Suicide Assessment and Prevention in Healthcare Settings

Jeanne Bereiter MD and Laura Rombach MA, LPCC

University of New Mexico

Department of Psychiatry and Behavioral Sciences

Division of Community Behavioral Health

Goals and Objectives

1. Appraise the suicide risk and protective factors for individuals presenting in health care settings.
2. Employ the use of suicide risk screening tools, triage, and safety planning in the management of the suicidal person.
3. Summarize the use of screening tools, risk assessment, and management of a suicidal person through a case example.

Disclaimer

- Dr. Bereiter and Laura Rombach have no financial relationship to this program

Background

Background-National Strategy for Suicide Prevention

- This talk is based in large part upon information provided in the National Suicide Prevention Resource Center's (SPRC) Suicide Prevention Toolkit for Rural Primary Care
- NSPRC is a federally funded resource center to promote the National Strategy for Suicide Prevention (NSSP)
- NSSP began in 2012, and is a national strategy to reduce suicides over the next 10 years
- One of their priorities is to encourage the transformation of health care systems to prevent suicide

Rates of Suicide in the United States

- Suicide rates have increased 24% from 1999 through 2014, to 13.0 per 100,000 population
- Nearly 43,000 people in the United States die from suicide annually
- Suicide is the 10th leading cause of death for all age groups and the 2nd leading cause of death for age groups 10-34 (CDC, 2016)
- There are 3.6 male suicides for every female suicide but more women than men attempt suicide
- More than half of suicide deaths for males occurred by use of a firearm, and poisoning was the most common method for females

Who Dies by Suicide in New Mexico?

(NM Dept. of Health Fact Sheet)

- Whites and Native Americans have the highest rates
  - Whites 25.3/100,000
    - Highest rate among 45 and older
    - Leading cause of death by suicide is firearms
  - Native Americans 21.4/100,000
    - Highest rate among 15-44
    - Leading cause of death by suicide is suffocation
  - Suicide rate for men is >3x as high as for women

Polling Question

- In 2013 _____% of **high school** students in New Mexico attempted suicide.

  a. 5%

  b. 9%

  c. 12%

  d. 20%

New Mexico Youth

- In 2013 - 7.8% of middle school students in New Mexico had attempted suicide
- In 2013 - 9.4% of high school students in New Mexico had attempted suicide
  - *This rate has decreased from 14.5% in 2003*
- In 2014 - 3,443 visits to emergency departments in New Mexico were due to self-injury

NMDOH Health Fact Sheet

September 2015

Prevalence of Suicide in Primary Care

- 77-90% of people who die by suicide had contact with their primary care provider (PCP) in the year prior to their death.
- 45-76% had contact with their PCP in the month prior to their suicide.
- They 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

Polling Question

- How many people saw their primary care doctor in the month prior to death by suicide?
    a. 20%
    b. 30%
    c. 50%
    d. 75%

Primary Care Providers See and Treat Patients at Risk of Suicide

- Many patients use PCP as their mental health services
  - In part due to stigma of seeing mental health providers
- Primary care providers identify almost 1/3 of their patients as “mental health patients” (Faghri,2010)
- PCPs are the largest providers of psychotropic drugs in the US
  - Psychiatrists and addiction specialists prescribed 23%
  - PCPs prescribed 59%

(Mark, Levit, & Buck, 2009)

Screening Recommendations

Common Concerns: Asking About or Assessing Suicide Risk

- Will asking about it upset someone, or put those thoughts in their mind?
- What about cultures in which suicide is never discussed—is it culturally appropriate to ask?
- We don't have enough behavioral health services available for the patients we already know about—what will we do with the new patients we find?
- I don't have enough time as it is to get through all I have to do with patients. I don't have time to ask about suicide.
- I'm not sure what to say/what to do/how to follow up.

Comorbidity

- Mental illness is strongly associated with suicide
  - >90% of people who die by suicide have a mental health disorder, substance use disorder (SUD) or both
  - >50% of suicides are associated with a major depressive episode
  - 10% of suicides are associated with a psychotic disorder such as schizophrenia
- Substance abuse is also associated with suicide
  - > 25% of suicides are associated with an SUD, especially alcohol
- Good treatment of psychiatric and SUD is an important part of PCP based suicide prevention

Depression Screening

- Depression is the psychiatric disorder most commonly associated with suicidality
- Depression is a common mental health problem and causes problems other than suicidality
- Recommended: screen all patients who are seen in healthcare and behavioral health care
- Different standardized assessment instruments available
- PHQ-2 and PHQ-9 very commonly used

Evidence Based Screening Tools for Depression and Substance Use

- Patient Health Questionnaire
  - PHQ 9 - Screen for depression +self harm/suicidality
  - PHQ- A for adolescents
- AUDIT-C - Screen for alcohol use
- DAST 10 - Screen for drug use
- AADIS – Adolescent Alcohol and Drug Involvement Scale
    - Screen for tobacco, alcohol and drug use

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____+_____+ _____

=Total Score: _____

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

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

PHQ-9

- 9 question self-administered scale designed to assess depressive symptoms within the past 2 weeks
- Designed to screen for depression, assess severity of depression, measure response to treatment
- 9th question addresses suicidal ideation:
  - **“Thinking that you would be better off dead or that you want to hurt yourself in some way.”**
  - Note that this is a broad screening question and will pick up non-suicidal self injurious behavior as well as lower risk suicidal ideation

Joseph
PHQ-A

Case Study - Joseph

- Joseph is a 15 year old, 10th grader who receives good to average grades.

- He feels tired and irritable, has trouble concentrating, and experiences sleep disruption. He feels hopeless about his future and has lost interest in spending time with friends. He is fidgety at school and at home, and has trouble sitting still. He argues with his family several times a week and feels like a failure.

- He has thoughts about killing himself by taking an overdose of over-the-counter sleep medication, although he does not have a specific plan.

- Joseph has good frustration tolerance, is involved in school sports and does not use drugs or alcohol. He has supportive parents.

PHQ-9 Modified for Adolescents (PHQ-A)

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:**_____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

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

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name: Joseph **Age:** 15 **Sex: Male** ☒ **Female** ☐ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	Clinician Use Item score
1.	Feeling down, depressed, irritable, or hopeless?			X		2
2.	Little interest or pleasure in doing things?		X			1
3.	Trouble falling asleep, staying asleep, or sleeping too much?			X		2
4.	Poor appetite, weight loss, or overeating?	X				0
5.	Feeling tired, or having little energy?		X			1
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?		X			1
7.	Trouble concentrating on things like school work, reading, or watching TV?				X	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?		X			1
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?		X			1
					Total/Partial Raw Score:	12
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Scoring the PHQ-A
Interpretation of Total Score

Total Score Depression Severity

- 0-4 None or minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

Screening for Alcohol and Drug Use

- Alcohol and drug use can increase impulsivity
- Many suicide attempts and suicides are impulsive, not planned
- Alcohol and drug use commonly co-occur with mental health problems
- Many screens exist, for adults we recommend AUDIT-C (alcohol) and DAST-10 (drug)
- For adolescents AAIDS – screens for drugs & alcohol

What is a Suicide Attempt?

- A self-injurious act committed with at least some intent to die as a result of the act
- People often have mixed motives/ambivalence
- Ask “Did any part of you want to kill yourself?”
- Client doesn’t need to verbalize that it was a suicide attempt

Non-Suicidal Self-Injurious Behavior

- Action done 100% for reasons other than to kill themselves
- Done to feel better, relieve pain, get attention, get a bed in a hospital, etc.
- Is a risk factor for suicide

Other Suicidal Behaviors

- Interrupted Attempt
  - Someone else stops the person
- Aborted or Self-Interrupted Attempt
  - Person stops him or herself
- Preparatory Acts or Behavior
  - Writing a suicide note
  - Buying a gun, collecting pills

Why Screen for Suicide Risk?

- Evidence exists that screening actually
  - DECREASES referrals to hospitals
  - Provides behavioral health resources to those who truly need them, not to those who weren't actually at high risk
  - May actually save lives

Polling Question

- How does your organization screen for suicide risk?
  a. Standardized screening
  b. Staff ask question about self-harm or suicidal thoughts.
  c. No screening is done for suicide risk

Suicide Risk Assessment

Components of a Suicide Risk Assessment

- 1. Assess risk factors
- 2. Assess protective factors
- 3. Do a suicide inquiry about thoughts, plan, intent, access to lethal means
- 4. Determine Risk Level/Intervention
- 5. Document

Columbia Suicide Severity Rating Scale

- Screener version appropriate for First Responders, gatekeepers, peer counselors
- Full version appropriate for behavioral health clinicians
- Available in many different languages
- Flexible format, don’t need to ask all the questions if not necessary
- Integrates information given by collateral sources family, caregivers

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Visit

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Visit	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6) Suicide Behavior ***Have you 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.		

When to Refer?

- Ideation: 4 or 5 in the past month
- Behaviors: any behavior in the past 3 months
- Score of 4 indicate some suicidal intent
- Risk doubles from 3 to 4

Joseph

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***	X	
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***	X	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might kill yourself?***	X	
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		X
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		X
6) Suicide Behavior ***Have you 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.		X

Key Risk Factors

- Prior suicide attempt
- Major depression
- Substance use disorders
- Acute stressors
- Acute agitation/anxiety

Other Risk Factors

- Suicidal ideation, behaviors, or non suicidal self injury
- Other current or past psychiatric/related disorders
- Medical illnesses especially TBI or chronic pain
- Key symptoms: impulsivity, hopelessness, anxiety, insomnia, command hallucinations, anhedonia
- Family history: of suicide attempts, suicide, mental health problems requiring hospitalization
- Change in level of care/treatment: recent discharge from ED, psychiatric hospital, change in or loss of provider, treatment change

Social/Environmental Risk Factors

- Chaotic social history/lack of social support
- Access to lethal means
- Local suicide clusters (contagion-especially for adolescents)
- Legal problems/incarceration
- Barriers to accessing healthcare, especially mental health and substance use treatment
- Cultural and religious beliefs in favor of suicide

Protective Factors

- Internal
  - Ability to cope with stress
  - Religious beliefs
  - Good frustration tolerance
  - Life satisfaction
- External
  - Responsibility to children or pets
  - Positive therapeutic relationships/engaged in treatment and willing to follow up
  - Social support, sense of belonging

Suicide Inquiry

- Remember that most people will not spontaneously report suicidal ideation to you, but may do so **if asked**
- 70% will communicate their suicidal thoughts to someone
- Ask patients directly about suicidal thoughts
- Seek collateral information from others
- Consider using screening instruments e.g. CSSRS screener

Clearest Warning Signs of Suicidality

- Threatening to kill self/others or talking about wanting to hurt self/others
- Seeking access to firearms, pills, etc.
- Talking or writing about death, dying or suicide (when someone doesn’t normally do this)

How to Ask About Suicidality

- How you ask increases the likelihood of getting a truthful response
- Practice asking about suicidality
- DO ASK: Have you had any thoughts of wishing you were dead, or of harming or killing yourself?
- If answer is yes, ask how they might do this?
  - What lethal means
- DON’T ASK: You’re not thinking of suicide, are you?

If Patient Endorses Suicidal Thoughts Ask About…

- Frequency
- Duration
- Intensity
- Plan
- Intent
- These items are covered on the 6 item CSSRS-Screener

Determine Risk Management Plan

- Plan differs depending upon High, Medium, Low Risk
- In all cases
  - Create safety plan with patient
  - Document
  - Follow up
  - Consider hospitalization (use your clinical judgment, consult if uncertain)

High Risk

- Patient has a suicide plan with preparatory or rehearsal behavior
- Patient has severe risk factors
- Patient has low protective factors or these are overwhelmed
- Hospitalize or call 911 or police if no hospital available
- If patient refuses hospitalization,
  - Ask police to transport patient to hospital for evaluation for involuntary hospitalization or
  - Consult psychiatry for a Certificate of Evaluation or “C of E”

Moderate Risk

- Patient has suicidal ideation but limited intent, no clear plan, may have had previous attempt
- Evaluate for psychiatric disorders, substance use disorders, stressors, and other risk factors
- Consider psychiatric referral/psychopharmacology, alcohol or drug assessment and referral, therapy referral
- Engage social support
- For non behavioral health staff, call therapist if patient has one
- Safety planning
- Document treatment plan

Low Risk

- Patient has thoughts of death “passive SI” but no plan or intent
- Evaluate for psychiatric disorders, substance use disorders, stressors, additional risk factors
- Engage social support
- Call therapist if patient has one
- Safety planning
- Document treatment plan

Joseph Risk Assessment

- PHQ – 9 = Moderate Depression with score of 12
- CSSRS = Positive question 1,2 & 3
- If we had completed AUDIT or DAST we would factor in drug/alcohol use and impulsivity
- Protective Factors External Internal
  - Supportive parents Previously well functioning
  - Friends Good frustration tolerance
  - Engaged in school
- Needs referral for behavioral health care
- What might increase his risk in the future?

Safety Planning

Educate Patients About Suicide Warning Signs & What to Do

- We educate patients about warning signs of stroke and heart attack
- Educating about warning signs of suicide is similar
- For severe warning signs, patient or family should call 911 or go to the nearest Emergency Department
- For less severe warning signs, activate safety plan: use coping skills, get support, call suicide prevention hotline

What Is a Safety Plan?

- A written list (or on an App) of coping strategies and resources to use during a suicidal crisis
- Is NOT a “no suicide contract”
- A “no suicide contract” asks patients to promise to stay alive but doesn’t give them tools to help them do so, apart from asking them to call you if feeling suicidal

Reasons for Safety Planning

- Suicide risk fluctuates over time
- Problem solving capacity is lower during times of crisis so it helps to plan ahead
- Learning to cope with suicidal crises without hospitalization helps increase a person's self-efficacy and self confidence
- Safety planning helps to instill hope!

1. Warning Signs: When To Use the Safety Plan?

- Person needs to be able to recognize warning signs/triggers
  - Write them down (thoughts, mood, behavior)
- Clinician can go through the events leading up to/during/after the last suicidal crisis
- Help patient to identify when they should use their safety plan

2. Internal Coping Strategies

- Activities a person can do on their own
- Usually these are meaningful activities that distract person and make them feel better (not alternate self harm or unhealthy activities)
- If person is able to cope on own even briefly this increases self-efficacy, self control
- Examine “road blocks” to using these strategies and problem solve ways around them
- Not wanting to help self can be a road block

3. Using Socialization for Distraction & Support

- If Step 2 doesn't resolve the crisis, patient moves to step 3
- Socialization is for distraction/meaning
- Go to a "healthy" social setting e.g., library, not bar
- Seek support from family, friends, acquaintances
- List more than 1 person as 1st person might not be available

4. Contacting Family or Friends to Ask for Help

- Use Step 4 if Step 3 doesn’t resolve the crisis
- Help patient to list people she or he would be likely to contact
- Problem solve obstacles to contacting these people
- Discuss whether safety plan can be shared with these people (a good idea to do so if possible)

5. Contacting Professionals or Agencies to Ask for Help

- Use Step 5 if Step 4 doesn't resolve the crisis
- Identify which clinicians should be on the safety plan
- Identify which agencies should be on the safety plan
- List address, phone numbers, location of:
  - Local Crisis lines
  - Suicide Prevention Lifeline: **800-273-TALK (8255)**
  - Emergency rooms, crisis centers

6. Reducing the Potential for Use of Lethal Means

- Ask about reduction to lethal means at the end of safety planning not the beginning
  - patients are more likely to discuss this if they have ideas about alternatives to suicide!
- Ask what means they might use during a suicidal crisis
- Even if they don't mention firearms, always ask if they have access to a firearm

Who Is Appropriate for Safety Planning & What Does it Do?

- Patients at increased risk for suicide who do not require immediate hospitalization
- Fills the gap between hospital or ED discharge and follow-up
- Provides an alternative for those who don't want or don't receive outpatient care

However…

- Hospitalization can always be part of a safety plan if other measures are ineffective

Restricting Means of Lethal Self-Harm

- Many suicide attempts occur during a short-term crisis
- Many suicide attempts are impulsive
  - Studies show many people report less than 5-10 minutes between decision to commit suicide and attempt
- 90% of attempters who survive do NOT go on to die by suicide later
  - 7% reattempted and died by suicide
  - 23% reattempted non-fatally
  - 70% made no further attempts

Br. J. Psychiatry 181:193–99

Recommendations to Reduce Access to Lethal Means

- Health care providers should counsel patients and families to remove firearms from the home or secure the guns and ammunition in separate locations
- Youth often know how to access the firearms even if parents think they don't
- When healthcare providers recommend that parents restrict access of their children to guns and medications, most of them do so
- Consider providing resource materials for educating patients and families
- Healthcare providers should also counsel on reducing access to lethal prescription and OTC medications and alcohol

Documentation

- Aids in communication/appropriate care of patient
- Helps to manage your legal risk
- Things to document:
  - The suicide risk assessment
  - Your management plan
  - Any consultation (e.g., with supervisor, psychiatrist, mental health provider)
  - What you did (e.g., spoke with family, police, school)
  - What you thought, why you made the decision you did

Follow Up Care

- Studies show that even a postcard or phone call reduces suicidal patients' risk for repeat attempts
- Follow up also allows you to reassess for recurrent or increased suicidality
- Consider using a flow chart to document management including follow up care

Resources

SAFE-T

- A suicide risk assessment tool
- Available from SAMHSA or the Suicide Prevention Resource Center

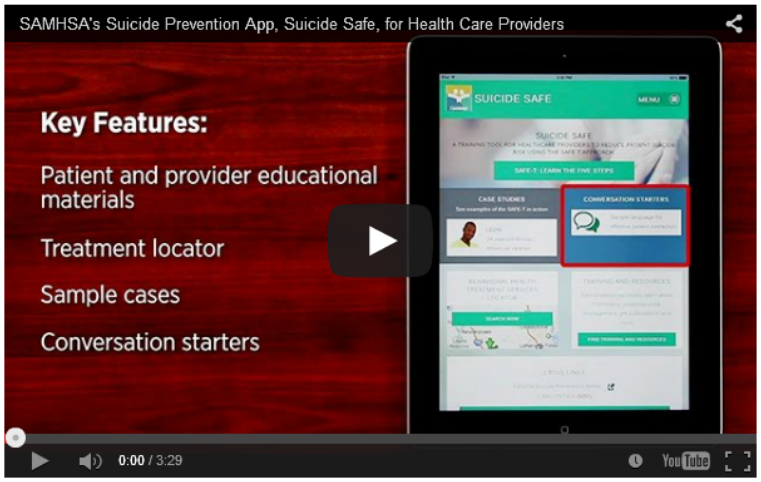
Apps

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA Home Contact Us

302

Suicide Safe: The Suicide Prevention App for Health Care Providers Free from SAMHSA



For individuals at risk of suicide, behavioral health and primary care settings provide unique opportunities to connect with the health care system and access effective treatment. Almost half (45%) of individuals who die by suicide have visited a primary care provider in the month prior to their death, and 20% have had contact with mental health services.[1]

Suicide Safe, SAMHSA's new suicide prevention app for mobile devices and optimized for tablets, helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients. Suicide Safe is a free app based on SAMHSA's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card.

Available Now

GET IT ON Google play Download on the App Store

Suicide Safe App

- Free mobile app for healthcare providers
- Education and support resources for providers
- Case examples
- Link to Safe-T
- Link to community resources

Suicide Prevention Lifeline 1-800-273-TALK (8255)

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

HOME ABOUT CONTACT US RESOURCES

Toolkit Champions Get Involved

Search

WHAT IS ZERO SUICIDE?

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

+

ZERO SUICIDE TOOLKIT

VIEW TOOLKIT »

FOR CHAMPIONS

Zero Suicide Champions believe that anything short of zero suicides in health care is unacceptable.

+

MAKING HEALTH CARE SUICIDE SAFE

Mike Hogan describes why now is the time for Zero Suicide.

Suicide Prevention Hotlines

- **NMCAL New Mexico Crisis and Access Line**
  - 1 (855) NMCRISIS (662-7474)
    1 (855) 227-5485 (TTY)
- **Agora Crisis Center**

  In Albuquerque: 277-3013
  Statewide: 1 (866) HELP-1-NM (435-7166)

Crisis Response of Santa Fe

In Santa Fe: 820-6333
Statewide: 1 (888)920-6333

- **Southern New Mexico Crisis Line**

  In Southern NM: (575) 646-CALL (2255)
  Statewide: 1 (866) 314-6841

National Hotlines

Suicide Prevention lifeline 1-800-273-TALK

Resources

- Depression management Tool Kit (MacArthur Initiative) 2009
  - http://otgateway.com/articles/13macarthurtoolkit.pdf

- **Recognizing and Responding to Suicide Risk in Primary Care**
  http://www.suicidology.org/training-accreditation/rrsr-pc
  A one-hour training program that provides physicians, nurses, nurse practitioners, and physicians assistants knowledge to integrate suicide risk assessments into routine office visits, to formulate relative risk, and to work collaboratively with patients to create treatment plans.

Resources

- Free, e-learning workshop from Columbia, NY OMH: Safety Planning Intervention for Suicidal Individuals www.zerosuicide.com
- Safety planning: A quick guide for clinicians http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf
- Safety Plan template, manual and other resources: www.suicidesafetyplan.com
- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf
- American Association of Suicidology http://www.suicidology.org

Resources

- Suicide Prevention Resource Center - http://www.sprc.org/
  - American Indian and Alaska Native Suicide Prevention Programs
  - Garrett Lee Smith State/Tribal Suicide Prevention Program
- Action Alliance for Suicide Prevention- http://zerosuicide.actionallianceforsuicideprevention.org/
- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- Military One Source http://www.militaryonesource.mil/
- Columbia-Suicide Severity Rating Scale Training http://www.cssrs.columbia.edu/
- CALM-Counseling on Access to Lethal Means http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means