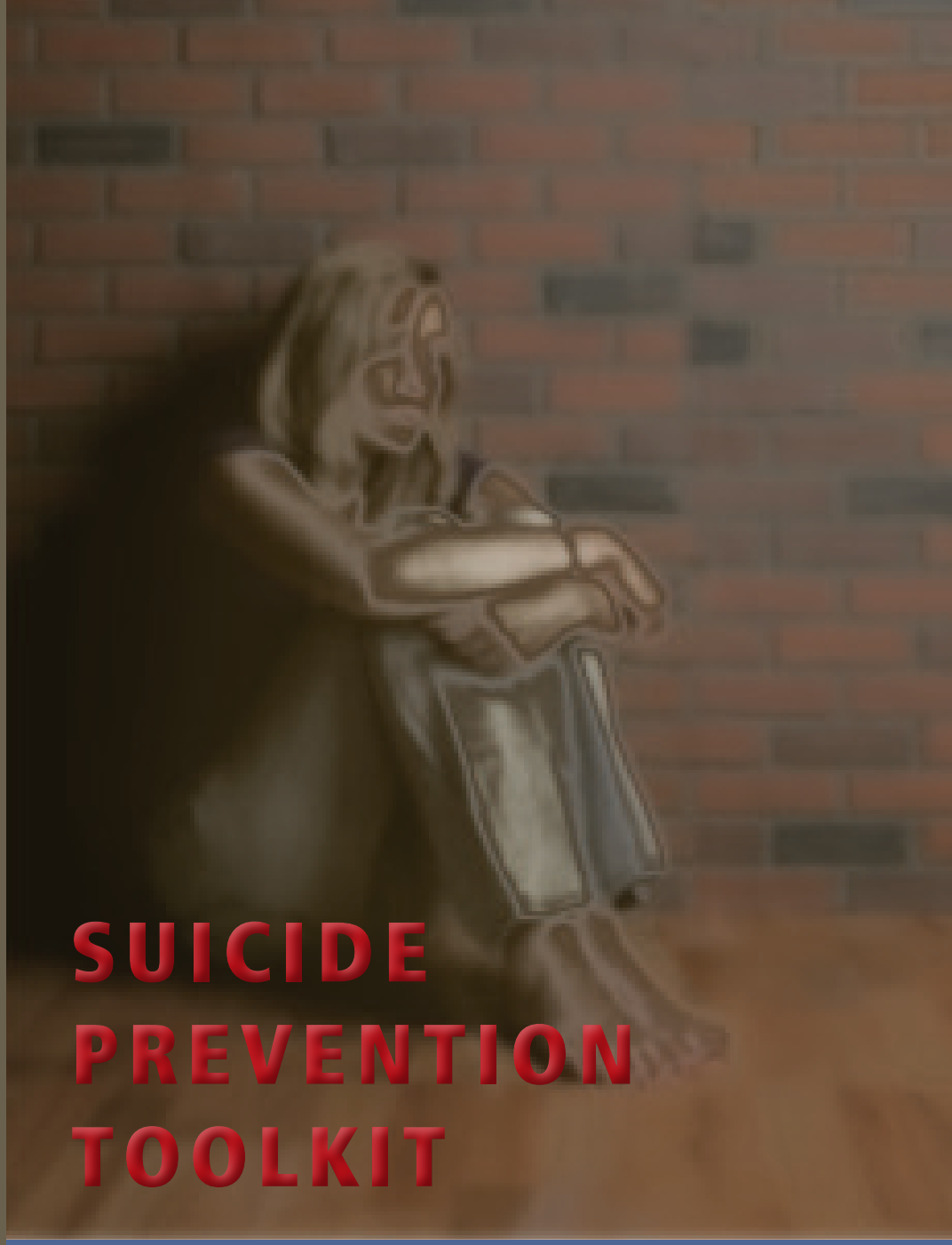
A GUIDE FOR PRIMARY CARE PROVIDERS AND RURAL MEDICAL PRACTICE MANAGERS



SUICIDE PREVENTION TOOLKIT

for

RURAL PRIMARY CARE PRACTICES

SPRC

WICHE Mental Health Program

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Special thanks to the following people for their reviews of drafts of this publication:

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Jean Demmler, PhD
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Suggested citation: Western Interstate Commission for Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) *Suicide Prevention Toolkit for Rural Primary Care. A Primer for Primary Care Providers.* Boulder, Colorado: Western Interstate Commission for Higher Education.

Rev. 2013

The Suicide Prevention Toolkit for Rural Primary Care Practices can be accessed in three different formats described below:

1. 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 http://www.sprc.org/webform/primary-care-toolkit-0. This version is available at no cost.
2. Online version. The online version is available at http://www.sprc.org/webform/primary-care-toolkit and provides brief web content for each section plus individual links to every tool and resource in the toolkit. This version is available at no cost and toolkit material may be printed directly from this website.
3. Hard copy. Hard copies of the toolkit are available for $25 through WICHE mental health program at mentalhealthemail@wiche.edu or by calling 303-541-0311.

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Dear Primary Care Provider:

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, between two and four percent of your patients are having thoughts of suicide. 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.

Start your suicide prevention journey 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 mid-life 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 – the lifeblood of your practice.

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 Setup Guide and get on your way to helping some of your most troubled patients find a pathway to a satisfying life.

Sincerely,

Suicide Prevention Resource Center
Western Interstate Commission for Higher Education – Mental Health Program

Tab 1: Getting Started

In This Section

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, between two and four percent of your patients are having thoughts of suicide. 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.

In This Section

Quick Start Guide

http://www.sprc.org/sites/sprc.org/files/quickstartguide.pdf

Start your suicide prevention journey 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.

Office Protocol Development Guide

http://www.sprc.org/sites/sprc.org/files/OfficeProtocolDevelopmentGuide.pdf

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 Development Guide to establish the roles and responsibilities, as well as the procedures you will follow when your 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.

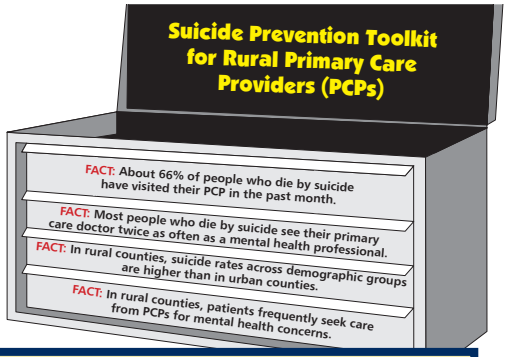
Primary Care Suicide Prevention Model

http://www.sprc.org/sites/sprc.org/files/Intervention_Scheme.pdf

This is a one-page overview of the suicide prevention model promoted by this Toolkit. It summarizes the actions needed in the preparatory phase, lists ongoing prevention activities for the clinic and presents a flow chart of the prescribed intervention for patients at heightened risk for suicide.

QUICK START GUIDE

How to use the Suicide Prevention Toolkit



STEP 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.

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

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

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

STEP 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.

STEP 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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Office Protocol Development Guide for Suicidal Patients

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 "crisis plan" for the office allows providers and office staff to be more prepared when needing to arrange a safe environment for 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. Having a posted office protocol will simplify the process of further assessing and potentially hospitalizing a high risk patient.

Some important questions to answer in developing your office protocol are:

1. **Who will conduct the initial assessment of a potentially suicidal patient (e.g., physician, nurse, mobile crisis team, in-house mental health professional)?**
2. **Who may be called/paged to provide consultation or assist with assessing a potentially suicidal patient (e.g., psychiatrist, mental health professional, telemental health consultation)?**
3. **Where will all necessary forms for hospitalizing suicidal patients be kept (it is assumed that the patient's physician will fill out all necessary paperwork for hospitalization.)**
4. **What emergency department is nearest to your clinic/facility? How do they handle potentially suicidal patients?**
5. **Who will call the ambulance, family member, police, mobile crisis team, or other means of transportation to the emergency department?**
6. **Who will call the emergency department to alert them that the patient is coming via ambulance or other means? What written information can be sent with the patient to give to ED clinicians? It is important that the ED clinicians have access to the information that led the provider to believe the patient may be high risk. Too often, by the time the patient arrives at the ED, they deny everything they said or did that caused concern.**
7. **Who will sit with the patient who is waiting for transport to the emergency department when necessary?**
8. **How will the office initiate follow up contact on a suicidal patient after discharge or in the event that the patient is not hospitalized? Who will initiate the follow-up?**
9. **What procedures will be used to flag the charts of patients at risk of suicide (e.g., a system similar to denoting medication allergies or diabetes)?**
10. **How soon should a patient be seen back in your clinic after being evaluated by the emergency department and/or hospitalized. How frequently should they be seen? For what duration should more intensive contact with the primary care provider occur?**

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 in order 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

the Prevention module of the Primer section of this Toolkit for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies require an investment of time and money, they may save lives.

Consider involving the 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 your state's involuntary treatment laws and post this in the office along with contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). The Lifeline offers free materials, including posters and cards with the Lifeline number.

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.).

✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization ...

✓ Our nearest Emergency Department or psychiatric emergency center is _____ _____. Phone # _____.

✓ _____will call_____to arrange transport.
(Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)

Backup transportation plan: Call_____.

✓ _____will wait with patient for transport.

Documentation and Follow-up ...

_____will call ED to provide patient information.

✓ _____will document incident in_____.
(Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)

✓ Necessary forms/ 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)

Primary Care Suicide Prevention Practice Model

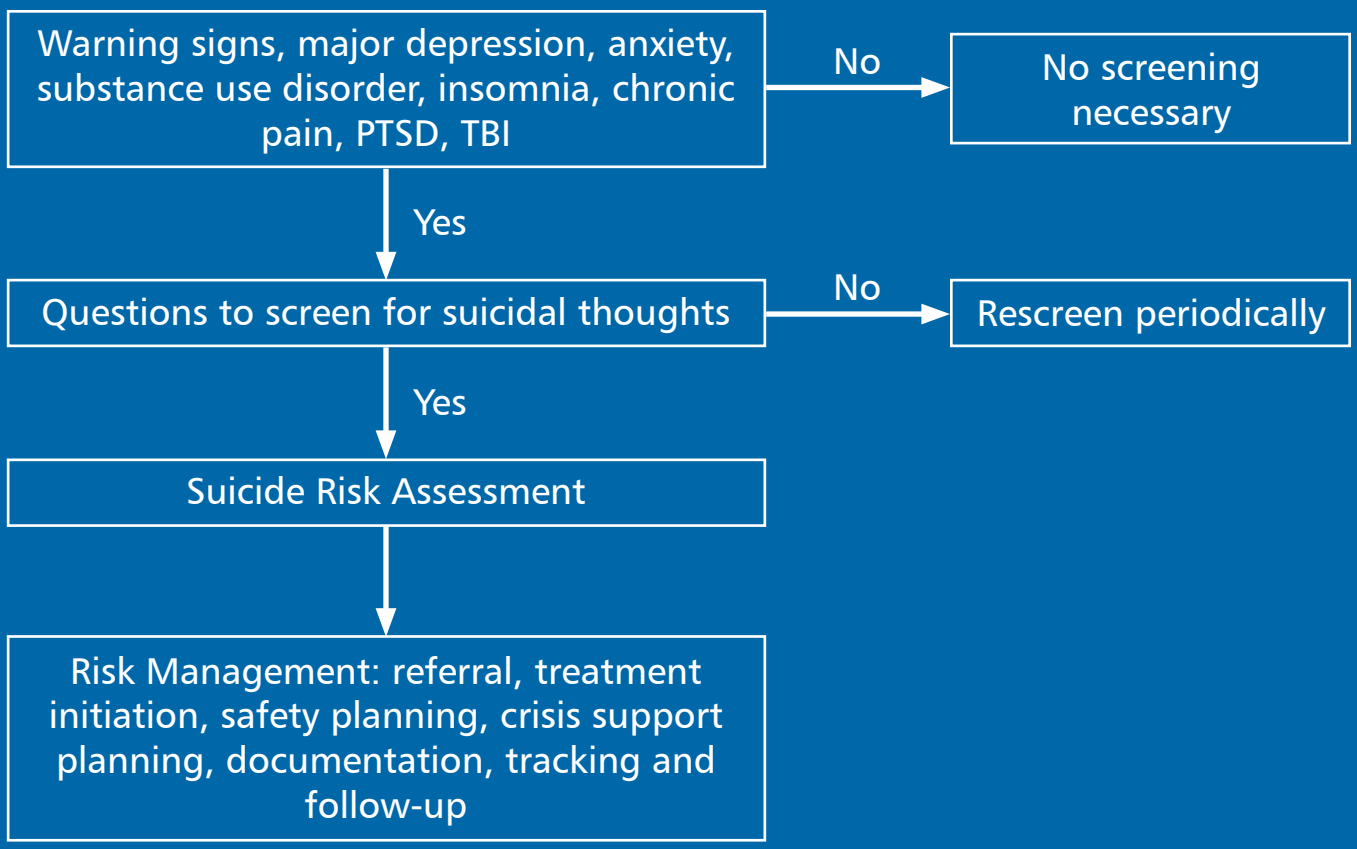
Preparation Phase

1. Develop office policies and protocols
2. Staff education:
   - All staff – warning signs, risk factors, protective factors, response
   - Clinicians – suicide risk assessment, depression screening and tx
3. Strengthen communication with mental health partners

Prevention Practices

1. Staff vigilance for warning signs and key risk factors
2. Depression screening for adults and adolescents
3. Patient education:
   - Safe firearm storage
   - Suicide warning signs and 1-800-273-TALK (8255)

Intervention



Tab 2: Educating Clinicians and Office Staff

In This Section

In This Section

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 maximally benefit the entire patient population. 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.

Module 1 – Prevalence and Comorbidity

This one-page learning module summarizes the magnitude of the suicide problem in the U.S. 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 one-page learning module summarizes the epidemiology of suicide attempts and suicide deaths in various demographic groups.

Module 3 – Prevention Practices

This four-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. This module should be read and discussed by the entire primary care staff.

Module 4 – Suicide Risk Assessment

This five-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 five-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.

SUICIDE PREVENTION PRIMER

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WICHE Mental Health Program

THE WICHE Center for Rural Mental Health Research: supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, *U1CRH03713* Suicide Prevention Resource Center, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant no. IU79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of HRSA or SAMHSA.

List of Modules

Module 1 – Prevalence and Comorbidity

Prevalence of Suicide

More than 38,000 deaths by suicide occur each year in the U.S.[1]

Suicide rates across demographic groups are higher in rural counties than in urban counties.[2]

Suicide is the second leading cause of death in persons 25-34 years old in the U.S.

Suicide is the third leading cause of death in persons 15-24 years old in the U.S.

Suicide is the tenth leading cause of death (all ages) in the U.S.[3]

In Primary Care:[4]

Up to 90% of people who die by suicide had contact with their primary care provider (PCP) in the year prior to their death.

Up to 76% had contact with their PCP in the month prior to their suicide.

These same individuals were more than twice as likely to have seen their PCP than a mental health professional in the year and month prior to their suicide.

Comorbidity

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

More than 90% of people who die by suicide have a mental health disorder or substance abuse disorder, or both. (For youths under 16, that percentage is much lower, but still significant.)

More than 50% of suicides are associated with a major depressive episode.

At least 25% of suicides are associated with a substance abuse disorder, especially with alcohol abuse or dependence.

Ten percent of suicides are associated with a psychotic disorder such as schizophrenia.[5]

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

Module 2 – Epidemiology

High Risk Populations:[6]

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 low-risk demographic group. There are some demographic groups that are at relatively greater risk than others.

Adults

Aging white males have the highest suicide rate of all demographic groups. Though males in all age groups die by suicide four times as frequently as females, females attempt suicide much more frequently.[7] Therefore, it is important to consider both males and females as targets for suicide prevention.

Adolescents[8]

Suicide rates rise rapidly during adolescence; rates are very low before age 14 and approach adult levels by age 19. Adolescents in general have high rates of suicide attempts; most are not fatal, but may be harbingers of future, lethal attempts. **Adolescent males complete suicide at a rate four times that of females; however, females have much higher rates of suicide attempts.** Hispanic females have the highest rates of suicide attempts among all youth. **The use of firearms accounts for approximately 60% of completed suicide among male adolescents.**

American Indians and Alaska Natives

For ages 10-39, Native American and Alaska Natives have the highest suicide rates of all races and ethnicities.[9]

Lesbian, Gay, Bisexual, and Transgendered Individuals

These groups have **disproportionately high rates of suicide attempts**.[10] This is likely due to being victims of discrimination and having increased risk of social isolation and depression. **Whether LGBT youths perceive their parents as being accepting or rejecting appears to play a major role**.[11]

Veterans

U.S. veterans often have multiple risk factors for suicide, including: male gender, elderly, diminished social support, medical and psychiatric conditions associated with suicide, and knowledge of and access to lethal means.[12] **Veterans in the general population are twice as likely to die by suicide as non-veterans**. Veterans who die by suicide are also more likely than non-veterans to own firearms and to use firearms to end their lives.[13]

Three-quarters of U.S. veterans receive their healthcare from primary care providers outside of the VA.[14] Additionally, veterans frequently return to rural home towns far from military or veterans services.

Module 3 – Effective Prevention Strategies

Primary care providers can implement some of the most effective strategies for suicide prevention. These include training staff to identify and respond to warning signs of suicide, training providers to recognize and effectively treat depression, and taking measures to limit access to lethal means.[15] Ideally, a primary care clinic would plan a comprehensive suicide prevention approach 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

- Training staff to recognize and respond to warning signs of suicide
- Universal screening for depression
- Aggressive treatment of depression
- Screening for suicidality in patients with key risk factors
- Educating patients about warning signs for suicide
- Restricting means for lethal self-harm

1. Training Staff to Recognize Warning Signs of Suicide

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

Suicide prevention trainings that teach recognition and response to suicide warning signs can be provided to clinic staff as an in-service. In most areas trainers are available to teach these important skills. Training is also available online. (See the Resource List for some of the national vendors of these programs or www.sprc.org for the suicide prevention coordinator in your state.) After even minimal training, staff can observe 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:[16]

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 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
- 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

2. Screening For and Managing Depression

Training providers to recognize and treat depression increases prescription rates for antidepressants and decreases suicidal ideation and completed suicides in their patients.[17]

A key factor in reducing 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://prevention.mt.gov/suicideprevention/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**.[18,19,20]

3. Screening for Suicide Risk

Screening for suicidal thinking appears to be an effective and efficient means of identifying individuals at risk when conducted on people who have key risk factors. Patients in whom warning signs or other risk factors are detected should be asked about suicidal thoughts as well. In other words, **it is essential to screen for suicidality if there is any suspicion that a patient might be suicidal**. Using screening tools such as the 9-item Depression scale of the Patient Health Questionnaire (the PHQ-9) can be an effective and time-efficient way to screen patients. **The PHQ-9 is a self-report measure, and the final item screens specifically for the presence of suicidal ideation**. 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 PHQ-9 may be downloaded free of charge as part of the MacArthur Initiative Toolkit discussed above.

Key Risk Factors

- Prior suicide attempt
- Major depression
- Substance use disorders

Other Risk Factors

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

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.**

Sample screening question:

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 requires additional assessment (Module 4). More formal suicide screening instruments, such as paper and pencil questionnaires, are also available for use in primary settings or can be devised using the question above or questions in Module 4. These instruments should always be used as an augment to the clinical interview.

4. Educating Patients 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 warning signs, the appropriate response may be to call 911 or go to a hospital emergency department. For other situations it may be appropriate to call the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). Calls to this number are routed to a nearby certified crisis center with trained counselors. Counselors are available 24/7 and provide services in English or Spanish language. Veterans calling the line may press "1" and be directed to a crisis center run by the Department of Veterans Affairs. The service is free anywhere in the United States.

This Toolkit contains wallet cards for consumers 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 through the clinic. For information on ordering the wallet cards for consumers, see the "National Suicide Prevention Lifeline Resources" web address in the Resource List of the Toolkit.

5. Restricting Means of Lethal Self-Harm

Youths have increased rates of suicide and suicide attempts if they live in homes where guns and ammunition are present and available.[21] Furthermore, when primary care providers recommend that parents restrict access of their children to guns and medications in the home, most of them do.[22]

Primary care providers should counsel parents or guardians of children and adolescents to either remove firearms from the home entirely or securely lock guns and ammunition – in separate locations. Anecdotal evidence suggests young people frequently know where guns and keys to gun cabinets are kept, even though parents may think they do not. Resource materials accompanying this Toolkit aid in educating patients and parents.

The same recommendation applies to restricting access to potentially lethal prescription and over the counter (OTC) medications (including containers of more than 25 acetaminophen tablets), and alcohol.

Module 4 – Suicide Risk Assessment

About 3% of adults (and a much higher percentage of youths) are entertaining thoughts of suicide at any given time; however, there is no certain way to predict who will go on to attempt suicide.

Key components of a suicide risk assessment

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

1. Risk Factors

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.[25]

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt.

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.[26]

Individual Risk Factors

- Previous suicide attempt
- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including TBI
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and certain alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD). In youths: ADHD and conduct disorders (antisocial behavior, aggression, impulsivity)
- Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Family history of suicide
- 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 isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Local clusters of suicide that 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)[27]
- Exposure to, including through the media, and influence of others who have died by suicide

2. 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.[28] How you ask the question 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"?

- **Practice questions several times prior to a clinical encounter**; 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.

Sample questions to uncover suicidal thinking:[29]

- 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 Attempt

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.

Sample question to assess prior attempt:

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

▶ If your questioning reveals no evidence of 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 see and what the patient says.

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

Sample 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?
- What did you do when they were the strongest ever?

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.[30] **Ask whether the patient has a plan and, if so, get the specifics**.

Sample 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. 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.[31] Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Sample 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 disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with adolescents, 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**.[32] It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.[33]

3. Protective Factors

While protective factors provide a poor counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment), **protective factors can 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.

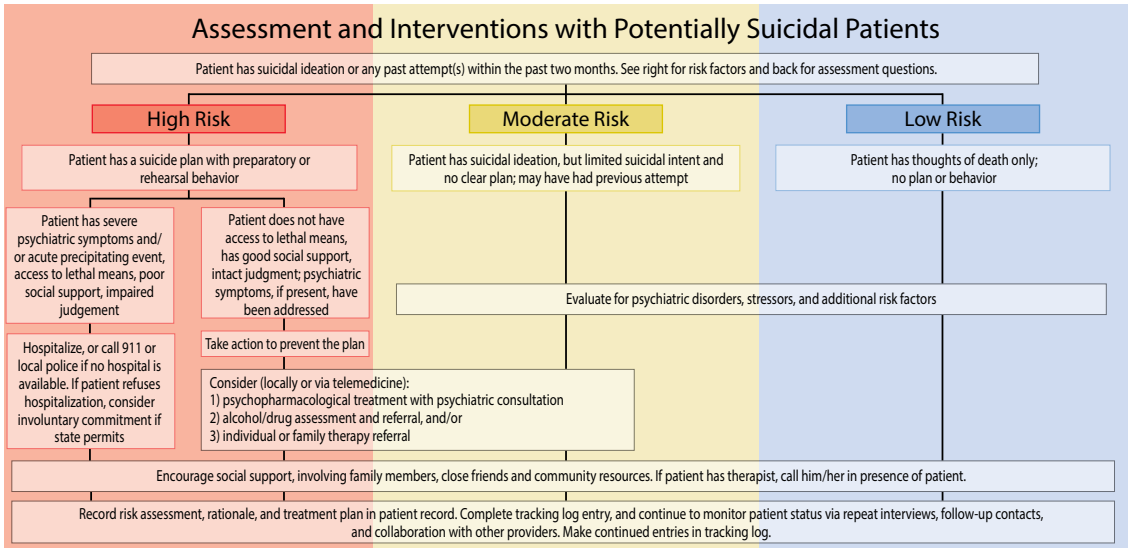
Some important protective factors are:[34]

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness

- Coping skills
- Problem-solving skills
- Strong therapeutic relationship
- Reality testing ability
- Religious faith

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 with thoughts of death or wanting to die, but without suicidal thoughts, intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can accurately predict 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.

1. Referral

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**. (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 **individual or family therapy**. For all patients at increased risk, be sure to provide information about 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. The Lifeline offers free materials, including posters and pocket cards with the Lifeline number (www.suicidepreventionlifeline.org).

For patients in the high risk group who are an imminent danger to themselves, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily. **Locate specific information about your state'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.

Criteria for involuntary commitment for 48-120 hours (depending on the state):

- Imminent danger to self or others
- Grave disability - Inability to provide for his/her own basic needs
- A psychiatric diagnosis (in most states)

Developing an office protocol for hospitalization

- Having an office protocol to follow once you have determined that a patient is high risk for suicide can ease the process of hospitalization. Some important questions to answer in developing your office protocol are:

- What are the laws in your state regarding involuntary psychiatric admission?
- Where will all necessary forms for hospitalizing suicidal patients be kept? (It is assumed that the patient's provider will fill out all necessary papers for hospitalization.)
- What emergency department is nearest to your clinic/facility?
- What transportation options are available for transporting suicidal patients to the nearest emergency department?
- Is there a mental health provider in your area who can assist in an involuntary psychiatric admission? How can you contact him/her?

See the full "Office Protocol" worksheet in this toolkit for more information about developing a protocol for your clinic.

2. PCP Intervention

Primary care providers, especially in rural areas, are invaluable in the treatment 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, strengthening the support network, developing a safety plan, and helping the patient practice coping strategies in the plan.

Depression treatment

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 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 in order to coordinate care and to share information about the patient's mental health status. **Follow-up care** should be documented carefully in order to ensure that the patient continues to receive recommended services.

Studies indicate that a small portion of children, adolescents, and young adults may experience an increase in suicidal thoughts upon introduction of an antidepressant medication (SSRIs); therefore, close monitoring of suicide risk during the first months of antidepressant treatment is essential. The United States Food and Drug Administration (FDA) requires that manufacturers of antidepressant medications include a Black Box Warning on prescription labels warning consumers that the use of antidepressant medications may increase the risk of suicidal thoughts and behaviors in individuals ages 24 years and younger. The FDA's labeling recommends that providers balance these risks against clinical need when considering the use of antidepressants in children.[35] **The general consensus of experts has been that the benefits of prescribing antidepressants to adolescents and young adults for treatment of depression far outweighs the risk of inducing suicidal thoughts**. Studies have found no evidence that antidepressants increase the risk of suicidal thinking in adults over age 24.[36]

Encourage a support network

Helping 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. The support network may include friends, family members, clergy/minister, co-workers, a therapist, primary care doctor, or a suicide prevention hotline. 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.

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: [37]

- Recognizing warning signs that a suicide crisis may be approaching
- Identifying coping strategies that can be used by the patient to soothe the emotions and avert the crisis
- Utilizing friends and family members that can be contacted in order to distract from suicidal thoughts and urges without discussing suicidal thoughts
- Contacting friends and family members who may help to resolve a crisis and with whom suicidal thoughts can be discussed
- Contacting health professionals or agencies, including dialing the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to a local hospital emergency room
- Reducing access to lethal means

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 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.

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, they must be practiced. 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.

The last step in safety planning addresses the issue of access to lethal means. This step is left for last because it is 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 relinquish his or her access to lethal means**. If the patient has described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting) it is essential to inquire about whether those specific means are available and to eliminate access to them. Lethal means may include guns, 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 limiting access.[38]

As the plan is developed write each step on a paper the patient can take home. 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. Patients should also have a supportive friend or family member who is aware that the patient is at risk for suicide and who is willing to help him or her follow the crisis plan. Both the patient and the support person should know the number for the Suicide Prevention Lifeline – 1-800-273-TALK (8255).

A pocket card developed by the Veterans Administration to guide the development of a safety plan is provided with this Toolkit and can be downloaded from the Department of Veterans Affairs at:

http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf

NOTE: No-suicide contracts have been found to be ineffective in preventing suicidal behavior. It is more important 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. Documentation and Follow-up Care

Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist). In the case of hospitalization, it will be necessary to provide this information to the admitting facility. Thorough documentation will help ensure that the patient receives appropriate referrals and follow up.

Close follow up with a potentially suicidal patient is critical. Studies show that even very simple follow-up contacts with suicidal patients reduce their risk of repeat attempts and death. Every

follow up contact is an opportunity to **assess for recurrent or increased suicidality**. Flagging the records of patients at risk for suicide with color coded labels, as is frequently done for allergies or certain chronic diseases, may help insure suicide risk is reassessed on follow up visits.

References

[1] Centers for Disease Control and Prevention. Web-Based Inquiry Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control. http://www.cdc.gov/injury/wisqars/index.html. Accessed August 15, 2008.

[2] Singh GK, Siahpush M. The increasing rural urban gradient in US suicide mortality, 1970-1997 *Am J Public Health*. 2003;93(5):1161-1167.

[3] Centers for Disease Control and Prevention. Web-Based Inquiry Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control. http://www.cdc.gov/injury/wisqars/index.html. Accessed August 15, 2008.

[4] Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159:909-916.

[5] Stovall J, Domino FJ. Approaching the suicidal patient. *Am Fam Physician*. 2003;68(9):1814-1818.

[6] National Institute of Mental Health. High risk populations. National Institute of Mental Health website. http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml. Accessed September 3, 2013.

[7] Centers for Disease Control and Prevention. (2008) Suicide: Facts at a glance. http://www.cdc.gov/ncipc/dvp/Suicide/suicide_data_sheet.pdf. Accessed July 28, 2008.

[8] Centers for Disease Control and Prevention. (2008) Suicide: Facts at a glance. http://www.cdc.gov/ncipc/dvp/Suicide/suicide_data_sheet.pdf. Accessed July 28, 2008.

[9] Centers for Disease Control and Prevention. Web-Based Inquiry Statistics Query and Reporting System (WISQARS) Atlanta, GA: National Center for Injury Prevention and Control. http://www.cdc.gov/injury/wisqars/index.html. Accessed August 15, 2008.

[10] King M, Semlyen J, Tai S, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 2008;8:70.

[11] Ryan, C, Huebner, D, Diaz, RM, Sanchez, J. Family rejection as a predictor of negative health outcomes in white and latino lesbian, gay, and bisexual young adults. *Pediatrics*, 2009;123:346-352.

[12] Congressional Research Service. Suicide Prevention Among Veterans. May 5, 2008. CRS Report for Congress. Washington DC: CRS. http://www.fas.org/sgp/crs/misc/RL34471.pdf. Accessed November 3, 2009.

[13] Kaplan MS, Huguet NH, McFarland BH, Newsom JT. Suicide among male veterans: A prospective population-based study. *J Epidemiol Community Health*. 2007;61:619-624.

[14] Department of Veterans Affairs. 2001 National Survey of Veterans final report. Chapter 6: Health care. http://www.va.gov/VETDATA/docs/SurveysAndStudies/NSV_Final_Report.pdf. Accessed September 3, 2013.

[15] Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: A systematic review. *JAMA*. 2005;294(16):2064-2074.

[16] Suicide Prevention Resource Center. (2007) Best Practices Registry for Suicide Prevention Fact Sheet: Warning Signs for Suicide Prevention. Newton, MA. http://www.sprc.org/bpr/section-II/warning-signs-suicide-prevention. Accessed September 3, 2013.

[17] Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: A systematic review. *JAMA*. 2005;294(16):2064-2074.

[18] Manber R, Kraemer H, Arnow B, et al. Faster remission of chronic depression with combined psychotherapy and medication than with each therapy alone. *J Consulting Clin Psychology*. 2008;76(3):459-467.

[19] March JS, Silva S, Petrycki S, et al. The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. *Arch Gen Psych*. 2007; 64(10):1132-1143.

[20] Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush A J. Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? *J Clin Psychiatry*, 2005; 66:455–468.

[21] Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. *JAMA*. 2005;293(6):707-714.

[22] Kruesi, MJP, Grossman J, Pennington JM, Woodward PJ, Duda D, Hirsch JG. Suicide and violence prevention: Parent education in the emergency department. *J Am Acad Child Adolesc Psychiatry*. 1999;38(3):250-255.

[23] Kessler RC, Berglund P, Borges G Nock M, Wang PS. Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA*. 2005;293(20):2487-2495.

[24] Jacobs, DG, Baldessarini, RJ, Conwell, Y, et al. (2003) Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. American Psychiatric Association. http://psychiatryonline.org/guidelines.aspx. Accessed September 3, 2013.

[25] Mann JJ. A current perspective of suicide and attempted suicide. *Ann Intern Med*. 2002; 136:302-311.

[26] Moscicki, EK. Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*. 1997;20:499-517.

[27] Maris RW, Berman AL, Silverman MM. (2000) Comprehensive Textbook of Suicidology. NY: Guilford Publications.

[28] Suicide Prevention Resource Center. (2008) Is your patient suicidal? Suicide Prevention Resource Center Web site. http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskPosterVert2.pdf. Accessed June 1, 2008.

[29] Stovall J, Domino FJ. Approaching the suicidal patient. *Am Fam Physician*. 2003;68:1814-1818.

[30] Suicide Prevention Resource Center. (2008) Is your patient suicidal? Suicide Prevention Resource Center Web site. http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskPosterVert2.pdf Accessed June 1, 2008.

[31] Screening for Mental Health and Suicide Prevention Resource Center. (2009) Suicide Assessment Five-step Evaluation and Triage (SAFE-T) pocket card. Suicide Prevention Resource Center Web site. http://www.sprc.org/library_resources/items/safe-t-pocket-card. Accessed September 3, 2013.

[32] Gliatto MF, Rai AK. Evaluation and treatment of patients with suicidal ideation. *Am Fam Physician*. 1999; 59: 1500-1506.

[33] Jacobs, DG, Baldessarini, RJ, Conwell, Y, et al. (2003) Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. American Psychiatric Association. http://psychiatryonline.org/guidelines.aspx. Accessed September 3, 2013.

[34] Kavan MJ, Guck TP, Barone EJ. A practical guide to crisis management. *Am Fam Physician*. 2006;74:1159-1164.

[35] United States Food and Drug Administration. (2004) Antidepressant Use in Pediatric Populations. http://www.fda.gov/NewsEvents/Testimony/ucm113265.htm. Accessed November 4, 2009.

[36] Suicide Prevention Resource Center Training Institute. (2008) Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. Newton, MA: Education Development Center, Inc.

[37] Stanley B, Brown G. (2008). Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. Washington DC: Department of Veterans Affairs. http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf. Accessed September 3, 2013.

[38] Gliatto MF, Rai AK. Evaluation and treatment of patients with suicidal ideation. *Am Fam Physician*. 1999; 59: 1500-1506.

[39] Rudd MD, Mandrusiak M, Joiner Jr TE. The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *J Clin Psychol*. 2006;62(2):243-251.

Tab 3: Developing Mental Health Partnerships

In This Section

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 is also 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

http://www.sprc.org/sites/sprc.org/files/MentalHealthOutreachLetter.pdf

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.

SAFE-T Pocket Card

http://store.samhsa.gov/shin/content//SMA09-4432/SMA09-4432.pdf

This pocket card, designed by mental health experts for mental health professionals contains a guide for assessment of and intervention with potentially suicidal patients and may be included with the outreach letter. You can download the card from the URL above; however, if you would like to order additional professionally printed and laminated, pocket-sized copies of the card, they are available by visiting the SAMHSA Publication Ordering website at: http://store.samhsa.gov/product/suicide-assessment-fice-step-evaluation-and-triage-safet-t-/sma09-4432

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 manage 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 (http://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 developed pocket card developed by mental health professionals for mental health professionals 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 would like to 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 Tool Kit.

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

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. The curriculum is a collaboration of the American Association of Suicidology and the Suicide Prevention Resource Center. For information contact amsr@edc.org. (Offered by the National Suicide Prevention Resource Center.) http://www.sprc.org/training-institute/amsr

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 information go to http://www.suicidology.org/training-accreditation/recognizing-responding-suicide-risk or contact Karen at the American Association of Suicidology, kkanefield@suicidology.org. (Offered by American Association of Suicidology.)

QPRT: Suicide Risk Assessment and Management Training. (QPRT stands for Question/Persuade/Refer/Treat.) A 10 - hour course available either on-line 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)

Suicide Care: Aiding life alliances. A one-day seminar that introduces frontline caregivers and professionals to advanced clinical practices beyond suicide first aid care. Available primarily in Canada. For information go to: http://www.livingworks.net/assets/Uploads/Resources/SC-Insert.pdf. (Offered by Living Works.)

Listings on the SPRC Best Practices Registry (BPR). Listings on the SPRC Best Practices Registry (BPR). The BPR lists best practices reviewed according to the following criteria: evidence-based programs, expert and consensus statements, and adherence to standards. To search listed trainings for mental health professionals visit: http://www.sprc.org/search/bpr/?filters=sm_resource_type%3Abpr_listing%20tid%3A33. Scroll to the bottom for list results.

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide 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 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

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline

1.800.273.TALK (8255)

SPRC

www.sprc.org

Screening for Mental Health

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

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

NATIONAL SUICIDE PREVENTION LIFELINE

1.800.273.TALK (8255)

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, 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 disorders 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., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

Tab 4: Patient Management Tools

In This Section

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

http://www.sprc.org/sites/sprc.org/files/PCPocketCard.pdf

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. Additional hard copies are available for $1 each, minimum order of 10, through the WICHE Mental Health Program.

Safety Planning Guide

http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf

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/sites/sprc.org/files/SafetyPlanTemplate.pdf

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

http://www.sprc.org/sites/sprc.org/files/CrisisSupportPlan.pdf

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.

Patient Tracking Log for Patients at Heightened Risk

http://www.sprc.org/sites/sprc.org/files/TrackingLog.pdf

Patients at risk for suicide should be tracked and contacted periodically to monitor their suicide risk. The period immediately following a suicide crisis, especially after an attempt or hospitalization, is marked by extremely high risk for a suicide attempt. Regular, frequent contacts with these patients, even a brief

Screening: uncovering suicidality[2]

- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought [are you thinking] of hurting yourself?
- Have you ever thought [are you thinking] about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

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 long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- 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?
- How confident are you that your 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 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?

Endnotes:

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

[2] Stovall, J., & Domino, F.J. Approaching the suicidal patient. American Family Physician, 68 (2003), 1814-1818.

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

Development of this pocket guide was supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH03713

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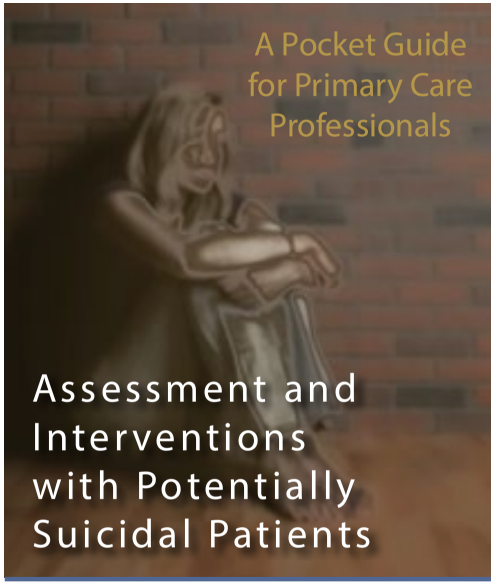

A Pocket Guide for Primary Care Professionals

Assessment and Interventions with Potentially Suicidal Patients

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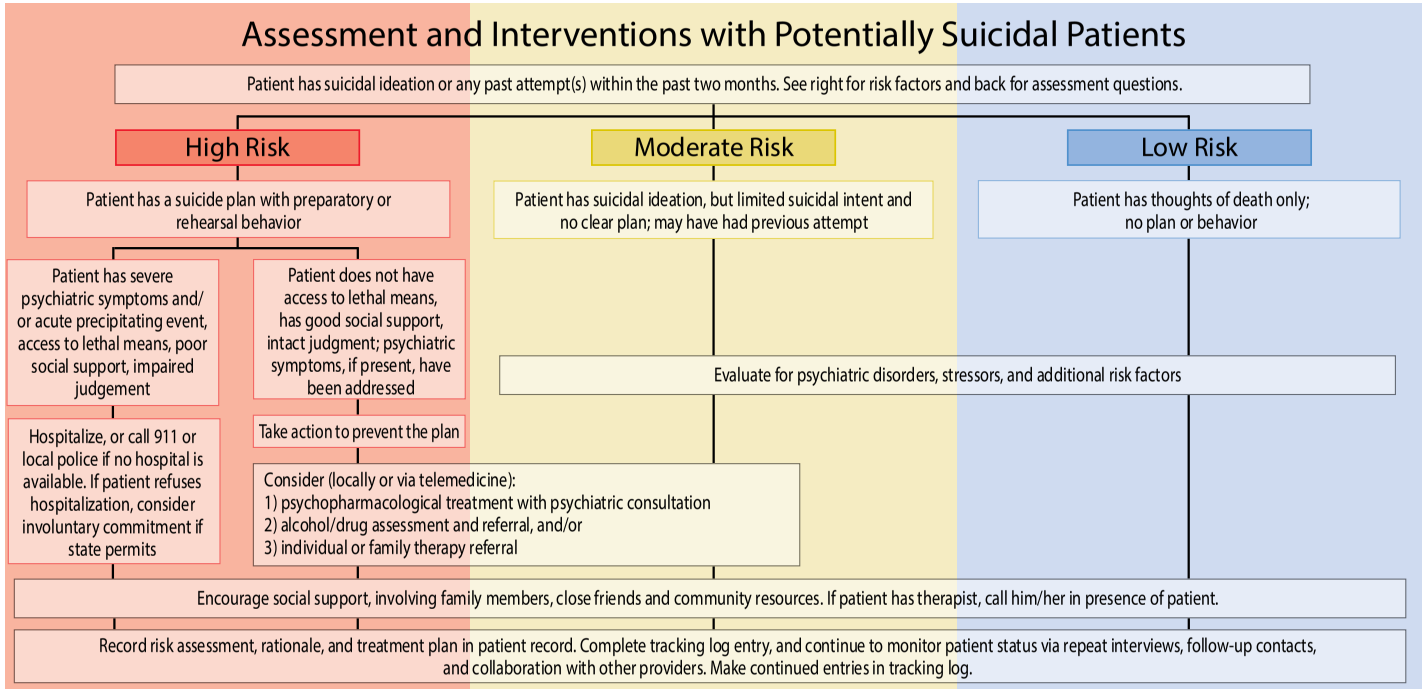

Suicide Risk and Protective Factors[1]

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.

- 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

THE WICHE Center for Rural Mental Health Research is supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH03713

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This Safety Planning Guide was adapted from content developed by Drs. Barbara Stanley and Greg Brown and the Department of Veterans Affairs.

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 suidical 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 acces to vehicle, ropes, flammables, 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: _____

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Suicidality Treatment Tracking Log (for Patient Chart)

Patient Name _____ Medical Record #_____ Primary Care Provider_____

Session Date								
V = Visit P = Phone C = Cancellation NS = No Show	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS
Suicidal thoughts?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Suicidal Behaviors?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Risk: H = High M = Moderate L = Low	H M L	H M L	H M L	H M L	H M L	H M L	H M L	H M L
Medication Prescribed?	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds
Medication Dosage/Start Date								
Medication Adherence	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Medication Side Effects								
Other Interventions								
Mental Health Provider	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____

Suicide Status Tracking discontinued (date _____/_____/_____) because: Suicidality Resolved_____Dropped out _____Other _____

Instructions for Completing the Treatment Tracking Log

The Treatment Tracking Log is designed to parsimoniously display critical information in a sequence of treatment sessions with primary care patients at-risk of suicide. More specific details about the patient and treatment (e.g. medication name and dosage) would be located in a patient's medical chart. This form is used to quickly update the primary care provider of the suicide status of an individual and to easily remind the provider of recent interventions or problems with regard to the patient's treatment.

1. **Session Date**. In this space write the date of the primary care "visit." Each visit contact should include the day, month and year of the visit. It is important to log scheduled appointments which are cancelled or are otherwise not kept. The other information about the patient would likely be unknown to the primary care provider for these sessions, but "missed" appointed sessions might be indicators of needed patient outreach.
2. Circle the letter that identifies the **type of session** interaction with the patient. A telephone conversation with a patient should be included as a treatment "session." It is also important to note if a patient was scheduled for a treatment session and either cancelled the visit or did not come to the appointment.
3. **Suicidal Thoughts?** At each session, the primary care provider should ask the patient if he or she currently has thoughts about dying as a result of one's own actions. The question can be asked in a variety of ways. Record the patient's response as a "Yes" or "No" by circling the appropriate response. Record "Yes" if there is ANY level or indication of suicidal thoughts. Thoughts can include thinking of a plan for suicide. For example, ask, "Are you currently thinking about ending your life?" If the response is positive, probes should be made to learn more. For example, "Have you thought about how you would kill yourself?"
4. **Suicidal Behaviors?** If the patient acknowledges suicidal thoughts, the primary care provider should probe if the patient has acted in any way that is suicidal. The primary care provider can gain this knowledge by asking questions such as "Have you spoken with anyone about your thoughts of killing yourself?" "Have you made an attempt to end our life since our last contact?" "Have you made any preparations toward ending your life?"
5. **Risk.** Circle the patient's level of risk as Low, Moderate or High according to the Assessment and Intervention Tool in this toolkit.
6. **Medication Prescribed.** Circle "Yes" if the primary care or a mental health provider has prescribed medication for a mental health diagnosis.
7. **Medication Dosage/Start Date.** Note the prescribed dosage on the date of the session. If medication is newly prescribed, note the date the medication is initially taken by the patient. If a different or additional medication is prescribed for the mental health condition, note the date the different or additional medication is initially taken by the patient.
8. **Medication Adherence.** To the best of the primary care provider's knowledge, note if the patient is taking the prescribed dosage by circling "Yes" or "No."
9. **Medication Side Effects.** Write in the space provided any complaints or noted problems related to the medication.
10. **Interventions.** In this space, note specific interventions that occurred during the session.
11. **Mental Health Provider?** Circle "Yes" if the primary care provider is aware that the patient is currently a client of a mental health provider. Space is provided to include the mental health provider's name or contact information, if having this information accessible is useful.

Once the primary care provider discontinues tracking the patient regarding suicide status, note the reason why the tracking is closed. This item should include the date of discontinuing the tracking process and should include both positive and negative reasons for discontinuing the process. If a patient drops out of care, any attempt(s) to try to contact or re-engage into care can be noted in one or more session columns. The date of the action should be entered on "Session date." Attempt(s) to contact or re-engage the patient, or inquire of others about the patient can be noted under "Other Interventions."

Tab 5: State Resources, Policy, and Billing

In This Section

State Resources, Policy, and Billing 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 Billing

http://www.sprc.org/sites/sprc.org/files/tipsandstrategiesforbilling.pdf

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.

Template for State Specific Resources and Policy

http://www.sprc.org/sites/sprc.org/files/statetemplate.pdf

This template may be used as 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 Billing for Mental Health Services in a Primary Care Setting

Overview

Billing for mental health services within a primary care setting can be a challenge, due in part to the variability in requirements across private and public insurers.

Mental health services, for which billing may prove a challenge, include:

- Screening and treatment of mental health problems (e.g. depression);
- Coordination and case management;
- Consultation with other providers;
- Use of telemedicine for service provision (important in rural areas);
- Outreach and education;

This module offers you:

- Tips to improve your billing success
- Links to web based information that will help you design a billing strategy

How to bill for Diagnostic and Treatment Services

Diagnosis is billed using the International Classification of Diseases (ICD) coding system. Treatment is billed using either the Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS.) Each is explained below:

MENTAL HEALTH DIAGNOSIS (ICD 9 and ICD 10 Overview)

Diagnoses are reported to both public and private insurance carriers using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) which provides a classification system for diseases and injuries.

The Department of Health and Human Services will replace the ICD-9-CM codes with greatly expanded ICD-10-CM (diagnosis) and ICD-10-PCS (hospital procedure) code sets effective Oct. 1, 2014.

MENTAL HEALTH TREATMENT (CPT and HCPCS Codes)

Mental health treatment services are reported to both public and private insurers using Current Procedural Terminology (CPT) codes or the Healthcare Common Procedure Coding System (HCPCS).

- **CPT Codes:**

  CPT codes were developed and are maintained by the American Medical Association. They are numbers assigned to every service a medical practitioner may provide to a patient including medical, surgical and diagnostic services and are used by insurers to determine the amount of reimbursement that a practitioner will receive.

- HCPCS Codes:

  Medicare and Medicaid use HCPCS codes. HCPCS (often pronounced by its acronym as "hick picks") codes are monitored by the Centers for Medicare and Medicaid Services (CMS).

  - Levels of HCPCS codes:

    There are three levels of HCPCS codes, two of which are relevant to mental health billing. Both Medicaid and Medicare use some of both Level I and Level II (see below) which can be confusing. Medicare more often uses Level 1 codes while Medicaid more often uses Level II codes.

    For Medicare payment, CMS specifies which HCPCS codes will be covered as part of their Medicare benefit design. For Medicaid payment, each State specifies the codes (more often Level II codes) for which they allow reimbursement, based on their State plan. Some Level II codes are for Medicaid only. They include the H and T codes which are for mental health and substance abuse.

    HCPCS Level I codes are numeric and are based on CPT codes.

    HCPCS Level II codes are alphanumeric and primarily include non-physician services such as ambulance services.

Tips for Diagnostic and Evaluation Codes to use in Billing for Mental Health Services:

Tip #1: Diagnosis Codes

Use one of the following ICD-9-CM diagnosis codes, if appropriate:

311	Depressive Disorder, Not Otherwise Specified (NOS)
296.90	Mood Disorder, NOS
300.00	Anxiety Disorder, NOS
296.21	Major depressive disorder, Single episode, Mild
296.22	Major depressive disorder, Single episode, Moderate
296.30	Major depressive disorder, Recurrent
309	Adjustment Disorder with Depressed Mood
300.02	Generalized Anxiety Disorder
293.83	Mood Disorder due to Medical Condition (e.g. Postpartum Depression)
314 or 314.01	Attention Deficit/Hyperactivity Disorder (Inattentive and combined types)

Tip #2: Evaluation and Management (E/M) CPT Codes

- Use E/M CPT codes 99201-99205 or 99215 with a depression claim with any of the ICD-9-CM diagnosis codes in Tip #1.
- Do not use psychiatric or psychotherapy CPT codes (90801-90899) with a depression claim for a primary care setting. These codes tend to be reserved for psychiatric or psychological practitioners only.

Note: According to the *American Medical Association (AMA) Current Procedural Terminology (CPT) 2005 Evaluation and Management Services Guidelines*, when counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter, then time may be considered the controlling factor to qualify for a particular level of E/M service; this may allow the physician to code a higher level of service.

(*Source*: Mid-American Coalition on Health Care, 2004)

CPT and HCPCS Codes for Medicare & Medicaid Payment for Mental Health Services *

Type of Code	Service Codes	Diagnosis Codes	Type of Practitioner Allowed to Bill - Medicare	Type of Practitioner - Medicaid
CPT Psychiatry Codes (Level 1 Current Procedural Terminology, maintained by AMA)	Initial Evaluation: 90801 Psychiatric therapeutic codes: 90802-90899. Use with ICD-9-CM Psychiatry diagnostic codes.	MH diagnosis as Primary. Use psychiatric services codes w/ ICD-9-CM Diagnostic Codes 290-319 to identify mental, psychoneurotic, and personality disorders.	Mental health specialists: physicians and nonphysicians, such as certified clinical social workers (CSWs) licensed by the state and clinical psychologists, licensed by and subject to state criteria, operating within the scope of their practice as defined by the state.	Many states allow payment for these codes; check with individual State Medicaid Program.
CPT Health Behavior Assessment and Intervention (HBAI) Level I CPT	96150-155	Physical Diagnosis from ICD-9-CM as Primary Diagnosis.	Nonphysician mental health practitioners, such as psychologists, licensed by the state and subject to state criteria. CSWs may not use.	Up to the State; many do not yet pay for these newer codes.
CPT Evaluation and Management (E/M) Level I CPT	99201-99215 (Office) 99241-99255 (Consultation)	Physical or Psychiatric Diagnosis from ICD-9-CM as Primary.	Physicians and primary care extenders, such as nurse practitioners, clinical nurse specialists, and physician assistants, licensed by the state.	Many states allow payment for use of E/M service code in primary care, and report use of E/M with ICD-9-CM Psychiatric Diagnosis Codes 290-319; check with individual State Medicaid Program.
Level II HCPCS ("State" Codes, used more often by Medicaid; maintained by CMS)	A-V codes are standardized nationally; G codes include some substance use codes; W-Z codes are state-specific.	Depends on service.	Medicare pays for some Level II codes, including A, G, J codes; Medicare does NOT pay for H (State mental health codes), S, or T codes. H codes are for Medicaid only. As of 2008, two new Medicare alcohol/drug assessment brief intervention "G" codes: G0396 and G0397.	Medicaid State agencies more often allow the Level II codes. The H and T codes are for Medicaid only. Check with individual State Medicaid Program.

Source*: **Reimbursement of Mental Health Services in Primary Care Settings: (Mauch, Danna, PhD; Kautz, Cori, MA and Smith, Shelagh, MPH: US DHHS,: SAMHSA), February 2008

Additional Strategies

BILLING FOR ACTUAL TIME OF SERVICE:

Many physicians spend a significant amount of time engaged in counseling patients or coordinating patient care. The CPT nomenclature for Evaluation and Management (E/M) coding defines counseling as a discussion with the patient and / or family or other caregiver concerning one or more of the following areas: Diagnostic results, impressions, and / or recommended diagnostic studies, Prognosis, Risks and benefits of management (treatment) options, Instructions for management (treatment) and / or follow-up, Importance of compliance with chosen management (treatment) options, Risk factor reduction, Patient and family education.

(Often, the higher levels of E/M services can be legitimately supported and consequently, higher reimbursement dollars may be received.)

MEDICAL RECORD DOCUMENTATION (Recommended Principles)

Effective medical record documentation improves success in billing. The general principles of medical record documentation for reporting of mental health services include:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
- Reason for encounter and relevant history;
- Physical examination findings and prior diagnostic test results;
- Assessment, clinical impression, and diagnosis;
- Plan for care; and
- Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented;
- CPT and ICD-9-CM codes reported on the health insurance claim should be supported by documentation in the medical record.

Resources: (additional information of billing codes and state by state benefits)

- **ICD-9-CM**: http://www.cms.gov/ICD9ProviderDiagnosticCodes/
- **ICD-10-CM**: http://www.aapc.com/ICD-10/index.aspx
- **CPT Codes**: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page
- **HCPCS codes**: http://www.cms.gov/medhcpcsgeninfo/162.99.3.205/Financing/file.axd?file=2010%2F11%2FBackgroundofHCPCScoding.pdf
- **Place of Service Codes**: http://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/website_POS_database.pdf
- **What insurance companies operate in your state?** Contact your state Insurance Commissioner: http://www.naic.org/state_web_map.htm

Suggested Reading

- 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://store.samhsa.gov/product/reimbursement-of-mental-health-services-in-primary-care-settings/SMA08-4324
- Primary Care Depression Reimbursement: Myth vs. Facts" Mid America Coalition on Health; 2004. http://www.machc.org/documents/8-Depression%20Myths%20vs%20Facts_12_14_04.pdf
- Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings; (Brief prepared by the National Association of State Medicaid Directors (NASMD) under contract with the Health Resources and Services Administration, U.S Department of Health and Human Services) April 18, 2008 http://www.aphsa.org/home/doc/IntegratedMentalHealthHRSA.pdf

Template for State-Specific Resources and Policy Information

This template is intended to assist primary care providers and staff within the practice setting to identify state-specific 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. Much of this information varies by state, so understanding where to obtain this information and what questions to ask will help providers be better informed and prepared to appropriately deal with behavioral health emergencies.

1. **Local crisis line numbers**. _____

Ideas on where to find local and state crisis numbers:

- National Suicide Hotline: Lifeline 800-273-TALK (8255). This number will connect you to a local certified crisis line.
- State Public Health or Human Services Department.
- State Mental Health/Behavioral Health Authority.
- Local/Regional/County Mental Health Authorities.
- State Chapters of Advocacy/Support Organizations such as:
  - Mental Health America (formerly Mental Health Association).

2. **Questions to answer regarding procedures for admission to an inpatient psychiatric facility or unit.**
   - Involuntary Commitment
     - State laws pertaining to involuntary mental health commitment.
     - Who can authorize an involuntary commitment?
     - What information about the patient will need to be provided?
     - What is expected of the PCP by the courts?
     - How many hours of involuntary observation and treatment are legally mandated by the state?
   - Voluntary Admission
     - Who is eligible for voluntary admission?
     - What information about the patient will need to be provided?
     - What is expected of the PCP?

- What are state policies and resources, if any, regarding transporting a patient with a psychiatric emergency? If resources exist, how can they be accessed?
- How is inpatient psychiatric treatment extended beyond the period of involuntary commitment? What are the terms and conditions of the extension process (e.g., how long, by what type of professional)?
- State Medicaid reimbursement for mental health treatment and hospitalization.

Suggestions on where to find this information:

- State Public Health or Human Services Department.
- State Mental Health/Behavioral Health Authority.
- State Medicaid Agency.
- State Hospital Authority/Association.
- State Office of Consumer & Family Affairs.
- State Behavioral Health/Medicaid Ombudsman Office.
- Local/Regional Mental Health Authorities.

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

- State Psychiatric Hospital/s: Location, Contact, Transportation, Admission Procedures.
- Acute Crisis Units: Location, Contact, Transportation, Admission Procedures.
- Psychiatric beds in private or public hospital settings: Location, Contact, Transportation, Admission Procedures.

Suggestions on where to find this information:

- State Public Health or Human Services Department.
- State Mental Health/Behavioral Health Authority.
- State Hospital Authority/Admissions Office.
- Hospital Association.
- Local/Regional/County Mental Health Authorities.

Tab 6: Patient Education Tools / Other Resources

In This Section

Patient Education Tools/ Other Resources

This section contains a list of additional tools to help increase awareness in patients, families, and communities about suicide. These 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 Additional 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.

Resource List

http://www.sprc.org/for-providers/primary-care-tool-kit-resources

This Additional Suicide Prevention Resources list is a resource guide for suicide prevention in Primary Care settings. The list is organized into Resources for Providers and Resources for Patients, Families, and Community Members.

Public Awareness Materials

The posters below represent a sample of those that may be ordered 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.

National Suicide Prevention Lifeline materials:
The National Suicide Prevention Lifeline (NSPL) offers free posters that target a range of ethnic and age groups. These posters are available in standard and modifiable versions. Many are available in Spanish. They may be ordered using the web link below. Other materials available free of charge through the NSPL website include wallet cards for patients with the Lifeline phone number and suicide warning signs, brochures, flyers, magnets, and more.

http://suicidepreventionlifeline.org/Materials/Default.aspx

SAMHSA suicide prevention materials:
The Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering page lists and displays suicide prevention posters, guides, and handouts that can be used in a health care provider office.

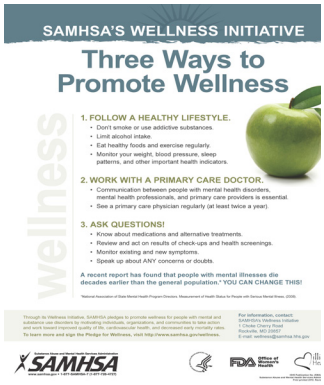
http://store.samhsa.gov/facet/Issues-Conditions-Disorders/term/Suicide?narrowToAdd=For-the-General-Public

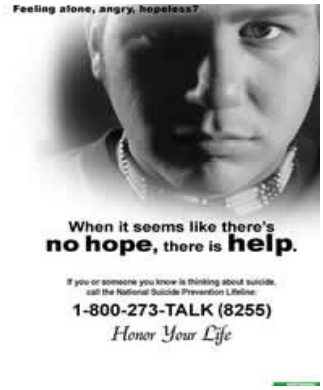
SAMHSA's wellness initiative:
SAMHSA's 10 by 10 Campaign for Wellness provides posters and brochures for general medical providers to post in their offices. Through its wellness initiative, SAMHSA pledges to promote wellness for people with mental and substance use disorders by motivating individuals, organizations, and communities to take action and work toward improved quality of life, cardiovascular health, and decreased early mortality rates.

http://store.samhsa.gov/product/The-10-By-10-Campaign-A-National-Wellness-Action-Plan-to-Improve-Life-Expectancy-by-10-Years-in-10-Years-for-People-with-Mental-Illness/SMA10-4476

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 web site.

http://www.sprc.org/states





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 Alaskan Natives
     - Gay, lesbian, bisexual, transgender
     - Veterans
   - Trainings and guides

3. **General Information on Rural Mental Health and Related Topics**

1. Resources for Providers

Depression

Macarthur Depression Toolkit

(http://prevention.mt.gov/suicideprevention/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/pdfs/02_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

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.

Mental Health Services Locator

(http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jspx)

1-800-662-HELP (4357)

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal government provides an online service to locate mental health services.

Substance Abuse Treatment Facility Locator

(http://findtreatment.samhsa.gov/)

1-800-662-HELP (4357).

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal government provides an online service to locate treatment facilities for substance abuse problems.

Telemental Health Guide

(http://www.tmhguide.org/)

The telemental health guide, which was funded by SAMHSA, contains an overview of what telemental health is and how it is being used to improve access to mental health services. It provides information about how to develop and sustain telemental health services in your community.

Means Restriction

Lok It Up Campaign

(http://www.kingcounty.gov/healthservices/health/injury/lokitup.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 provide by state.

Safe Use of Prescription Pain Medication Brochure
(http://here.doh.wa.gov/materials/safe-use-of-prescription-pain-medication/33_PainMeds_E11L.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

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 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/library_resources/items/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

(http://www.cdc.gov/ViolencePrevention/pub/Suicide_factsheet.html)

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.

Is Your Patient Suicidal?

(http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskPosterVert2.pdf)

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, resource guide (http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskGuide8.pdf) and accompanying information insert (http://www.sprc.org/sites/sprc.org/files/library/UsingIsYourPtSuicidal.pdf) can be ordered from the Emergency Nurses Association through the ENA Marketplace (https://admin.ena.org/store/).

Recognizing and Responding to Suicide Risk in Primary Care

(http://www.suicidology.org/trainingg-accreditation/recognizing-responding-suicide-risk)

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://store.samhsa.gov/shin/content//SMA09-4432/SMA09-4432.pdf)

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 PDF image of the card prints out on 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 http://www.sprc.org/sites/sprc.org/files/SAFE-TOrderForm.pdf. To obtain a free print-quality file for reproducing the cards, please email info@sprc.org, include your name, organization/company, and your plans for using the SAFE-T Cards.

Safety Planning Guide

(http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf)

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.

State Suicide Prevention Coordinators

(http://www.sprc.org/states/all/contacts)

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

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/product/Talking-with-Your-Adult-Patients-about-Alcohol-Drug-and-or-Mental-Health-Problems/SMA12-4584)

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.

2. Resources for Patients, Families, and Community Members

General Resources

National Suicide Prevention Lifeline

(http://www.suicidepreventionlifeline.org)

1-800-273-TALK (8255)

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 nearest crisis center to the caller.

National Suicide Prevention Lifeline Resources

(http://www.suicidepreventionlifeline.org/GetInvolved/Promote)

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

Population Specific Resources

American Indians and Native Alaskans

American Indian and Alaska Native Suicide Prevention Website

(http://www.ihs.gov/NonMedicalPrograms/nspn/index.cfm?page=NSPN_A40_S222.cfm)

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. (1-866-4-U-TREVOR).

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.pdhealth.mil/respect-mil/downloads/PCC_Final.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 Suicide Prevention Hotline

1-800-273-TALK, Veterans Press 1
http://www.veteranscrisisline.net/

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) has 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.

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/library_resources/items/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.

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. The SafeTALK fact sheet is at The Living Works web site is (www.livingworks.net).

3. General Information on Rural Suicide Prevention and Related Topics

American Association on Suicidology:
http://www.suicidology.org

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

Centers for Disease Control and Prevention/NCIPC:
http://www.cdc.gov/ncipc/

Health Workforce Information Center (HWIC):
http://www.healthworkforceinfo.org

NAMI (formerly National Alliance for the Mentally Ill):
http://www.nami.org

National Association of Rural Health (NRHA):

http://www.ruralhealthweb.org

National Institutes of Health/National Institute on Mental Health:
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 Assistance Resource Center (RAC):
http://www.raconline.org

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

Suicide Prevention Action Network:
http://www.spanusa.org

Suicide Prevention Resource Center:
http://www.sprc.org