TBHCE Webinar Series:
Screening, Assessing, Documenting Suicidality and the Ask Suicide-Screening Questions (ASQ) Tool

Presented by
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Disclosure Statement

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Learning Objectives

1. Examine terms used to describe suicidality.
2. Differentiate between screening and assessing for risk utilizing the Ask Suicide-Screening Questions (ASQ) tool.
3. Provide appropriate and ethical documentation and coding of suicidality and risk for self-harm.
Suicide is a serious Public Health problem

- Suicide remains in the top 10 leading causes of death for the United States.
  - Suicide increased nationally 37% between 2000 and 2018; decreased by 5% between 2018 and 2020; however nearly returned to their peak in 2021.

- In 2021, suicide was among the top 9 leading causes of death for people ages 10-64.

- Suicide was the second leading cause of death for people ages 10-14 and 20-34.

https://www.cdc.gov/suicide/facts/data.html
Terminology related to Suicide

- **Suicidal Behaviors**: Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

- **Suicidal Plan**: A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

- **Suicidal Ideation**: Is a broad term to describe a range of contemplations/thoughts, ideas, wishes, and preoccupation with taking one’s own life.

- **Suicide Attempt**: Is when someone tries to injure or harm themselves with any intent to end their life, but they do not die as a result of their actions.

- **Suicide**: Is death caused by injuring oneself with the intent to end their life.

- **Non-Suicidal Self Injury**: Intentional injury to the body such as cutting, pinching, scarring, burning, etc., of oneself as a means of coping with stressors; and without the intent to die.
Suicidal Thoughts and Suicide Attempts

Suicidal Behavior (U.S., 2021)

- 12,303,000 Had serious thoughts of suicide in past year* (18+)
- 3,525,000 Made any suicide plans in past year* (18+)
- 1,748,000 Reported suicide attempts* (18+)
- 45,979 Suicide deaths (includes adults and youth)

*Self-report

Source: CDC, 2021; SAMHSA, 2021
A higher percentage of all ages (18+) had **suicidal thoughts** than **made plans** or **attempted suicide** (U.S., 2021).

Across all age groups, a greater percentage of adults think about suicide than make a suicide plan or attempt suicide.³

Source: SAMHSA, 2023
Rates of suicidal thoughts and suicide plans and attempts were higher in **females** than **males** among **high school youth** (U.S., 2021).

In 2021, the percentages of female high school youth who felt sad, seriously considered suicide, made a suicide plan, or attempted suicide were higher than the percentage of male high school youth and male and female high school youth combined. Rates of suicidal thoughts and suicide attempts were higher among high school youth than among adults in general.  

Source: CDC, 2023
Past-Year Suicidal Thoughts and Behaviors Among High School Youth, U.S. 2021

Among high school youth, suicidal thoughts and behaviors vary by race and ethnicity. In 2021, American Indian and Alaska Native youth were more likely than youth of other racial or ethnic groups to seriously consider attempting suicide, make a suicide plan, or attempt suicide.³
States with the highest suicide rates in 2021:

1. Wyoming
   32 per 100,000

2. Montana
   32 per 100,000

3. Alaska
   31 per 100,000

4. New Mexico
   25 per 100,000

5. South Dakota
   23 per 100,000

Preventing Suicide Requires a Comprehensive Approach Infographic. CDC. (2023)
https://www.cdc.gov/suicide/pdf/2023_CDC_SuicidePrevention_Infographic.pdf
### Suicide rate disparities

Some groups have disproportionately high rates of suicide.

The racial/ethnic groups with the highest rates in 2021 were non-Hispanic American Indian and Alaska Native people and non-Hispanic White people.

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<thead>
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<th>Race/ethnicity</th>
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<td>Non-Hispanic American Indian/Alaska Native</td>
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</table>

Preventing Suicide Requires a Comprehensive Approach Infographic. CDC. (2023) https://www.cdc.gov/suicide/pdf/2023_CDC_SuicidePrevention_Infographic.pdf
Past-Year Suicidal Thoughts and Behaviors Among Adults in American Indian and Alaska Native (AI/AN) Populations (U.S., 2020)

- Past-Year Suicidal Thoughts: 9% (AI/AN) vs. 5% (Overall U.S.)
- Made a Past-Year Plan for Suicide: 1.7% (AI/AN) vs. 1.4% (Overall U.S.)
- Past-Year Suicide Attempt: 1.3% (AI/AN) vs. 0.7% (Overall U.S.)

A much higher percentage of American Indian and Alaska Native (AI/AN) populations reported past-year suicidal thoughts compared to the overall U.S. population (9% and 5%, respectively). The percentages of AI/AN populations reporting past-year suicide plans and suicide attempts are slightly higher than the percentages in the overall U.S. population.²

*Non-Hispanic
Source: SAMHSA, 2023

Past-Year Suicidal Thoughts and Behaviors Among High School Youth in American Indian and Alaska Native (AI/AN) Populations (U.S., 2021)

- Felt Sad or Hopeless: 40% AI/AN, 42% Overall U.S.
- Seriously Considered Attempting Suicide: 22% AI/AN, 27% Overall U.S.
- Made a Suicide Plan: 22% AI/AN, 18% Overall U.S.
- Attempted Suicide: 16% AI/AN, overall U.S.
- Suicide Attempt Requiring Treatment: 0% AI/AN, 3% Overall U.S.

**Percentage estimates for AI/AN youth who had a past-year suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse were too small to be reliable and are not included in this chart.

In 2021, a higher percentage of American Indian and Alaska Native (AI/AN) high school youth reported seriously considering attempting suicide in the past year, making a past-year suicide plan, and attempting suicide in the past year compared to youth in the overall U.S. population. The percentage of AI/AN high school youth who reported feeling sad or hopeless was similar to the percentage of the overall U.S. population.
Among American Indian and Alaska Native populations, the rates of death by suicide increased from 17 per 100,000 in 2011 to 24 per 100,000 in 2020. Over the same time period, the overall U.S. rates of death by suicide increased slightly, from 12 to 14 per 100,000.1

*Non-Hispanic
Source: CDC, 2021

Suicide Rates Among American Indian and Alaska Native (AI/AN) Populations in the U.S. by Age, 2011-2020

Among American Indian and Alaska Native (AI/AN) populations, suicide rates peak among those ages 25-34 and decline at age 35. Suicide rates begin to increase again at age 75.1

*Non-Hispanic
Source: CDC, 2021

Screening and assessment
Tools and Resources
Screening and Risk Assessment

• The current standard for identifying and responding to suicide risk is *screening* followed by a suicide *risk assessment*.

• *Universal screening* involves asking questions about suicide risk. For example, the Columbia-Suicide Severity Rating Scale asks about suicidal ideation and attempts in the past month or year.

• *Risk assessments*/stratifications classify individuals as high or low risk for future suicidal behaviors in order to determine the allocation of after-care aimed at preventing these behaviors.
Understanding Screening

• An interviewing or testing process that identifies areas of a client's life that might need further examination.

• Usually in the form of a questionnaire
  – Done through interview or form

• Evaluates for the possible presence of a problem

• Does not diagnose

• Does not usually tell you the severity of a problem
  – This is what assessments are for
Screening: refers to a procedure in which a standardized instrument or protocol used to identify individuals who may be at risk for suicide

Examples:

Screening tools:

- **Ask Suicide Screening Question (ASQ)** is a resource for medical settings and has variations available depending on type of setting:
  - ED, Inpatient/surgical unit, outpatient/primary care
  - Also available for child clients/patients

- The **Patient Safety Screener (PSS-3)** is a 3 item tool for use in acute care settings and for use for all patients entering care.

- **SAFE-T**: for use in outpatient settings. The items explore ideation, plan, behaviors, and intent.

- **Columbia Suicide Severity Rating Scale (C-SSRS)** can be used in several settings including primary care, ED, EMS, Governments, Military, Corrections, School systems, and even for use in families.
Assessments

- A more in-depth evaluation
- Confirms the presence of a problem
- Determines the severity and intensity of a problem
- Important to tailor treatment plan to client’s needs
- Surveys client strengths and resources for addressing life problems
- Examines possible diagnoses and how symptoms of the diagnoses affect a person’s life.
Screening and Risk Assessment

- Best practice recommendations for a more comprehensive suicide risk assessment include:
  - Assessing for suicidal ideation, intent, and planning
  - Identifying risk factors, warning signs, and protective factors
  - Identifying lethal means
  - Assessing the guardians’ capacity to provide an emotionally and physically safe environment
  - Gathering information from multiple sources including parents, teachers, and other collateral contacts.
Assessment: is a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to an individual, and help determine a course of treatment.

Examples:

- **Beck Scale for Suicide Ideation** measures passive and active suicidal desire for individuals in inpatient and outpatient settings; and can be used for adults and adolescents.
- **Marsha Linehan’s Reasons for Living** focuses on an individual’s reason for not dying by suicide/protective factors.
- The **Columbia Suicide Severity Rating Scale (C-SSR)** also has an assessment tool that expands off of the C-SSR screener.
- The **Chronological Assessment of Suicide Events (CASE)** is an interviewing strategy that assesses an individual’s risk for suicide.
- The **Ask Suicide Question (ASQ)** also has an assessment tool that expands off of its screener.
Co-Occurring Disorders
Screening and Assessment

• At least 3.8% of adults over the age of 18, approximately 9.5 million people in total had any co-occurring disorder

Suicide and Serious Mental Illness

Current Mental Health Status for Suicide Decedents in 46 States by Gender (U.S., 2020)

- Current Depressed Mood: 32% for Males, 32% for Females, 32% for Both
- Current Mental Health Problem: 44% for Males, 63% for Females, 48% for Both
- Current Treatment for Mental Illness: 21% for Males, 36% for Females, 24% for Both

Source: CDC, 2023

This bar graph presents the mental health status of suicide decedents at time of death in 46 U.S. states by gender. An equal percentage of male and female decedents in 2020 were experiencing current depressed mood. Compared to male decedents, a greater percentage of female decedents was identified as having a current mental health problem. Higher current treatment for mental illness was reported among females than among males.\(^1\)
Mental Health and Suicide History of Suicide Decedents in 46 States by Gender (U.S., 2020)

This bar graph presents the mental health and suicide history of suicide decedents in 46 U.S. states by gender in 2020. Compared to male decedents, a greater percentage of female decedents had been treated for a mental health problem in the past. A higher percentage of female decedents also had a history of suicidal thoughts or suicide attempts.¹

Source: CDC, 2023
Substance Abuse, Dependence, and Criminal Legal Problems Among Suicide Decedents in 46 States by Gender (U.S., 2020)

This bar graph presents substance abuse, dependence, and criminal legal problems among suicide decedents in 46 U.S. states by gender in 2020. Compared to female decedents, a greater percentage of male decedents was identified as having current alcohol dependence. The percentage of male decedents identified as having a current other substance abuse problem was slightly lower compared to female decedents. Other criminal legal problems percentages were higher in males than in females.¹
Problems with Assess & Refer Approach to Acute Suicidality

• Assessing risk for suicide is a crucial component of evaluations aimed at treatment disposition and planning for individuals with psychological problems. Typically, when suicidal patients are evaluated in the ED and hospitalization is not clinically indicated, they are provided with a referral for outpatient mental health.

• This “assess and refer” approach can be disconcerting to patients and their families. People can experience formal risk assessment and management processes as disempowering, as life context and personal decision making is mediated by clinical appraisal. The patient is not in the center of decisions about their plan.
Problems with Assess & Refer Approach to Acute Suicidality

• Adding to the anxiety of discharging patients who are experiencing some measure of suicidal feelings is the fact that many suicidal individuals do not attend recommended outpatient treatment following the ED visit.

• Between 11% and 50% of attempters refuse outpatient treatment or drop out of outpatient therapy very quickly.

• Furthermore, up to 60% of suicide attempters attend only 1 week of treatment post-discharge from the ED.

• Of those suicide attempters who attend treatment, 38% terminate within three months, a statistic that is particularly troubling because the first three months following a suicide attempt is when individuals are at the highest risk of additional suicidal behavior.
Ask Suicide Screening Questions (ASQ)
Screening and Brief Suicide Safety Assessment Tool
Indian Health Services and the ASQ

- The Zero Suicide initiative was launched within I.H.S. in 2018 to “develop a comprehensive model of culturally-informed suicide care within a system of care framework.”
  - Cohort One provided funding and training to eight sights including five Tribal partners and three federal facilities.

- In 2020, two years after ZS initiative launched the Phoenix Area agreed to participate in a QI pilot project utilizing the ASQ as a screening and assessment tool for suicide risk.
  - One facility noted an increase to 55% in screening among all ages, and jumped to 69% in 2021.
I.H.S Suicide Prevention Strategies Evaluation

• Based on findings from the Zero Suicide Initiative, a recent evaluation report noted three primary recommendations:
  – Formation of an I.H.S Suicide Risk Mitigation Program
  – Establishment of a formal policy to adopt the ASQ screening instrument I.H.S wide
    • “With the national adoption of the ASQ, IHS can improve and monitor patients’ clinical needs, support treatment referrals, and coordinate wrap-around services.”
  – Coordinate the national usage of the IHS Emergency Department Suicide Screening Dashboard
Ask Suicide Screening Questions Screening Tool

• The Ask Suicide Screening Questions (ASQ) is set of four brief suicide screening questions validated for use with both youth, as young as age 8 through adults.

• It can be used in multiple settings and includes resources for the clinical pathways below:
  – Emergency Department
  – Inpatient medical/surgical units
  – Outpatient primary care
  – Specialty clinics

• The screener is a set of four questions that takes minimal time to administer, and a fifth question that helps to tease out acuity.
Ask Suicide Screening Questions Screening Tool

• In the past few weeks, have you wished you were dead?
• 2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
• 3. In the past week, have you been having thoughts about killing yourself?
• 4. Have you ever tried to kill yourself?

If yes to any of the above questions, the next question must be asked to assess acuity.

• 5. Are you having thoughts of killing yourself right now?
If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (Clinical judgment can always override a negative screen).

- “Yes” to question #5 = acute positive screen (imminent risk identified)
  - Patient requires a STAT safety/full mental health evaluation.
  - Patient cannot leave until evaluated for safety.
  - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.

- No” to question #5 = non-acute positive screen (potential risk identified)
  - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an “against medical advice” (AMA) discharge.
  - Alert physician or clinician responsible for patient’s care.

Ask Suicide-Screening Questions

What to do when an adult patient screens positive for suicide risk:

1. **Praise patient** for discussing their thoughts

   "You’re here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling me. I want to ask you a few more questions."

2. **Assess the patient**

   - **Frequency of suicidal thoughts**
     - **Ask the patient:** "In the past few weeks, have you been thinking about killing yourself?"
     - If yes, ask: "How often?" (once or twice a day, several times a day, a couple times a week, etc.)
     - "When was the last time you had these thoughts?"
     - "Are you having thoughts of killing yourself right now?" (If yes, patient requires urgent STAT mental health evaluation and cannot be left alone. A positive response indicates treatment risk.)

   - **Suicide plan**
     - If the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).
     - Ask the patient: "Do you have a plan to kill yourself? Please describe." If no plan, ask: "If you were going to kill yourself, how would you do it?"

   - **Note:** If the patient has a very detailed plan, this is more concerning than if they haven’t thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and remaining or sending dangerous item (medications, guns, ropes, etc.).

   - **Post behavior**
     - Evaluate past self-harm and history of suicide attempts (method, estimated date, intent).
     - Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
     - "Did you want to die?" (for youth, intent is as important as lethality of method)
     - Ask: "Did you receive medical/psychiatric treatment?"

   - **Symptoms**
     - **Ask the patient about:**
       - Depression: "In the past few weeks, have you felt sad or depressed that it makes it hard to do the things you would like to do?"
       - Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly on edge?"
       - Impulsivity/recklessness: "Do you often act without thinking?"
       - Hopelessness: "In the past few weeks, have you felt hopeless like things would never get better?"
       - Isolation: "Have you been keeping yourself more than usual?"
       - Ineffectiveness: "In the past few weeks, have you been feeling less irritable or grouchy than usual?"
       - Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?"
       - "How much?"
       - Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

   - **Social Support & Stressors**
     - **Support network:** "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask: "When and for what purpose?"
     - **Safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety.)
     - **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"
3 Determine disposition

After completing the assessment, choose the appropriate disposition plan.
- Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).
  Urgent/non-urgent psychiatry; keep patient safe in ED.
- Further evaluation of risk is necessary:
  Request full mental health health/safety evaluation in the ED.
- No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)
  - Send home with mental health referrals.
  - or
  - No further intervention is necessary at this time

Comments: ____________________________

4 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
  En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741
SUICIDE RISK SCREENING PATHWAY

Yes to Question 8?

BSSA outcome
(Free possibilities)

LOW RISK
No further evaluation needed in the ED

HIGH RISK
Further evaluation of suicide risk is necessary; should not leave without a full safety assessment

EMERGENCY RISK
Patient is at imminent risk to suicide with current suicidal thoughts

SAFETY PRECAUTIONS
- Inpatient psychiatric or consult patient under direct observation; remove dangerous items, etc.

INITIATE SAFETY PRECAUTIONS
- Should not leave without a full safety assessment
- Notify family; alert ED provider

Conduct Full Suicide Safety Assessment

REFERRAL
To further mental health care or appropriate facility. Confirm emotional suicide safety education, i.e., "Communicate suicide

15 SAFETY EDUCATION
- Create safety plan for presented future suicidal thoughts
- Discuss suicide means restriction
- Provide resources:
  - 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255)
  - 688-663-5467
  - Crisis Text Line: Text "SOI" to 714-741

Initiate or maintain safety precautions; medically stabilize patient

Is patient being admitted for medical treatment?

NO

YES

Transfer to psychiatric unit
Safeguards precautions to be followed throughout transfer process

Handoff clinical risk assessment information to accepting psychiatric unit upon transfer from ED

Transfer to medical unit
Safeguards precautions to be followed throughout transfer process

Handoff clinical risk assessment information to accepting medical unit upon transfer from ED

Inpatient MEDICAL UNIT

V4.5.18

Documentation and Coding
Zero Suicide in the Emergency Department: The Chickasaw Nation Experience

Suicidal Behavior

- New DSM-5-TR symptom codes allow clinicians to indicate the presence or history of suicidal behavior and nonsuicidal self-injury.

- The suicidal behavior symptom code can be used for individuals who have engaged in potentially self-injurious behavior with at least some intent to die as a result of the act.
- Evidence of intent to end their life can be explicit or inferred from the behavior or circumstances.
- A suicide attempt may or may not result in self-injury. If the individual is dissuaded by another person or changes their mind before initiating the behavior, this category does not apply.

- Evidence of intent to end their life can be explicit or inferred from the behavior or circumstances.

- A suicide attempt may or may not result in actual self-injury.
Suicidal Behavior Coding

- The suicidal behavior symptom code may be used for individuals who have engaged in potentially self-injurious behavior with at least some intent to die as a result of the act. Evidence of intent to end one’s life can be explicit or inferred from the behavior or circumstances.

- (T14.91A) Initial encounter: Use while the individual is receiving active treatment for the condition (e.g., emergency department encounter, evaluation and treatment by a new clinician)

- (T14.91D) Subsequent encounter: Use for encounters after the individual has received active treatment for the condition and when they are receiving routine care for the condition during the healing or recovery phase (e.g., medication adjustment, other aftercare and follow-up visits).

- (Z91.51) History of Suicidal Behavior: If suicidal behavior has occurred during the individual’s lifetime
Nonsuicidal Self-Injury Coding

- The Nonsuicidal Self-Injury symptom code may be used for individuals who have engaged in intentional self-inflicted damage to their body that is likely to induce bleeding, bruising, or pain (for instance, by cutting, burning, stabbing, hitting, or excessive rubbing) in the absence of suicidal intent.

- (R45.88) Current Nonsuicidal Self-Injury
  - If nonsuicidal self-injurious behavior is part of the clinical presentation

- (Z91.52) History of Nonsuicidal Self-Injury
  - If nonsuicidal self-injurious behavior has occurred during the individual’s lifetime

Slide Courtesy Dr. Avron Kriechman, UNM Department of Psychiatry and Behavioral Sciences
Elements of Responsible and Effective Care for Suicidal Patients

- Informed consent: initiated at the onset to disclose ethical and legal responsibilities of the provider and limits to confidentiality so provider and patient work together to keep the patient safe.

- Thorough assessment of suicide risk: use of suicide risk factors and warning signs, standardized suicide risk assessment frameworks, risk categorizations, and suicidal symptom severity scales.
Elements of Responsible and Effective Care for Suicidal Patients

- Empirically supported suicide-specific treatment plans and treatments: include safety planning, crisis response planning, appropriate use of medication and hospitalization, and “the explicit development of coping techniques that may render suicidal coping obsolete over time.”

- Consultation with colleagues and possible use of decisions by consensus for difficult or complex cases.

- Careful documentation: of risk level, action taken, safety planning, treatment response and modification, and continuity of care.

- Dissemination of accurate, nonjudgmental information regarding suicide and its prevention.
Upcoming IHS Suicide Prevention Webinars
National Strategy for Suicide Prevention

- Lessening Harms and Preventing Future Risk: Teaching Coping and Problem-solving Skills via Safety Planning
- Lessening Harms and Preventing Future Risk: Lethal Means Restriction Counseling
- Youth, Social Media, Suicidality and the LGBTQ Community
- Postvention: Supporting Survivors of Suicide Attempts
- Postvention: Supporting Survivors of Suicide Loss
Resources

• Ask Suicide Screening Question Toolkit: https://sprc.org/sites/default/files/resource-program/asQToolkit_0.pdf

• CALM Course:  https://zerosuicidetraining.edc.org/enrol/index.php?id=20

• Columbia Suicide Severity Rating Scale: https://childadolescentpsych.cumc.columbia.edu/professionals/research-programs/columbia-suicide-severity-rating-scale-c-ssrs

• ICD-10 codes used to define underlying causes of death due to alcohol, drugs or suicide

• Minino, A. Coding and classification of causes of death in accordance with the Tenth Revision of the International Classification of Diseases

• Stanley Brown Safety Plan:  https://suicidesafetyplan.com/forms/

• Suicide Prevention Resource Center: www.sprc.org
References

• The Action Alliance: www.theactionalliance.org

• Suicide Prevention Resource Center: www.sprc.org

• Centers for Disease Control and Prevention: www.cdc.gov
  https://www.cdc.gov/suicide/facts/index.html

• NIH: National Library of Medicine

• Rural Health Info.
  https://www.ruralhealthinfo.org/toolkits/suicide/2/community-connectedness
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