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

Julie Goldstein Grumet, PhD
Peggy West PhD, MSW
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
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](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](http://actionallianceforsuicideprevention.org/nssp)
Announcements

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

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.


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
Examples of SPRC Products and Services
The Best Practices Registry (BPR)

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

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

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

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/ai

American Indians/Alaska Natives Suicide Fact Sheet:

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

PCSSmentor.org
Physician Clinical Support System - An Educational Resource for Those Addressing Suicide Risk in Primary Care

What is the Physician Clinical Support System (PCSS-P)?

The Physician Clinical Support System is a supported program that brings alcohol, tobacco, and drug screening to primary care settings. It is a system or software to put physicians in touch with each other. When you sign up with PCSS-P you are assigned a mentor who can contact for assistance directly by e-mail or phone. You can contact for assistance directly by e-mail or phone.

There are similar systems for physicians and for physicians using methadone to manage chronic pain. PCSS-Methadone

SAMHSA-HRSA Center for Integrated Health Solutions

Making It Work: Center for Integrated Health Solutions

Achieving the Promise: Transforming Mental Health Care in America

Executive Summary

Sponsored by

American Association for Suicidology
National Association of Counties
American Osteopathic College of Addiction Medicine
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

<table>
<thead>
<tr>
<th>All Ages</th>
<th>Month Prior</th>
<th>Year Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>45% (up to 76%)</td>
<td>77% (up to 90%)</td>
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<table>
<thead>
<tr>
<th>Age &lt;36</th>
<th>Month Prior</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>15%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>23%</td>
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<tr>
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<th>Month Prior</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>11%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>58%</td>
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</table>
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](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
✓ 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
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

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 “Providing Mental Health Psychosocial” materials in...
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

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 Factors

**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.
Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Screening: uncovering suicidality

- 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 plans

- 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).
### Assessment and Interventions with Potentially Suicidal Patients

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Moderate Risk</th>
<th>Low Risk</th>
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<tbody>
<tr>
<td><strong>Patient has suicidal ideation or any past attempt(s) within the past two months.</strong></td>
<td><strong>Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt.</strong></td>
<td><strong>Patient has thoughts of death only; no plan or behavior</strong></td>
</tr>
<tr>
<td><strong>Patient has a suicide plan with preparatory or rehearsal behavior</strong></td>
<td><strong>Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgment</strong></td>
<td><strong>Take action to thwart the plan</strong></td>
<td><strong>Evaluate for psychiatric disorders, stressors, and additional risk factors</strong></td>
</tr>
<tr>
<td><strong>Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits.</strong></td>
<td><strong>Consider (locally or via telemedicine):</strong></td>
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<td></td>
<td>1) psychopharmacological treatment with psychiatric consultation</td>
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<td></td>
<td>2) alcohol/drug assessment and referral, and/or</td>
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<td>3) individual or family therapy referral</td>
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<td></td>
<td><strong>Encourage social support, involving family members, close friends and other community resources. If patient has therapist, call him/her in presence of patient.</strong></td>
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<td></td>
<td><strong>Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and community resources. Make continued entries in tracking log.</strong></td>
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Patient Management

• “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
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 consulting 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. Name_____________________ Phone_____________________________
4. Place____________________ Phone_____________________________

Step 4: People whom I can ask for help:
1. __________________________ Phone_____________________________
2. __________________________ Phone_____________________________
3. __________________________ Phone_____________________________
4. __________________________ 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 ____________________________ Address ______
   Urgent Care Services Phone ____________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:
1. ______________________________________________________________
2. ______________________________________________________________

The one thing that is most important to me and worth living for is: ____________________________________________________
CRISIS SUPPORT PLAN

FOR: ________________________________  DATE: ______________

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

Things I can do:

- Provide encouragement and support
  - ______________
  - ______________
- Help ______________ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms & 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

• 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
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

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/untiring
- 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?

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.
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Challenges/Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Assess risk</td>
<td>• Reliability of self-report</td>
</tr>
<tr>
<td>✓ If a patient presents for physiological problems, (e.g., headache) look in the chart for repeat visits</td>
<td>• Patient fear of admitting to SI due to past experiences with involuntary commitment</td>
</tr>
<tr>
<td>✓ Collect information from collaterals; collect additional risk and protective factors</td>
<td>• Sometimes no collateral information is available</td>
</tr>
<tr>
<td>✓ Determine the presence of substance abuse issues; discuss risks of suicide while intoxicated</td>
<td>• ED providers may be reluctant to ask questions that may lead to spending more time on the patient</td>
</tr>
<tr>
<td>✓ Determine whether to discharge or admit</td>
<td>• Need better decision-making tools</td>
</tr>
<tr>
<td>✓ In settings with limited BH resources, use tele-health resources, crisis center professionals and on-call psychiatric specialists</td>
<td>• Physicians/hospitals need better understanding of legal risks and protections of discharging someone who is suicidal</td>
</tr>
<tr>
<td>✓ Assess means risk; conduct means counseling</td>
<td>• Lethal means counseling training is needed</td>
</tr>
<tr>
<td>✓ Use a motivational interviewing approach to talk to patients*</td>
<td>• Providers need motivational interviewing training</td>
</tr>
<tr>
<td>✓ Re-engage patients with outpatient treatment; explore what is not working with outpatient care</td>
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<tr>
<td>✓ Document conversations that took place</td>
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<tr>
<td>Recommendations</td>
<td>Challenges/Barriers</td>
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<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>✓ Use sample discharge planning instructions</td>
<td>• Sample discharge instructions need to be developed</td>
</tr>
<tr>
<td>✓ If possible, bring family/supports into ED for after care planning</td>
<td>• Difficult for ED physician to determine family reliability</td>
</tr>
<tr>
<td>✓ Conduct safety planning</td>
<td>• Staff are busy</td>
</tr>
<tr>
<td>✓ 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</td>
<td>• Outpatient care options and community resources can be limited</td>
</tr>
<tr>
<td>✓ Activate crisis center follow-up protocol</td>
<td>• Difficult to talk in-person with outside provider(s)</td>
</tr>
<tr>
<td>✓ Consider substance abuse treatment</td>
<td>• Hospital should collaborate with substance abuse treatment community to make connections</td>
</tr>
<tr>
<td>✓ Communicate with outpatient provider</td>
<td></td>
</tr>
<tr>
<td>✓ Provide written instructions with Lifeline or other crisis center number and community resources</td>
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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

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

A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
ED: Discharge Planning

• Low rate of adherence to follow-up plan after ED discharge

• 50% fail to arrive at 1\textsuperscript{st} 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
Is Your Patient Suicidal? ED poster
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
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
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.


**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.

Contact Us:

Suicide Prevention Resource Center
Education Development Center, Inc.
1025 Thomas Jefferson Street, NW Suite 700
Washington, DC 20007
Phone: 202-572-3721
Fax: 202-223-4059
jgoldstein@edc.org
pwest@edc.org

http://www.sprc.org/

SPRC funded by the U.S. Department of Health and Human Service’s Substance Abuse and Mental Health Services Administration (SAMHSA) under grant no.5U79SM059945-02

SPRC is a project of EDC