



Suicide Prevention Resource Center

**Introduction to Available Clinical Resources from SPRC:
Suicide Prevention Tools for Primary Care Providers and
Emergency Departments**

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August 12, 2013**

Overview of Presentation

- Share information about and resources available from the Suicide Prevention Resource Center (SPRC)
- Introduce the *Suicide Prevention Toolkit for Rural Primary Care*
- *Introduce the ED Poster: Is Your Patient Suicidal*
- Review ways resources can be used

Who We Are

What is the Suicide Prevention Resource Center (SPRC)?

- Established in 2002
- Funded through a cooperative agreement by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- SPRC serves individuals, groups, and organizations that play important roles in suicide prevention.
- Increase knowledge, build capacity, and promote collaboration.
- Nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

Services and Resources

Technical Assistance to states, tribes, campuses--Garrett Lee Smith grants

Training <http://training.sprc.org>

- CALM (Counseling on Access to Lethal Means)
- AMSR (Assessing and Managing Suicide Risk)
- Webinars (Self-Injury, Alcohol Use, Bullying)

Publications

- Weekly SPARK
- Customized Information Sheets (Foster parents, First Responders, Teachers)
- Toolkits/Resources (Seniors, LGBT Youth, Juvenile Justice, ED Poster)

Best Practices Registry

- Evidence-based suicide prevention programs and practices

National Action Alliance for Suicide Prevention

- Public-Private Partnership
- National Strategy for Suicide Prevention

<http://actionallianceforsuicideprevention.org/nssp>

The Weekly Spark



The screenshot shows the top portion of a newsletter. At the top left is the SPRC logo, which consists of a stylized 'S' and 'P' in a circle, followed by the text 'SPRC SUICIDE PREVENTION RESOURCE CENTER'. To the right of the logo is a blue grid pattern. Below the logo, the title 'The Weekly Spark' is written in a large, bold, green font, with the date 'March 29, 2012' underneath it. A link 'Read this newsletter on the web' is positioned to the right of the date. The main content area is divided into two columns. The left column has a blue header 'Announcements' and contains a bolded title 'SAMHSA and the MacArthur Foundation collaborate to improve juvenile justice system response to youth behavioral health needs' followed by a paragraph of text. The right column has a blue header 'Research' and contains a bolded title 'Suicide Screening in Emergency Departments' followed by a paragraph of text. Below the research section is another blue header 'National News' followed by a bolded title 'Army reviewing traumatic stress diagnostic practices' and a paragraph of text.

SPRC
SUICIDE PREVENTION RESOURCE CENTER

The Weekly Spark

March 29, 2012

[Read this newsletter on the web](#)

Announcements

SAMHSA and the MacArthur Foundation collaborate to improve juvenile justice system response to youth behavioral health needs

SAMHSA and the MacArthur Foundation are collaborating on a \$1 million effort targeting the behavioral health needs of youth in contact with the juvenile justice system. Youth with mental, substance use, and co-occurring disorders often end up in the juvenile justice system rather than getting the proper help they need. This initiative will support state efforts to develop and implement policies and

Research

Suicide Screening in Emergency Departments

A study by investigators affiliated with the Emergency Department Safety Assessment and Follow-Up Evaluation (ED-SAFE) project found that emergency departments (EDs) are failing to conduct suicide screenings for many patients who exhibit characteristics associated with a high risk of suicide (such as psychiatric complaints or a history of substance abuse). The research also revealed that many patients who screen positive for suicidal ideation or behavior are not provided with appropriate follow-up care.

This research summary is based on information in:
Ting, S. A., Sullivan, A. F., Millar, I., Espinola, J. A., Allen, M. H., Camargo, C. A., & Boudraux, E. D. (2012). Multicenter study of predictors of suicide screening in emergency departments. *Academic Emergency Medicine*, 19, 239-243.

National News

Army reviewing traumatic stress diagnostic practices

Reuters
The Army surgeon general has initiated a review to make sure that all Army psychiatrists follow standardized

Sign up for The Weekly Spark at:
<http://go.edc.org/0ooq>

Examples of SPRC Products and Services

The Best Practices Registry (BPR)

A screenshot of the SPRC Best Practices Registry website. The page has a blue header with the SPRC logo and navigation links. The main content area features a grid of buttons for "BPR Overview", "Advice on Using the BPR", "Search All Listings", "SECTION I: Evidence-Based Programs", "SECTION II: Expert/Consensus Statements", "SECTION III: Adherence to Standards", "FAQ", "How to Apply", "Help", and "Marketing Materials". A sidebar on the left lists various resources like "Using the BPR", "Section I: Evidence-Based Programs", etc. Below the grid, there is a paragraph explaining the purpose of the BPR and a section titled "BPR Structure" with a bulleted list of criteria for Section I.

About SPRC | Contact Us | FAQ Search this site Login

SPRC • Suicide Prevention Resource Center
Promoting a public health approach to suicide prevention

SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

Suicide Prevention Basics News & Events Training Institute **Best Practices Registry** Library & Resources Who We Serve

Best Practices Registry

Using the BPR

- Section I: Evidence-Based Programs
- Section II: Expert/Consensus Statements
- Section III: Adherence to Standards
- All Listings
- BPR FAQs
- How to Apply
- Marketing Materials
- BPR Search

For More Information
Program developers are encouraged to contact Philip Rodgers for assistance.

American Foundation for Suicide Prevention

Home » Best Practices Registry

BPR Overview **Advice on Using the BPR** **Search All Listings**

SECTION I: Evidence-Based Programs **SECTION II: Expert/Consensus Statements** **SECTION III: Adherence to Standards**

FAQ **How to Apply** **Help** **Marketing Materials**

The purpose of the Best Practices Registry (BPR) is to identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention. The BPR is a collaborative project of the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP). It is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

BPR Structure

The BPR is organized into three sections, each with different types of best practices. In essence, the BPR is three registries in one. The three sections do not represent levels, but rather they include different types of programs and practices reviewed according to specific criteria for that section.

Click on the section name below for section-specific criteria and listings:

- Section I: Evidence-Based Programs lists interventions that have undergone evaluation and demonstrated positive outcomes.

http://www.sprc.org/featured_resources/bpr/index.asp

BPR: How to Ask the Question

ASIST/safeTALK

Jerry Swanner

Living Works

910-867-8822

usa@livingworks.net

www.livingworks.net

QPR/QPR-T (Question, Persuade, Refer), QPR for Nurses, QPR for Primary Care Providers

Kathy White

The QPR Institute, Inc.

888-726-7926

qinstitute@qwest.net

www.qprinstitute.com

Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training

Janet Kemp, RN, Ph.D.

VA National Suicide Prevention Coordinator

585-393-7939

jan.kemp@va.gov

Assessing and Managing Suicide Risk (AMSR)

Isaiah Branton

SPRC

202-572-3789

ibranton@edc.org

www.sprc.org

Recognizing and Responding to Suicide Risk in Primary Care (RRSR—PC)

Alan L. Berman

American Association of Suicidology

202-237-2280

berman@suicidology.org

www.suicidology.org

AT-RISK in PRIMARY CARE/AT-RISK in the ED

Ron Goldman

Kognito

212- 675-9234

ron@kognito.com

www.kognito.com

American Indian/Alaska Native Suicide Prevention Resources

American Indian/Alaska Native Section of SPRC website:

<http://www.sprc.org/aian>

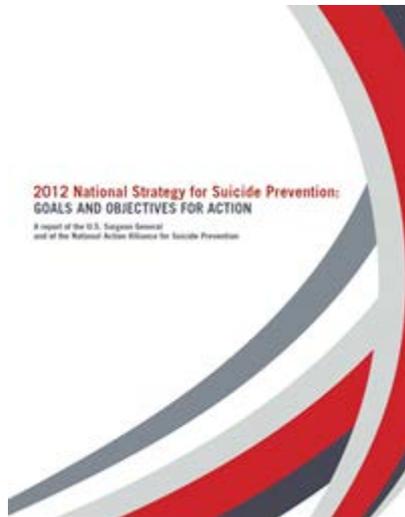
American Indians/Alaska Natives Suicide Fact Sheet:

[http://www.sprc.org/sites/sprc.org/files/library/AI ANFactSheet.pdf](http://www.sprc.org/sites/sprc.org/files/library/AI_ANFactSheet.pdf)

To live to see the great day that dawns: Preventing suicide by
American Indian and Alaska Native youth and young adults:

[http://www.sprc.org/sites/sprc.org/files/library/Suicide Prevention
Guide.pdf](http://www.sprc.org/sites/sprc.org/files/library/Suicide_Prevention_Guide.pdf)

Why Primary Care?





PCSSmentor.org

Physician Clinical Support System -
An Educational Resource for Those Addressing Su

<p>PCSS-P HOME</p> <p>ABOUT PCSS-P</p> <p>PCSS-P MEDICAL DIRECTORS & CLINICAL ADVISORS</p> <p>RESOURCES</p> <p>ADMIN LOGIN</p> <p>MENTOR LOGIN</p>	<h3>What is the Physician Clinical Support System (PCSS-P)?</h3> <p>The Physician Clinical Support System is a supported program that brings you curl alcohol, tobacco, and drug screening, b primary care settings. It is a system or emails to put physicians in touch with r When you sign up with PCSS-P you are can contact for assistance directly by e group of mentors with expertise in prim</p> <p>There are similar systems for physician and for physicians using methadone to manage chronic pain PCSS-Methadone</p>
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Recognizing and Responding to Suicide Risk in Primary Care

Information Brochure



20% of those who died by suicide visited their PCP within 24 hours prior to their death.

You could be the last medical professional seen by a patient on the brink of a life or death decision.

Sponsored by




Making It

SAMHSA-HRSA Center for Integrated Health Solutions







THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

EXECUTIVE SUMMARY
FINAL REPORT
JULY 2003

Suicide in Primary Care

Salient Risk Factors

- Depression
- Substance use disorders
- PTSD/anxiety disorders
- Chronic pain
- Physical illnesses, especially CNS disorders (TBI)

Roles

- Detection and treatment/referral
- Screening for suicide risk when indicated
- Surveillance for warning signs of suicide

Contact with Primary Care and Mental Health Prior to Suicide

All Ages	Month Prior	Year Prior
Mental Health	19%	32%
Primary Care	45% (up to 76%)	77% (up to 90%)

Age <36	Month Prior
Mental Health	15%
Primary Care	23%

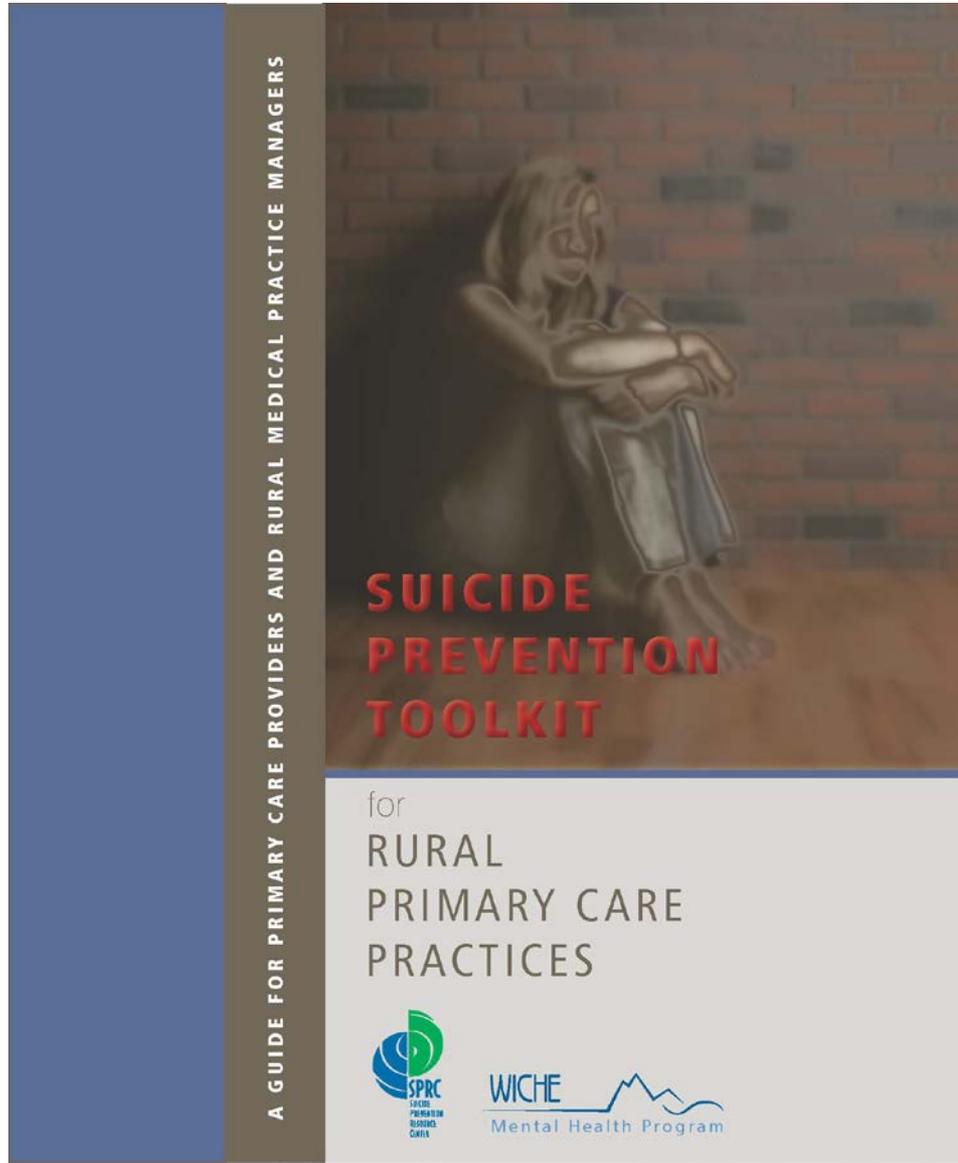
Age >54	Month Prior
Mental Health	11%
Primary Care	58%

- Luoma J, Martin C, Pearson J. Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence Am J.Psychiatry 159:6 (2002) 909-916.

Primary Care in Rural Settings

- More than 65% of rural Americans get their mental health care from their primary care provider
- Primary care providers are central to mental health delivery system in rural settings
- Why?
 - May be the only providers there
 - Less stigma in seeking care in a doctor's office
 - May not self-identify with mental health symptoms but seeking care for physical symptoms with underlying mental health issues

Suicide Prevention Toolkit for Rural Primary Care



How to Get a Copy of the Toolkit

Free Online: <http://www.sprc.org/for-providers/primary-care-tool-kit>

To order a Hard Copy: Hard copies of the toolkit are available for \$25.00 through WICHE Mental Health Program. For more information, please contact Tamara DeHay at tdehay@wiche.edu (preferred option) or 303-541-0254

WICHE



Western Interstate Commission for Higher Education

Overall Layout

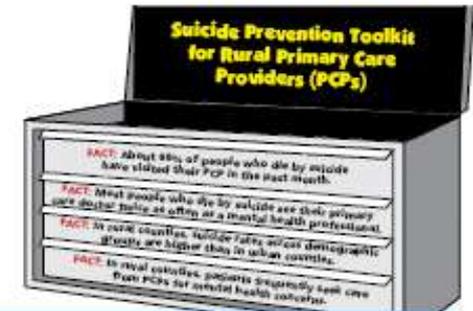
- ✓ Includes 6 sections
 - Getting Started
 - Educating Clinicians and Office Staff
 - Developing Mental Health Partnerships
 - Patient Management Tools
 - State Resources, Policy, and Billing
 - Patient Education Tools/Other Resources

Getting Started

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QUICK START GUIDE

How to use the Suicide Prevention Toolkit



STEP

1

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

STEP

2

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

STEP

3

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

STEP

4

Develop a referral network to facilitate the collaborative care of suicidal patients. Use the “Developing Mental Health Referrals” materials in

Getting Started: Protocol Template & Instructions

To be used with instruction sheet to create an office protocol that may be referred to when a potentially suicidal patient presents

If a patient presents with suicidal ideation or suicidal ideation is suspected...

- ✓ _____ should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).
- ✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization...

- ✓ Our nearest Emergency Department or psychiatric emergency center is _____ . Phone # _____ .
- ✓ _____ will call _____ to arrange transport.
(Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)
- Backup transportation plan: Call _____ .

Documentation and Follow-Up...

- ✓ _____ will wait with patient for transport.
_____ will call ED to provide patient information.
- ✓ _____ will document incident in _____ .
(Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- ✓ Necessary forms are located _____ .
- ✓ _____ will follow-up with ED to determine disposition of patient.
(Name of individual or job title)

Educating Clinicians and Office Staff

- A Primer for Primary Care Providers
 - 5 brief learning modules
 - Module 1- Prevalence & Comorbidity
 - Module 2- Epidemiology
 - Module 3- Prevention Practices
 - Module 4- Suicide Risk Assessment
 - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
 - Module 5- Intervention
 - Referral, PCP Intervention, Documentation & Follow-up

Developing Mental Health Partnerships

SAFE-T

Suicide **A**ssessment **F**ive-step
Evaluation and **T**riage

for Mental Health Professionals

1

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

2

IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3

CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4

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

5

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

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

Letter of introduction to potential referral resources template

- Increasing vigilance for patients at risk for suicide
- Referring more patients
- SAFE-T card for Mental Health Providers
- Invitation to meet to discuss collaborative management of patients

Patient Management Tools

- Pocket Guide for Primary Care Professionals
 - Designed for PCP's specifically
- Safety Planning Guide
 - Used to guide the development of a safety plan
- Safety Plan Template for use with/by a potentially suicidal patient
- Crisis Support Plan for use with/by the family members/friends of potentially suicidal patients
- Patient Tracking Log for at-risk patients

Patient Management Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals



Suicide Risk and Protective Factors¹

RISK FACTORS

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

PROTECTIVE FACTORS

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

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

Patient Management Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals



Screening: uncovering suicidality²

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

Assess suicide ideation and plans³

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

Assess suicide intent

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

Endnotes:

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

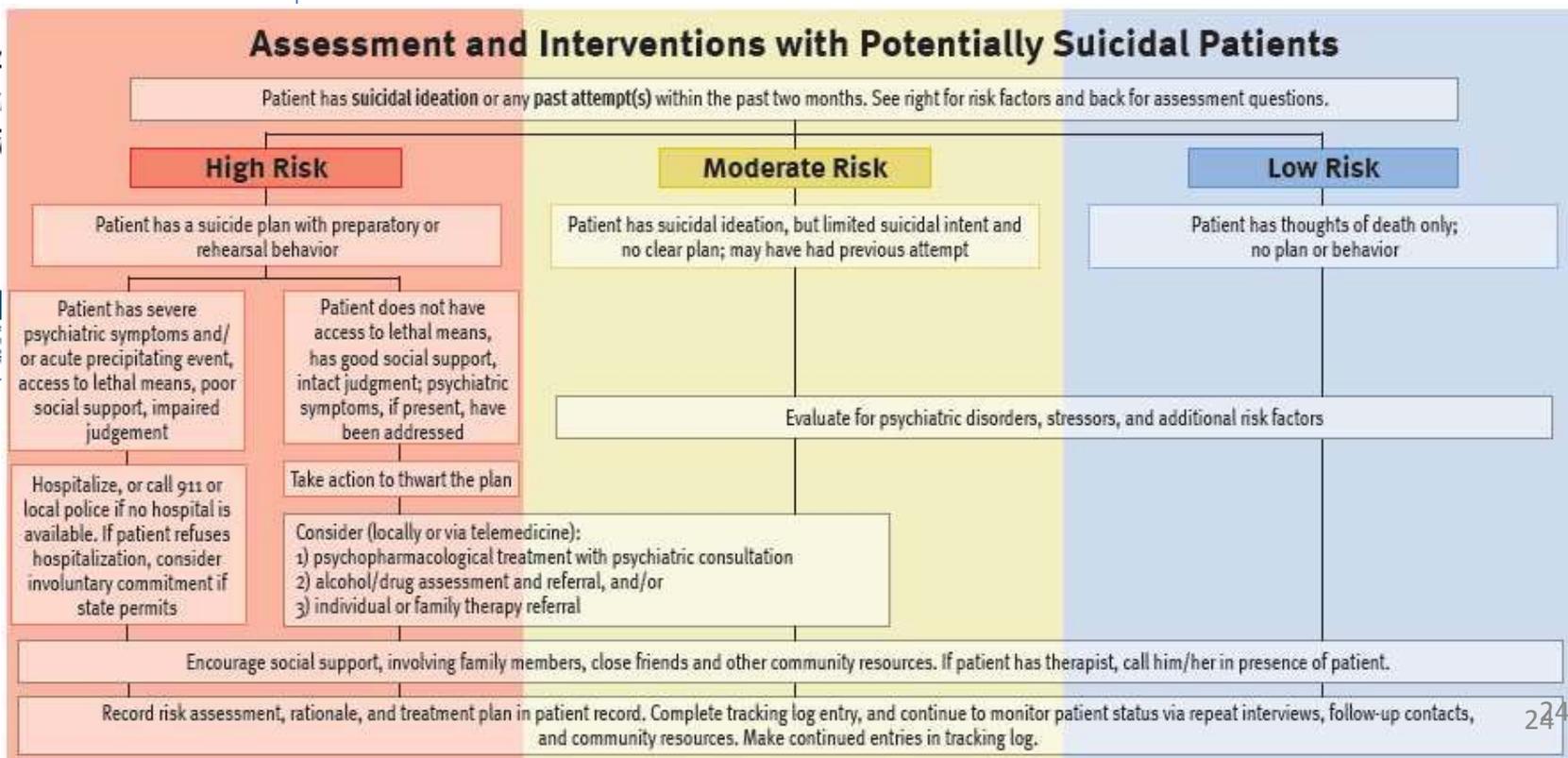
² Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

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

Patient Management Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

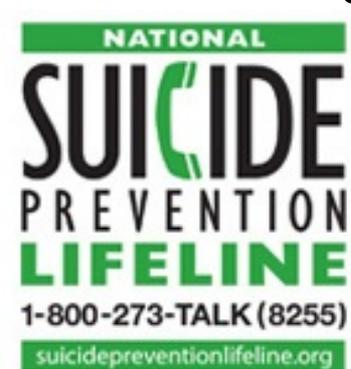
A Pocket Card for Professionals



Patient Management

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- “Safety Plan”
 - Collaboratively developed with patient
 - Template that is filled out and posted
 - Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers
- “Crisis Support Plan”
 - Provider collaborates with Pt and support person
 - Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed



CALL US 24 HOURS A DAY
FOR VETERANS PRESS 1
EN ESPAÑOL OPRIMA EL 2

Patient Management

Safety Planning Guide

*A Quick Guide for Clinicians
may be used in conjunction with the "Safety Plan Template"*

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

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

WHO SHOULD HAVE A SAFETY PLAN?

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

HOW SHOULD A SAFETY PLAN BE DONE?

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

IMPLEMENTING THE SAFETY PLAN

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



SAMPLE SAFETY PLAN

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 4: People whom I can ask for help:

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

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

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Revised Version (Sanley & Brown, 2008).

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

Patient Management

CRISIS SUPPORT PLAN

FOR: _____

DATE: _____

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

Things I can do:

- Provide encouragement and support
 - _____
 - _____
- Help _____ follow his/her Crisis Action Plan
- Ensure a safe environment:
 1. Remove all firearms & ammunition
 2. Remove or lock up:
 - knives, razors, & other sharp objects
 - prescriptions & over-the-counter drugs (including vitamins & aspirin)
 - alcohol, illegal drugs & related paraphernalia
 3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
 4. Pay attention to his/her stated method of suicide/self-injury and restrict

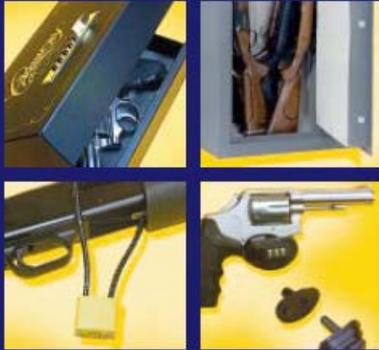
Patient Management Tracking Log

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- Log & Instruction sheet
- Provider uses:
 - Update PCP on suicide status of a patient
 - Remind provider of recent interventions or problems with regard to the patient's treatment

Patient Education

Firearm Locking Devices



Which one is right for you?



Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Comments from the Field:

Benewah Training

- One of the greatest things I heard was in the afternoon of the first day of the training. I was called to our medical department to work with an emergent situation. When I contacted one of the nurses, she stated, "I got to use what I learned this morning! The training was great!" She was so excited about being able to feel safe enough to ask the question, "Have you ever thought about killing yourself?" and have the patient answer honestly.
- One of our counseling staff members said "I'm happy to have the Safety Plan form to give to my clients. It is something we can develop together and they can use on their own."

Suicide in the Emergency Department

- EDs are frequently the first treatment site for the 350,000 individuals who attempt suicide each year.
- Many people with suicidal ideation present to the ED with complaints seemingly unrelated to their suicidality.
- Therefore, EDs are a critical venue to assess and respond.

Opportunities for improved care in EDs

- ✓ Screening
- ✓ Risk assessment
- ✓ Provider knowledge and attitudes
- ✓ Safety planning
- ✓ Education and brief treatment
- ✓ Discharge plan and follow-up

Suicide Risk: A Guide for ED Evaluation and Triage

Companion resource to the *Is Your Patient Suicidal?* poster.

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of acute suicide risk

- ❖ **Talking about suicide** or thoughts of suicide
- ❖ **Seeking lethal means** to kill oneself
- ❖ **Purposeless**—no reason for living
- ❖ **Anxiety or agitation**
- ❖ **Insomnia**
- ❖ **Substance abuse**—excessive or increased
- ❖ **Hopelessness**
- ❖ **Social withdrawal**—from friends/family/society
- ❖ **Anger**—uncontrolled rage/seeking revenge/partner violence
- ❖ **Recklessness**—risky acts/unthinking
- ❖ **Mood changes**—often dramatic

Other factors:

- ❖ **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- ❖ **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- ❖ **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

*** Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.**

Ask if you see signs or suspect acute risk— regardless of chief complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

These questions ease the patient into talking about a very difficult subject.

- Patients who respond “no” to the first question may be “faking good” to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
 - frequency, intensity, and duration of thoughts;
 - the existence of a plan and whether preparatory steps have been taken; and
 - intent (e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

Patient with some known level of suicide risk

Recommendations	Challenges/Barriers
TREATMENT / MANAGEMENT	
✓ Assess risk ✓ If a patient presents for physiological problems, (e.g., headache) look in the chart for repeat visits	<ul style="list-style-type: none">• Reliability of self-report• Patient fear of admitting to SI due to past experiences with involuntary commitment
✓ Collect information from collaterals; collect additional risk and protective factors	<ul style="list-style-type: none">• Sometimes no collateral information is available
✓ Determine the presence of substance abuse issues; discuss risks of suicide while intoxicated	<ul style="list-style-type: none">• ED providers may be reluctant to ask questions that may lead to spending more time on the patient
✓ Determine whether to discharge or admit ✓ In settings with limited BH resources, use tele-health resources, crisis center professionals and on-call psychiatric specialists	<ul style="list-style-type: none">• Need better decision-making tools• Physicians/hospitals need better understanding of legal risks and protections of discharging someone who is suicidal
✓ Assess means risk; conduct means counseling	<ul style="list-style-type: none">• Lethal means counseling training is needed
✓ Use a motivational interviewing approach to talk to patients*	<ul style="list-style-type: none">• Providers need motivational interviewing training
✓ Re-engage patients with outpatient treatment; explore what is not working with outpatient care	
✓ Document conversations that took place	

Patient with some known level of suicide risk

Recommendations

Challenges/Barriers

DISCHARGE PLANNING / AFTERCARE

✓ Use sample discharge planning instructions	• Sample discharge instructions need to be developed
✓ If possible, bring family/supports into ED for after care planning	• Difficult for ED physician to determine family reliability
✓ Conduct safety planning	• Staff are busy
✓ Make an appointment for outpatient follow-up care (mental health, primary care, club house, bridge clinic, and partial hospitalization); make appointment within 48 hours if possible	• Outpatient care options and community resources can be limited • Difficult to talk in-person with outside provider(s)
✓ Activate crisis center follow-up protocol	
✓ Consider substance abuse treatment	• Hospital should collaborate with substance abuse treatment community to make connections
✓ Communicate with outpatient provider	
✓ Provide written instructions with Lifeline or other crisis center number and community resources	

Educating the Patient

**National Suicide Prevention Lifeline:
After an Attempt**



**A Guide for Medical
Providers in the
Emergency Department
Taking Care of Suicide
Attempt Survivors**



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

**National Suicide Prevention Lifeline:
After an Attempt**



**A Guide for Taking
Care of Yourself After
Your Treatment in the
Emergency Department**



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

**National Suicide Prevention Lifeline:
After an Attempt**



**A Guide for Taking Care
of Your Family Member
After Treatment in the
Emergency Department**

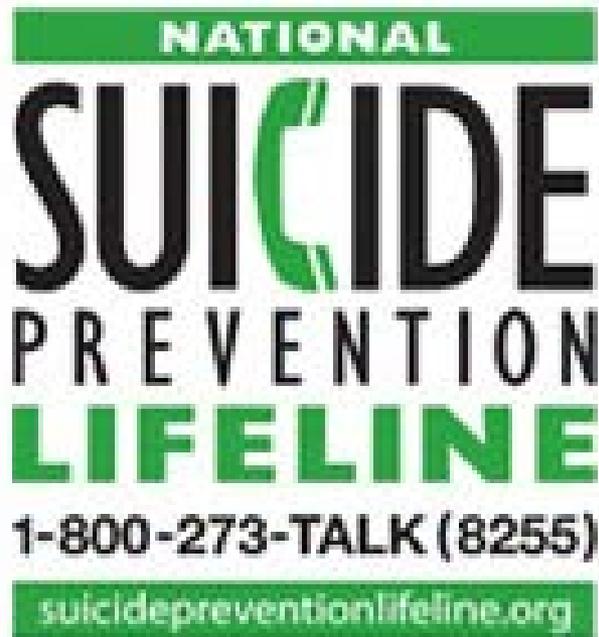


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

ED: Discharge Planning

- Low rate of adherence to follow-up plan after ED discharge
- 50% fail to arrive at 1st follow-up visit
- As many as 70% either fail to arrive or drop out of treatment after 1-2 visits

Discharge Planning and After Care: National Suicide Prevention Lifeline



- Make appointment with mental health provider before they leave ED
- Provide them with NSPL number
- Follow-up with patient
- Did they go to 1st appointment?
- Sending postcards, texts, calling on phone

Press 1 for veteran's line

ED Resources

<http://www.sprc.org/for-providers/emergency-department-resources#general>

Is Your Patient Suicidal? ED poster

http://www.sprc.org/library/ER_SuicideRiskPosterVert2.pdf

A four-color poster that provides emergency department practitioners with information on recognizing and responding to acute suicide risk.

Suicide Risk: A Guide for Evaluation and Triage

http://www.sprc.org/library/ER_SuicideRiskGuide8.pdf

For emergency department staff, a short companion piece to the Is Your Patient Suicidal?

ED poster.

Using the “Is Your Patient Suicidal?” Poster and Triage Guide

<http://www.sprc.org/library/UsingIsYourPtSuicidal.pdf>

A brief set of instructions for emergency department staff who are displaying the poster and referencing the resource guide.

Additional Resources

Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department or an Inpatient Psychiatry Unit

A comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in emergency departments and hospitals.

<http://www.sprc.org/sites/sprc.org/files/library/continuityofcare.pdf>

Suicide Care in Systems Framework

Transforming health systems - (1) Emergency Departments and Medical - Surgical Units; (2) Primary Care and General Medical Settings; (3) Behavioral Health Entities; and (4) Crisis Services.

<http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf>

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