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

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

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

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

This Guide Focuses on Four Core Components:

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

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

In each section of this guide you will find:

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

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

**Background: Why Primary Care Should Make Suicide Care a Priority**

**Pediatric Suicide—The Problem and the Opportunity**

The Rate of Suicide Deaths Is Increasing

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

**Pediatric Suicide**

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

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

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

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

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

- From 1999 through 2018, the suicide rate for males was 3.5-4.5 times the rate for females in the U.S., and suicide rates for both males and females increased.\textsuperscript{14}
- Suicide was the 8th leading cause of death among all males in the U.S. and the 2nd leading cause of death for males aged 10-34 and females aged 10-24 in 2019.\textsuperscript{15}
- Although males are at higher risk for suicide, the suicide rate for females increased 55% from 1999 to 2018, compared to a 28% increase for males.\textsuperscript{16}

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

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

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

“For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care; and to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.”

– Mike Hogan, PhD, Former Commissioner for Mental Health Services, New York State

How Teams Can Take Action

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

Getting Started with Key Action Steps:

- Establish protocols for routine suicide screening, assessment, intervention, and referral
- Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling
- Work with your local healthcare delivery system partners to enhance continuity of care by sharing patient health information with emergency care and behavioral care providers to create seamless care transitions
- Provide information on the National Suicide Prevention Lifeline crisis line and services
In addition to integrating routine suicide screening into primary care, it is important for primary care teams to understand the risk factors, warning signs, and the difference between the two. Knowing the risk factors can help primary care teams identify patients that may require further assessment for suicide and responsive care through brief interventions.

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

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

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

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

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


Routine Screening and Assessment in Pediatric Settings

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

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

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

Linking Suicide and Depression Screening Health Settings

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

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

Screening Best Practices

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

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22 In 2014, the U.S. Preventive Services Task Force reviewed current evidence and concluded, “Limited evidence suggests that primary care feasible screening instruments may be able to identify adults at increased risk of suicide, and psychotherapy targeting suicide prevention can be an effective treatment in adults. Evidence was more limited in older adults and adolescents...research is needed.”
23 https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf
24 Suicidal thoughts, or suicidal ideation, means thinking about or planning suicide.
Review of Screening Protocols and Tools

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

1. **Screen all patients ages 18 and up using a basic Patient Health Questionnaire (PHQ-9).**
   Many primary care settings rely on the PHQ-9 for screening all patients over age 12 for depression. This screening tool includes item 9, which asks specifically about suicidal thoughts, “Over the past two weeks, have you been bothered by...thoughts that you would be better off dead or of hurting yourself in some way?” The PHQ-A is a modified version of the PHQ-9 utilized for adolescents.

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

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

Resources

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

Screening and Assessment

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

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### Patient Health Questionnaire - 9 (PHQ-9)

Over the **last 2 weeks** how often have you been bothered by any of the following problems? (Use a **0** to indicate your answer)

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

**For office coding**

\[ \begin{array}{cccc}
0 & 1 & 2 & 3
\end{array} \]

\[ = \text{Total Score: } \_ \_ \_ \_ \_ \]

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

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Heverk and colleagues, with an education grant from Pfizer Inc.

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# PHQ-9 modified for Adolescents (PHQ-A)

Name: ___________________________  Clinician: ___________________________  Date: ____________

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

<table>
<thead>
<tr>
<th></th>
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<th>(1) Several days</th>
<th>(2) More than half the days</th>
<th>(3) Nearly every day</th>
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<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
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<td>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?</td>
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<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes  ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all  ☐ Somewhat difficult  ☐ Very difficult  ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes  ☐ No

Have you **EVER** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes  ☐ No

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

**Office use only:**

Severity score: ____________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)
Screening Tools for Children Under 12

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

Interpreting ASQ Screening Results
- If the patient responds “no” to all 4 of the ASQ questions, the screen is a negative.
- If the patient responds “yes” to any of the 4 ASQ questions, or refuses to answer any question, and answers “no” to the 5th acuity questions, the screen is a non-acute positive.
- If the patient responds “yes” to any of the 4 ASQ questions, or refuses to answer any question, and answers “yes” to the 5th acuity questions, the screen is an acute positive.

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

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

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Ask-Suicide Screening Questions (ASQ)

Ask the patient:

1. In the past few weeks, have you wished you were dead?  ○ Yes  ○ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  ○ Yes  ○ No
3. In the past week, have you been having thoughts about killing yourself?  ○ Yes  ○ No
4. Have you ever tried to kill yourself?  ○ Yes  ○ No
   If yes, how? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   When? ____________________________________________
   ____________________________________________
   ____________________________________________

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

5. Are you having thoughts of killing yourself right now?  ○ Yes  ○ No
   If yes, please describe: ____________________________________________

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen). If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - “Yes” to question #5: acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - “No” to question #5: non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255)  En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741
Say to parent/guardian:
“National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child’s safety, we will let you know.”

Once parent steps out, say to patient:
“Now I’m going to ask you a few more questions.”
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
“I’m so glad you spoke up about this. I’m going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you.”

If patient screens positive, say to parent/guardian:
“We have some concerns about your child’s safety that we would like to further evaluate. It’s really important that he/she spoke up about this. I’m going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child.”
Your child’s health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

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

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

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

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

Thank you in advance for your cooperation.
Help from Your EHR

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

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

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

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

Add Suicide to Your EHR Problem List:

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

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

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

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

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

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

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

Caring and Clear Provider-Patient Communication

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

**Provider Communication Tip: Brief Interventions**
- Thank you for sharing your suicidal thoughts.
- I won’t be asking for the details now, but they are important.
- Suicidal thoughts are not unusual, but they are a good indication of how bad things are.
- It is hard to think clearly when our brains are so overwhelmed with emotions – and others don’t understand this.
- Some people in despair imagine suicide because their brain wants a way out of the intense pain.
- It would really help me out if you removed the gun from your home, at least temporarily.
- What you do with the suicidal thought makes all the difference: Acknowledge them but direct your attention away from them by focusing your attention on something else.
## Ask Questions 1 and 2

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had any actual thoughts of killing yourself?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 3. Have you been thinking about how you may do this?  
   e.g. “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.” |     |    |
| 4. Have you had these thoughts and had some intention of acting on them?  
   As opposed to “I have the thoughts but I definitely will not do anything about them.” |     |    |
| 5. Have you started to work out or worked out the details of how to kill yourself?  
   Do you intend to carry out this plan? |     |    |
| 6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?  
   Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | Lifetime |    |

If YES to question 6, ask: **Was this in the past 3 months?**

### Response Protocol to C-SSRS Screening

- Item 1 and Item 2: Lethal Means Restriction & Safety
- Item 3: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4 and Item 5: Patient Safety Precautions
- Item 6: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precaution
- Item 6: 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
### Columbia Suicide Severity Rating Scale (C-SSRS) — Pediatric (≤11 years) Quick Screen

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

#### Suicidal Ideation

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions 1 and 2.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Have you thought about being dead or what it would be like to be dead?</td>
<td>Yes</td>
<td><strong>Wish to be dead.</strong> Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: “I’ve wished I wasn’t alive anymore.”</td>
</tr>
<tr>
<td>Have you wished you were dead or wished you could go to sleep and never wake up?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Do you ever wish you weren’t alive anymore?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Have you thought about doing something to make yourself not alive anymore?</td>
<td>Yes</td>
<td><strong>Non-specific active suicidal thoughts.</strong> General non-specific thoughts of wanting to end one’s life/commit suicide. Example: “I’ve thought about killing myself.”</td>
</tr>
<tr>
<td>Have you had any thoughts about killing yourself?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you thought about how you would do that or how you would make yourself not alive anymore (or kill yourself)?</td>
<td>Yes</td>
<td><strong>Active suicidal ideation with any methods (not plan) without intent to act.</strong> Person endorses thoughts of suicide and has thought of at least one method. Example: “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.”</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4. When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from having thoughts but knowing you wouldn’t do anything about them.</td>
<td>Yes</td>
<td><strong>Active suicidal ideation with some intent to act.</strong> Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: “I have had the thoughts, and I have considered acting on them.” Not: “I have the thoughts but I definitely will not do anything about them.”</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. Have you ever decided how or when you would make yourself not alive anymore (or kill yourself)? Have you ever planned out how you would do it? What was your plan? When you made this plan (or worked out these details), was any part of you thinking about doing it?</td>
<td>Yes</td>
<td><strong>Active suicidal ideation with specific plan.</strong> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: “Next Thursday when my parents are sleeping, I am going to take the sleeping pills in the upstairs medicine cabinet.”</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

#### Suicidal Behavior

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Did you ever do anything to try to make yourself not alive anymore (or kill yourself)? Did you ever hurt yourself on purpose?</td>
<td>Yes</td>
<td><strong>Actual attempt.</strong> A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt.</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>In the past 3 months?</td>
<td>Yes</td>
<td><strong>Aborted or self-interrupted attempt.</strong> When person takes steps toward making a suicide attempt but stops before actually engaged in any self-destructive behavior.</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>In the past 4 weeks?</td>
<td>Yes</td>
<td><strong>Interrupted attempt.</strong> When the person is interrupted by an outside circumstance from starting the potentially self-injurious act (if not for that, an actual attempt would have occurred.)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td><strong>Preparatory acts or behavior.</strong> Acts or preparation toward imminent making a suicide attempt.</td>
</tr>
</tbody>
</table>

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Clinician Signature: ___________________________  Date: ___________  Time: ___________

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C-SSRS Pediatric Quick Screen
SP006 - 08/14
©2014 Intermountain Healthcare. All rights reserved.
Patent and Provider Publications. 801-442-2983
Adapted with permission from the Research Foundation for Mental Hygiene, Inc.

PediatricSuicidePrevention 18  www.clinicians.org
Advantages to Using the C-SSRS

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

Resources: Routine Screening and Assessment in Primary Care

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Trainings and Resources</th>
</tr>
</thead>
</table>
| Training for Nonclinical Team Members | - SafeTALK curriculum  
- Mental Health First Aid |
| Regulatory | - Joint Commission Alert with Eight Steps on How to Prevent Suicide: Mental Health First Aid |

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

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

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

Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

**Foundational Performance Metrics:**
- Percentage of patients with a positive response to Question 9 (Q9) on the Patient Health Questionnaire-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
- Percentage of patients with a positive C-SSRS screen that have a suicide related entry added to the problem list.
- Percentage of patients with suicide active on the problem list that have a completed: Safety Plan, C-SSRS Lifetime/Recent scale, Risk Assessment.

**Icon Key:**
- Indicates that Best Practice Advisory Alert supports movement along pathway.
- Indicates cascading features in place to support movement along pathway.

**Notes:**
1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of “No” on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of “Yes” on Question 2 or 6.
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance.
Primary care providers can help support patients at risk for suicide using brief interventions. These can be utilized during the period between assessment and referral to follow-up behavioral healthcare. These brief interventions may also assist care teams to begin offering Suicide Safer Care in areas where access to behavioral health care is limited. Brief interventions include:

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

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

1. Make a Safety Plan

Complete a safety plan:

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

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

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

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

---

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

The Safety Plan should:

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

Provide the local crisis center phone number or the National Suicide Prevention Lifeline number at (800) 273-TALK (8255) to every patient as part of the safety plan.

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

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NowMattersNow.org Safety Plan

NowMattersNow.org Emotional Fire Safety Plan

Select those that fit you, cross out those that don’t, add your own. Based on research, and advice from those who’ve been there.

Visit nowmattersnow.org/get-involved for most recent version, last updated 09.11.11 © 2013

Direct advice for overwhelming urges to kill self or use opioids

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

— No Important Decisions —
- Especially deciding to die. Do not panic. Ignore thoughts that you don’t care if you die. Stop drugs and alcohol.
- Make a connection —
- A difficult but powerful pain reliever. Look in their eyes and say “Can you help me get out of my head?” Try video chat. Keep trying until you find someone.

Things I Knew How To Do For Suicidal Thoughts and Urges To Use (practice outside of crisis situations)

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

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

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

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

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

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

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

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

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

☐ Choose A-Team member(s)__________________________
☐ Message or call A-Team members, individually or as a group to let them know they are A-Team
☐ Discuss in advance what would be helpful in crisis (“I believe in you”, support this plan, just listen, hospitalization or not)
☐ Decide how to ask for help effectively (be willing to take help, try to communicate before a crisis)

Watch Out For These

☐ Not sleeping  ☐ Validating myself, “my emotions make sense”
☐ Feeling really anxious or irritable  ☐ Talk to someone in recovery
☐ Increased alcohol or drug use or relapse  ☐ Make plans to get out of these situations
☐ Being in frustrating and painful situations  ☐ Go to scheduled appointments or schedule one
☐ Stop taking medication without support  ☐ Message an A-Team member a caring message
☐ Avoiding calls or messages  ☐ Suicidal thoughts or images
NowMattersNow.org Emotional Fire Safety Plan (Additional Notes)
Select those that fit you, cross out those that don’t, add your own. Based on research, and advice from those who’ve been there.
Visit nowmattersnow.org/get-involved for most recent version, last updated 18.09.11 ©2018

Direct advice for overwhelming urges to kill self or use opioids

- **Shut it down** — Sleep (no overdosing). Can’t sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.
- **No Important Decisions** — Especially deciding to die. Do not panic. Ignore thoughts that you don’t care if you die. Stop drugs and alcohol.
- **Make Eye Contact** — A difficult but powerful pain reliever. Look in their eyes and say “Can you help me get out of my head?” Try video chat. Keep trying until you find someone.

**Things I Know How To Do for Suicidal Thoughts and Urges to Use**
Visit NowMattersNow.org

**Put Crisis Resources in Phone**
- □ Suicide Prevention Lifeline 1-800-273-8255, Press 1 for veterans, 2 for Spanish
- □ Crisis Text Line 741741 Help

The reason(s) I want to live and not use drugs
The #1 thing leading to suicidal thoughts or urges to use

**Keeping Myself Safe**

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

**Watch Out for These**

**Things I’d Be Willing to Try**
### Patient Safety Plan Template

**Step 1:** Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. 
2. 
3. 

**Step 2:** Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):
1. 
2. 
3. 

**Step 3:** People and social settings that provide distraction:
1. Name __________________________ Phone __________________________
2. Name __________________________ Phone __________________________
3. Place __________________________ 3. Place __________________________

**Step 4:** People whom I can ask for help:
1. Name __________________________ Phone __________________________
2. Name __________________________ Phone __________________________
3. Name __________________________ Phone __________________________

**Step 5:** Professionals or agencies I can contact during a crisis:
1. Clinician Name __________________________ Phone __________________________
   Clinician Emergency Contact # __________________________
2. Clinician Name __________________________ Phone __________________________
   Clinician Emergency Contact # __________________________
3. Local Urgent Care Services __________________________
   Urgent Care Services Address __________________________
   Urgent Care Services Phone __________________________
4. Suicide Prevention Lifetime Phone: 1-800-273-TALK (8255) __________________________

**Step 6:** Making the environment safe:
1. 
2. The one thing that is most important to me and worth living for is:

---

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.
Basic Sections Can Include:

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

Reduce Access to Lethal Means

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

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

Online Training

- CALM – Counseling Access to Lethal Means
- CSSRS

Access to Lethal Means Handouts

- Information for Families
- Guidelines for Clinicians

Action Steps

Develop organizational policies that clearly state what clinicians and care teams can do to counsel patients on lethal means, including the protocol to follow.

In the event a patient brings a weapon or other lethal means to the clinical setting.

Trainings and Resources

- Reducing Access to Lethal Means (CALM)
- Sample Policies and Procedures for Securing Weapons for Suicidal/Homicidal Clients
- Recommendations from the Harvard T. H. Chan School of Public Health, Means Matter Campaign for clinicians regarding guns and medications

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


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

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

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

“I’m a suicide caregiver and this is exactly what I didn’t know I needed! Thanks for reminding me to take care of myself.” - Suicide Is Different User

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

Provider Communication Tip: Connecting Patients to Crisis Support Services

- Do you have a phone? I’d like you to enter 1-800-253-8255 in your phone right now.
- You may never need it, but you want to have it in case someone you care about is suicidal.
- Next, let’s open a website called NowMattersNow.org and look at a 40-second video by Marsha on suicidal thoughts. I want you to go to the website after our visit.
Examples of resources that providers can share with patients include NowMattersNow. This website can be given to patients or even pulled up during your primary care visit. The website offers resources and tips for providers.

**Other Resources to Consider**

- **National Suicide Prevention Lifeline**
  - 1-800-273-TALK (8255)
  - Spanish/Español: 1-888-628-9454
- **Crisis Text Line**
  - Text HOME to 741-741
- **Suicide Prevention Resource Center**
- **National Institute of Mental Health**
- **Substance Abuse and Mental Health Services Administration**
Follow Up with Caring Contacts

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

Examples of caring contacts include:

- Postcards, letters, patient portal emails, and text messages.
- Some EHR systems may have automated patient engagement systems that can be used.
- Phone calls made by care management staff, patient navigators, or peer providers.
- Home visits.

Organizations can explore developing partnerships with local crisis centers that can provide follow-up caring contacts with patients during transitions in care.

Caring Messages

We asked over 1000 people. Here is the top results. These are the ones you like for those that care about.

- When you’re in a hard place, it feels like the world is against you. You can never feel like you’re enough.
  - Bob Dylan
- Life is not about finding the right person. It’s about finding the right moment.
  - Glenn Greenberg
- Don’t stop fighting. You are more capable than you realize.
  - Eleanor Roosevelt
- Sometimes you can be in the dark place and you just need a little light.
  - Bob Dylan
- Life is about making the most of what you have.
  - John Wooden

References:

Alternative Levels of Care

The process of making safety plans in collaboration with the patients can help the provider determine what kind of referral may be appropriate. The patient’s level of engagement in creating these plans will also be a factor in determining the level of ongoing follow-up the patient will need. While risk stratification for patients at risk for suicide is not yet well developed, new models of care suggest that treatment and care for patients at risk for suicide should be provided in the least restrictive setting.

Multi-disciplinary or integrated care teams can deliver care management focused on patient engagement in care plans, care coordination, risk monitoring, and evidence-based clinical interventions to address medical and behavioral health conditions. Increased patient engagement and effective care management supports may help reduce suicide risk. Patients with a moderate-to-high risk score on assessments and who have symptoms of mental illness may require referral to a behavioral health provider for evaluation and treatment. Patients who continue to be an imminent danger to themselves even after intervention efforts may require hospitalization; however, emerging evidence suggests that hospitalization should be avoided if at all possible. An article in the American Journal of Preventive Medicine (2014) recommends a “stepped care treatment pathway” for intervention.40

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

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

A Reminder About HIPAA

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

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Care Transitions

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

- For patients who are admitted for inpatient care, make a follow-up appointment for a patient before discharge. Ideally follow-up care should be scheduled within 48 hours of discharge, for both medical and psychiatric admissions.
- Involve family, friends, and other loved ones in the plan for care transition.
- Make follow-up contacts (e.g., by email, text or phone) with patients after inpatient hospitalizations.
- Patients transitioning from incarceration.
- Patients ending substance use treatment.

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

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

Again, a Little Help from the EHR:

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

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

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Trainings and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor to ensure that care transitions are</td>
<td>• Structured Follow-up and Monitoring for</td>
</tr>
<tr>
<td>documented and flagged for action in an</td>
<td>Suicidal Individuals</td>
</tr>
<tr>
<td>electronic health record or a paper record.</td>
<td></td>
</tr>
</tbody>
</table>

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

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Recommendation for Monitoring Through the Quality Improvement Program

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

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

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

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

The following list was developed based on actual court cases\(^4^\) and offers strategies for proper documentation:

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

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

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Trainings and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get a brief sense of case law and successful malpractice and negligence cases involving suicide.</td>
<td>• <a href="https://www.researchgate.net/publication/240314951">Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines</a></td>
</tr>
<tr>
<td>Review best practices in documentation.</td>
<td>• <a href="https://www.clinicians.org">Legal and Liability Issues in Suicide Care</a></td>
</tr>
</tbody>
</table>

\(^4\) Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines.
**Resources: Other Considerations**

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

**Resources and Tools for Workforce Development**

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

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

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<thead>
<tr>
<th>Action Steps</th>
<th>Length</th>
<th>Trainings and Resources</th>
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<tbody>
<tr>
<td>Assessing and Managing Suicide Risk (AMSR)</td>
<td>1 day (in-person)</td>
<td><a href="http://zerosuicideinstitute.com/amsr">http://zerosuicideinstitute.com/amsr</a></td>
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<tr>
<td>Structured Follow-up and Monitoring</td>
<td>45 min. (online)</td>
<td><a href="http://zerosuicideinstitute.com">http://zerosuicideinstitute.com</a></td>
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<tr>
<td>SafeTALK</td>
<td>3 hrs. (in-person)</td>
<td><a href="https://www.livingworks.net/">https://www.livingworks.net/</a></td>
</tr>
<tr>
<td>Suicide Care at the Institute for Family Health</td>
<td>4 hrs (in-person)</td>
<td><a href="https://institute.org/">https://institute.org/</a></td>
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<tr>
<td>Job Title</td>
<td>Required Suicide Prevention Trainings</td>
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<tr>
<td>• Associate Director</td>
<td>• Assessment of Suicidal Risk Using C-SSRS</td>
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<tr>
<td>• Associate Director of Psychiatry</td>
<td>• Safety Planning Intervention for Suicide Prevention</td>
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<tr>
<td>• Associate Regional Director</td>
<td>• Counseling on Access to Lethal Means</td>
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<td>• Behavioral Health Faculty</td>
<td>• Assessing and Managing Suicide Risk</td>
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<td>• Care Management Coordinator</td>
<td>• Structured Follow-up and Monitoring</td>
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<td>• Care Manager</td>
<td>• Suicide Care at the Institute for Family Health</td>
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<td>• Director Clinical Quality &amp; Compliance</td>
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<td>• Director Of Technology Implementation</td>
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<td>• Mental Health Clinician</td>
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<td>• Program Director</td>
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<td>• Director Of Family Programs</td>
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<td>• Psychiatric Provider</td>
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<td>• Rn Care Coordinator</td>
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<td>• Social Worker</td>
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<td>• Substance Abuse Director</td>
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<td>• Care Coordinator</td>
<td>• Safety Planning Intervention for Suicide Prevention</td>
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<td>• Case Manager</td>
<td>• Counseling on Access to Lethal Means</td>
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<tr>
<td>• Community Health Worker</td>
<td>• Structured Follow-up and Monitoring</td>
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<td>• Family Assessment Worker</td>
<td>• safeTALK</td>
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<td>• Medical Assistant</td>
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<td>• Outreach And Assessment Coordinator</td>
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<td>• Patient Navigator</td>
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<td>• Retention &amp; Adherence Specialist - Bachelors</td>
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<td>• Director, Process Improvement &amp; Analytics</td>
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<td>• Health Education &amp; Access Coordinator</td>
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<td>• Lead Patient Services Rep</td>
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<td>• Billing + Referral Coordinator</td>
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<tr>
<td>• Mental Health Billing Director</td>
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<td>• Nutritionist</td>
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<td>• Outreach Worker</td>
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<td>• Patient Service Representative</td>
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<td>• Practice Administrator</td>
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