

Assessment and Interventions for Potentially Suicidal Patients in Primary Care and Emergency Rooms

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Disclosure

- The presenters have no financial relationship to this program.

Goals and Objectives

- Review suicide risk and protective factors for patients presenting to primary care and emergency departments.
- Apply suicide risk screening tools, triage, and safety planning in the management of the suicidal patient.
- Describe the rationale for counseling on access to lethal means.

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

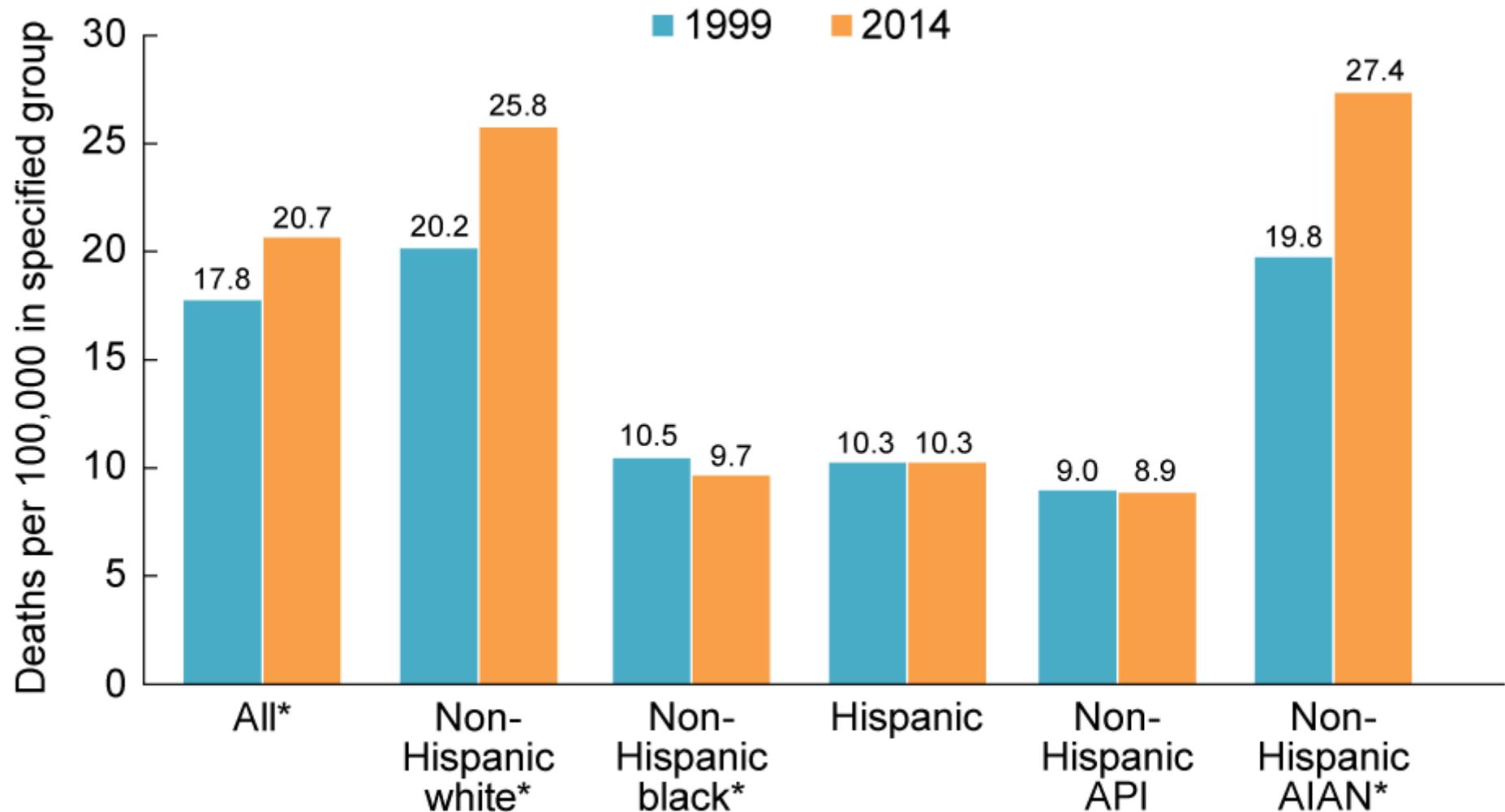
“At any given time, between two and four percent of your patients are having thoughts of suicide. They may come to your exam rooms presenting with many different concerns, but the one they may not be telling you about could be the one that will kill them – unless you and your staff are prepared.”

SPRC Suicide Prevention Toolkit

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

Figure 2. Age-adjusted suicide rates for males, by race and Hispanic origin: United States, 1999 and 2014

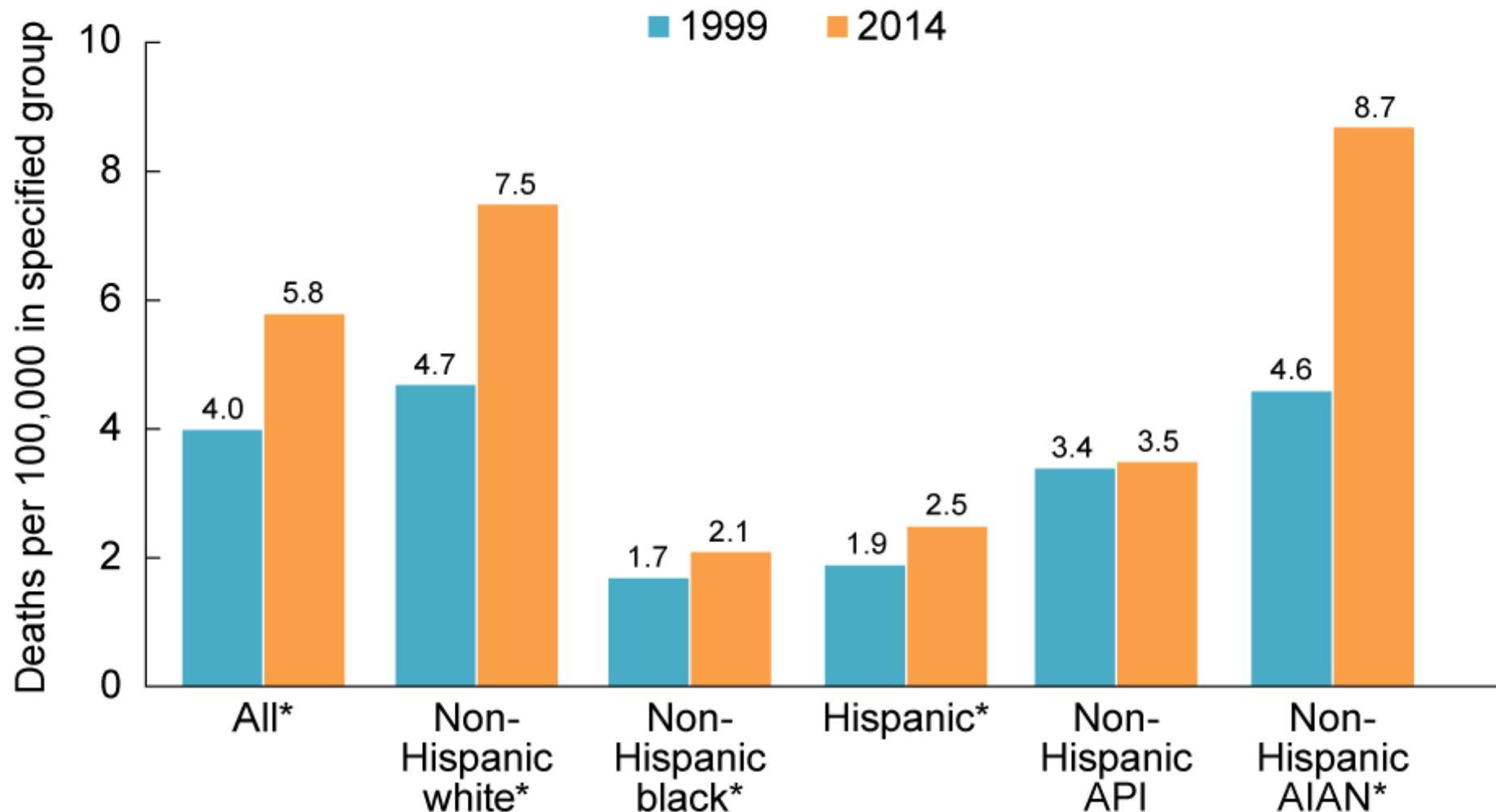


* Difference in rates between 1999 and 2014 was significant ($p < 0.05$).

NOTES: Suicide is identified with ICD-10 codes U03, X60–X84, and Y87.0. Death rates for non-Hispanic American Indian or Alaska Native (AIAN), non-Hispanic Asian or Pacific Islander (API), and Hispanic persons may be underestimated and should be interpreted with caution; see Data source and methods.

SOURCE: NCHS, National Vital Statistics System mortality data, 1999 and 2014, available from: [CDC WONDER online database](#).

Figure 1. Age-adjusted suicide rates for females, by race and Hispanic origin: United States, 1999 and 2014



* Difference in rates between 1999 and 2014 was significant ($p < 0.05$).

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SOURCE: NCHS, National Vital Statistics System mortality data, 1999 and 2014, available from: [CDC WONDER online database](https://wonder.cdc.gov/).

New Mexico Suicide Statistics

- The suicide rate in NM has been consistently at least 50% higher than the US rate
- In 2014 NM's suicide rate was the highest it's been in 20 years
- New Mexico ranks 3rd in the nation in deaths by suicide

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

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

PCPs 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)

ED Suicide Prevention

- Up to 8% of ED patients have active or recent suicidal ideation
- Multiple ED visits is a risk factor for suicide
- Up to 20% of patients who die by suicide were seen in the ED within 2 months of their death
- ED based suicide prevention interventions might decrease suicide deaths by 20% annually

Bad News/Good News

- PCPs and ED providers see patients at risk of suicide but...
 - Lack training in how to identify, assess, treat, and manage patients at risk of suicide
 - Are at risk of failing to identify patients at risk of suicide
 - In a study by USPTF suicide was discussed in 11% of encounters in which pts had screened + for suicidality (unbeknownst to their PCPs)
- The good news
 - Providers can learn to identify, assess, and manage patients at risk of suicide

Effective Prevention Strategies

- Train staff to identify and respond to warning signs of suicide
- Train providers to recognize and effectively treat depression
- Screen for suicide risk
- Educate patients about suicide warning signs
- Limit patients' access to lethal means of self-harm
- Develop safety plans with patients
- Follow up with potentially suicidal patients

Screening Recommendations

Comorbidity

- Mental illness is strongly associated with suicide
 - >90% of people who 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

Screen for Depression

- The US Preventative Services Taskforce recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

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
- Many other screening tools available

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

Screening for and Managing Depression

- If we train providers to recognize and treat depression we:
 - Increase prescription rates for antidepressants
 - Decrease suicidal ideation and completed suicides in patients
- Free downloadable toolkit for treating depression is available through **MacArthur Initiative on Depression and Primary Care**
- Best treatment approach combines medication and psychotherapy

Jose- Case History

- Jose is a 61 year old Hispanic male with grown children. He works as an electrician, is active in his church, and enjoys hunting with his sons. He owns a hunting rifle. He comes to see you due to tingling and numbness in the fingers of his right hand that is interfering with his work. He mentions feeling down and lonely a few days a week ever since his wife's death 2 years ago. His appetite is poor, he isn't sleeping well, and energy is low. You have him fill out a PHQ-9.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Jose PHQ-9

NAME: Jose DATE: 9/23/16

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 | 0 | 1 | 2 | 3 |

add columns 4 + 4 + 3

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: 11 = moderate depression

10. 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

Screen for Suicidality

JCAHO Sentinel Alert Event #56 (Feb 2016)

- **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** recommends that primary, emergency, and behavioral health clinicians take the following 3 steps to detect suicide ideation:
 - Review each patient's personal and family medical history for suicide risk factors
 - Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool
 - Review screening questionnaires before the patient leaves
 - Take action based upon the assessment results

Screening for Suicide Risk

- Patients with warning signs and/or screened +ve on PHQ 9 or other screening should be screened for suicidal thinking
- Ask directly about suicidal thoughts
 - Asking about suicide does not put the idea in someone's head
- Standardized instruments are available
 - E.g. Columbia Suicide Severity Rating Scale

Columbia Suicide Severity Rating Screeners

- Screener version appropriate for First Responders, gatekeepers, peer counselors
- Full version appropriate for behavioral health clinicians
- Versions for children, intellectually disabled
- Available in 100+ languages
- Versions to assess lifetime/recent/since last visit
- Flexible format, don't need to ask all the questions if not necessary
- Integrates information given by collateral sources family, caregivers

Jose 9/23/16

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points

Jose CSSRS
 Screener

| SUICIDE IDEATION DEFINITIONS AND PROMPTS: | Past month | |
|--|------------|----|
| | Yes | NO |
| Ask questions that are in bolded and underlined | | |
| 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? <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u> | ✓ | |
| 2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan." <u>Have you actually had any thoughts of killing yourself?</u> | ✓ | |
| 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." <u>Have you been thinking about how you might kill yourself?</u> | ✓ | |
| 4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent</u> to act on such thoughts, as oppose to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u> | | ✓ |
| 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. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u> | | ✓ |
| 6) Suicide Behavior Question <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> 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. If YES, ask: <u>How long ago did you do any of these?</u> • Over a year ago? • Between three months and a year ago? • Within the last three months? | | ✓ |

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 means
- 4. Determine Risk Level/Intervention
- 5. Document your thinking and what you did

High Risk Groups

- Aging white males have the highest suicide rate
- Adolescents have higher rates of suicide attempts, lower completion rates
- Hispanic females have the highest rate of youth suicide attempts
- Native Americans and Alaska natives age 10-39 have the highest suicide rate of all races and ethnicities
- LGBT
- Veterans are twice as likely to die of suicide as the general population
 - $\frac{3}{4}$ of US veterans received their healthcare from PCPs outside the VA

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

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

Assessing Protective Factors

- Important for everyone
- Are not a guarantee that someone will not attempt suicide especially in times when patient experiencing severe or multiple acute risk factors
- These can mitigate risk in people with moderate to low suicide risk
- Strengthening protective factors is part of safety planning

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?
- Ask if patient has attempted suicide in the past
- 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

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

Determine Risk Level/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-1

- 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”

Criteria for Involuntary Psychiatric Hospitalization

- **Criteria:**
 - Has a psychiatric disorder
 - Imminent danger to self or others due to suicidality, aggression, or grave passive neglect
 - Inability to maintain safety in a lower level of care (least restrictive means)
- **Special Issues with Minors**
 - If 14 or older, minor and guardian must both consent for a voluntary hospitalization; if either disagree or are not available, it is an involuntary hospitalization

High Risk-2

- Patient has suicide plan with preparatory or rehearsal behavior
- Patient has lower risk factors and good protective factors
- Take action to prevent the plan
 - Psychiatric consultation/psychopharmacology
 - Alcohol/drug assessment and referral
 - Therapy referral
 - Engage social support
 - Safety planning
- Call therapist if patient has one
- Document treatment plan

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
- 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

Jose-High, Medium, or Low Risk?

- Risk factors?
- Protective factors?
- Results of suicide inquiry?
 - Thoughts, plans, intent, access to lethal means

Psychiatric Emergency Protocol

- Just as offices have protocols for evaluation and management of medical emergencies, protocols should be developed for management of psychiatric emergencies

PCP Interventions

- Treatment of psychiatric symptoms
 - Depression
 - Anxiety
- Addressing substance use
 - Medication Assisted Treatment
 - SBIRT or other brief intervention
 - referral
- Strengthening the support network
 - Help patient identify and list supportive individuals and their contact information
- Developing a safety plan
 - Helping patient practice coping strategies
 - Limiting access to lethal means

Safety Planning

Educate Patients About Suicide Warning Signs & What to Do

- We educate patients about warning signs of stroke, 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 ED
- 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”
- In behavioral health, safety plans are usually done by patient working with a clinician
- In busy EDs/medical practices, safety plans may be done by the patient alone, with staff instructing patient on how to do so

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!



Components of a Safety Plan

1. Recognizing warning signs of a suicidal crisis
2. Identifying coping strategies (e.g. distraction, self soothing)
3. Utilizing friends and family members who can help distract from suicidal thoughts
4. Contacting friends and family who can help with the crisis (discuss the suicidal thoughts with them)
5. Contacting health professionals, including suicide warm lines or crisis lines, or going to local ED
6. Reducing access to lethal means

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

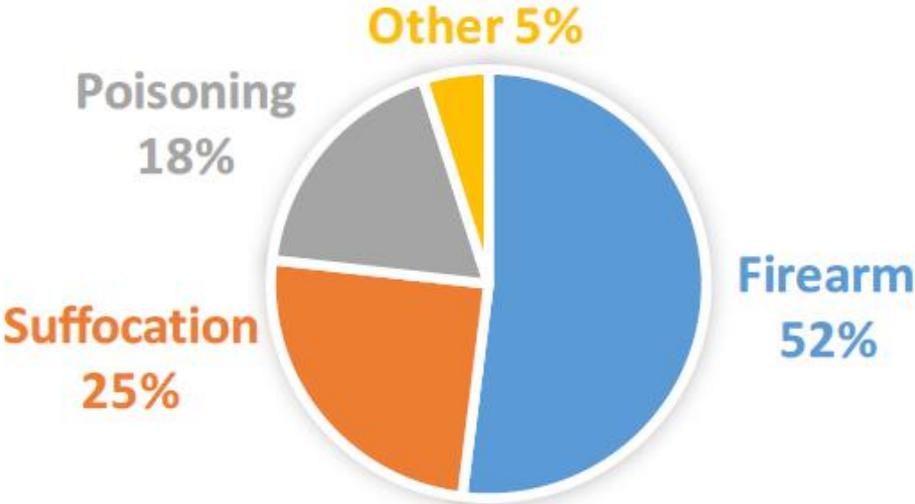
Br. J. Psychiatry 181:193–99 (Sept 2002)

Lethality of Methods of Suicide

- Intent isn't all that determines whether an attempter lives or dies
- Lethality of methods differs:
 - Guns are the most lethal means 84% fatal
 - Suffocation/Hanging 69% fatal
 - Falls 31% fatal
 - Poisoning/overdose 2% Fatal
 - Cutting 1% Fatal

Case fatality ratio by method of self-harm, USA 2001

Suicide Deaths by Mechanism, New Mexico, 2010-2014



Recommendations to Reduce Access to Lethal Means

- 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
- Consider handing out resource materials for educating patients and families
- Counsel patient 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

Discharge Planning-Best Practices

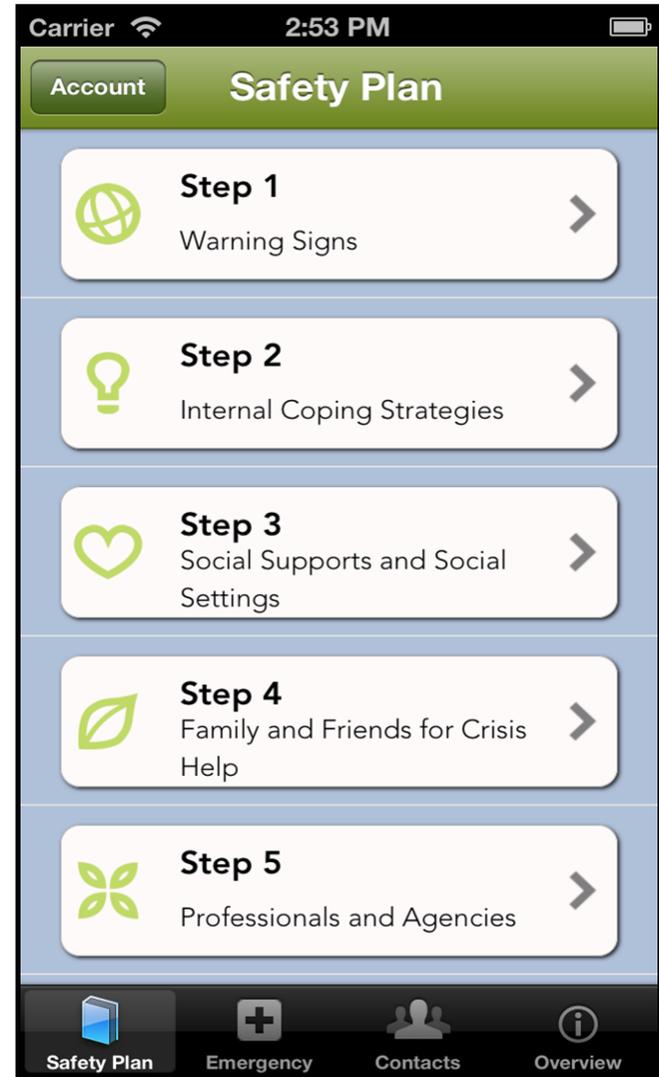
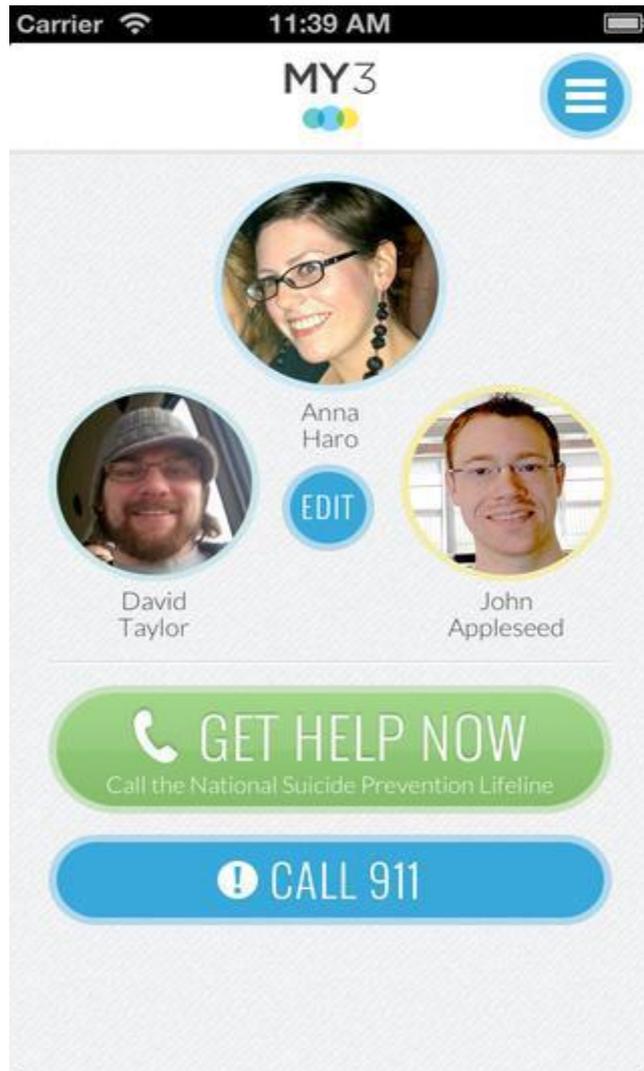
- Involve the patient in discharge planning
- Make follow-up appointments
- Review and discuss the patient care plan including review of medications and safety plan
- Discuss barriers to follow up
- Provide crisis line phone number
- Discuss limiting access to lethal means
- Provide written instructions and education materials
- Confirm that the patient understands the patient care plan
- Share patient health information with referral providers
- Communicate care and concern

Jose Case History-Discharge Plan

- Psychoeducation about grief and depression
- Encourage increased social support
- Do a Safety Plan with Jose
 - Consider having his son keep the rifle at his home
- Make a referral to behavioral health (non urgent)
- Consider referral to bereavement group
- Consider pharmacological treatment for depression
- Document what you did and why
- Caring Contact/Follow Up

Resources

My3 and Safety Plan Apps



SAFE-T

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



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



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>

NMCAL New Mexico Crisis and Access Line

- Statewide crisis and access line
- Toll-Free 24/7:
- 1 (855) NMCAL (662-7474)
1 (855) 227-5485 (TTY)
 - Veterans can press “1” and be directed to a crisis center run by the Dept. of Veterans Affairs
- Services:
 - Crisis intervention for suicidal and homicidal thoughts
 - Assistance with non-life-threatening mental health emergencies
 - Trauma response
 - Assistance with finding treatment resources
 - Assistance for those who have family members or loved ones who are experiencing a mental health crisis.

Other Suicide Prevention Hotlines

- **Suicide Prevention lifeline** 1-800-273-TALK
- **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

Peer “Warmline”

- New Mexico Peer to Peer Warmline number:
- 1-855-4NM-7100 or 1-855-466-7100
- Staffed with certified peer support specialists
- Hours 3:30-11:30 pm 365/7