Suicide Prevention in Primary Care

A Toolkit for Primary Care Clinicians and Leaders

association of clinicians for the underserved

CENTENE® Corporation

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Addressing Suicide Prevention for Underserved Patients

A Toolkit for Primary Care Clinicians and Leaders

Suicide prevention has been named a national priority and much work has been done to review existing evidence and identify gaps in how our nation's mental health and health care systems address this public health challenge. A national task force that was part of the effort to update the national suicide prevention strategy reviewed research and best practices from the field and concluded that suicide prevention could be improved in health care. The task force found three common characteristics among successful suicide prevention programs in health care settings. Health care staff in these organizations:

- **Believed that suicide can be prevented in the population they serve through improvements in service access and quality, and through systems of continuous improvement;**
- **Created a culture that finds suicide unacceptable and sets and monitors ambitious goals to prevent suicide; and**
- **Employed evidence-based clinical care practice, including standardized risk stratification, evidence-based interventions, and patient engagement approaches[1].**

The task force's recommendations formed the foundation of the Zero Suicide Approach for health care organizations. **The recommendations contained in this guide are based on those offered in the comprehensive Zero Suicide in Health and Behavioral Health Care Toolkit [http://zerosuicide.sprc.org/toolkit]. Here they have been adapted specifically for primary care organizations and clinicians who care for underserved populations.**

The guide focuses on two core components:

1. **Screening and assessment**
2. **Care management and referral processes**

The final section contains some additional information on administrative and legal issues providers and leaders may find helpful to support integration of safer suicide care in practice. Many providers and clinical leaders erroneously assume if they discuss suicide with a patient they open up themselves to liability. Utilizing a patient safety approach, primary care organizations can establish safer suicide care practices that deliver high quality care to patients and reduce risk to the organization.

In each section of this guide you will find:

- **Information summarized for providers, including some helpful provider communication tips.**
- **A list of recommended trainings and resources to learn more.**
- **Leadership actions organizations may wish to undertake to help providers reduce suicide in their organization's patient population, and**
- **Relevant tools, templates and case studies.**

This toolkit begins with a brief background on the impact of suicide and offers a case study illustrating how one federally qualified health center adopted a safer suicide care model.

[1] Hogan, M.F., Goldstein Grumet, J. (2016). Suicide Prevention: An Emerging Priority for Health Care. Health Aff. Jun 1;35(6):1084-90. doi: 10.1377/hlthaff.2015.1672.

BACKGROUND:
Suicide—The Problem and the Opportunity

A. Why primary care should make suicide care a priority

The rate of suicide deaths is increasing

Suicide is a leading cause of death of the United States, cited as the cause of death for nearly 45,000 Americans in 2016[2]. The suicide rate among individuals age 10 and older has increased by 30 percent since 1999[3]. A report released by the Centers for Disease Control and Prevention (2018) revealed that suicide rates increased in all but one state between 1999 and 2016. In 2016, 9.8 million adults aged 18 and older, or about 4 percent of the adult population, reported serious thoughts of suicide[4].

Suicide is linked to social determinants of health[5]

Suicide is rarely caused by any single factor. Diagnosed depression or other mental health conditions are reported for less than half (46 percent) of suicide deaths. Other factors that contribute to suicide deaths include relationship problems, substance use, physical illness and chronic conditions, job loss, and financial troubles[6]. The National Strategy for Suicide Prevention calls for a comprehensive approach to suicide prevention that includes action at individual, family, community, and societal levels[7].

Primary care teams are uniquely positioned to identify risk and intervene

Primary care providers in particular have a unique opportunity to incorporate suicide prevention into established health risk assessment and patient safety practices[8]. **Approximately 45 percent of individuals who died by suicide visited a primary care provider in the month before their death[9, 10].**

Suicide is often discussed in the context of mental illness, and suicide prevention is considered an issue that mental health agencies and systems should address. **However, given that mental health conditions are only one of many factors that contribute to suicide risk, it is incumbent upon all sectors of the U.S. healthcare system to adopt evidence-based approaches to identify and care for those at risk for suicide.**

2 Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1
3 ibid.
4 Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/
5 According to Health People 2020, social determinants of health Soc conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
6 Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1
7 Office of the Surgeon General; National Action Alliance for Suicide Prevention. 2012 National strategy for suicide prevention: goals and objectives for action. Washington, DC: US Department of Health and Human Services, Office of the Surgeon General; 2012. https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf
8 National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc.
9 Ahemdani, B.K., Simon, G.E., Steward, C., Beck C., Waitzfelder, B.E., Rossom, B. …Solberg, L.I. (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, 29(6), 870-877.
10 Luoma JB, Martin CE, Pearson JL. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002 Jun;159(6):909-16

Health Disparities and Suicide Facts

Gender

- → The suicide rate for males (21.3 per 100,000) is triple the rate for females (6.0) in the U.S. in 2016[11].
- → Suicide was the 7th leading cause of death among all males in the U.S. and the 2nd leading cause of death for males aged 15-34 in 2015[12].
- → Although males are at higher risk for suicide, between 1999 and 2016 the suicide rate increased at a higher rate among females (2.6%) as compared to males (1.1%)[13].

Age

- → Young adults, aged 18 to 25 are more likely to have serious thoughts of suicide (approximately 8.8 percent)[14].
- → Although White males 75 years of age and older have the highest rates of suicide (48.0 per 100,000), the highest number of deaths from suicide occur among males aged 50-54[15].

Race/Ethnicity

- → American Indian and Alaska Native populations have the highest rates of suicide overall, followed by non-Hispanic Whites, Asian and Pacific Islands, Blacks, and Hispanic/Latino(a).

Urban/Rural

- → Suicide rates are higher in rural communities than in urban communities overall. The gap in suicide rates between rural and urban areas grew steadily between 1999 and 2015.
- → Non-Hispanic blacks were the only population that differed in this trend and have higher suicide rates in urban areas than in rural areas.
- → The suicide rate among American Indian and Alaska Native populations in rural areas is double the national average[16].
- → Access to firearms may contribute to disparities in suicide rates in rural areas[17].

Special Populations

- → Justice involved individuals are at increased risk for suicidal thoughts or behaviors. Suicide is the third leading cause of death in prisons[18].
- → The suicide rate among Veterans is 41% higher than among the general U.S. population[19].
- → Youth in foster care may also be at an increased risk for suicidal behaviors.

11 NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. Accessed at: https://wisqars-viz.cdc.gov/.
12 Centers for Disease Control and Prevention. Leading Causes of Death in Males, 2015. https://www.cdc.gov/healthequity/lcod/men/2015/index.htm
13 Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1
14 Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/
15 NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. Accessed at: https://wisqars-viz.cdc.gov/.
16 Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017.
17 Ivey-Stephenson AZ, Crosby AE, Jack SP, Haileyesus T, Kresnow-Sedacca M. Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death — United States, 2001–2015. MMWR Surveill Summ 2017;66(No. SS-18):1–16. DOI: http://dx.doi.org/10.15585/mmwr.ss6618a1
18 Mumola C. Suicide and homicide in state prisons and local jails. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2005. (Bureau of Justice Statistics Special Report
19 Suicide among veterans and other Americans 2001-2014. (2016). Office of Suicide Prevention, Department of Veterans Affairs. Retrieved from https://www.mentalhealth.va.gov/docs 2016suicidedatareport.pdf.

B. Primary care teams can be champions of the Zero Suicide Approach

Suicide is a public health problem and suicide prevention can be integrated into routine primary care services, along with other preventive screenings and interventions. Leaders that help to equip care teams with the right training and tools can help to advance two core beliefs:

1. **Suicide can be prevented.**
2. **Zero suicides is an ambitious and just goal.**

Implementing the Zero Suicide Approach in the primary care setting is an organization-wide initiative that begins with strong leadership. Implementation of the approach will have far greater success if it is built upon a foundation of organizational culture that embraces these two core beliefs and makes clear that suicide prevention is everyone's responsibility.

Although primary care clinicians do play a critical role in addressing suicide risk with patients, all members of the care team participate in preventing suicide and providing care to those at risk.

Innovative primary care organizations and other early adopters of the Zero Suicide approach have led the way. Acting on the foundational belief that it's possible to prevent suicide deaths for individuals under care within health and behavioral health systems, Zero Suicide presents "both a bold goal and an aspirational challenge," according to leaders of the national effort.

> "For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care; and to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients."
>
> **Mike Hogan, PhD**, Former Commissioner for Mental Health Services, New York State

Providing safer suicide care is now a nationwide effort, involving primary care providers, professional associations, and state government agencies.

C. How primary care providers and administrators can take action

No single strategy or approach will prevent suicide within a primary care organization's patient population. Rather, a comprehensive approach that embeds evidence-based practices throughout the organization can reduce suicide deaths.

Getting Started with Key Action Steps:

- **Establish protocols for routine suicide screening, assessment, intervention and referral,**
- **Review care management and referral processes to identify opportunities to enhance support offered to patients at risk for suicide,**
- **Adopt evidence-based brief interventions proven to help at risk patients,**
- **Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling,**
- **Work with your local health care delivery system partners to enhance continuity of care by sharing patient health information with emergency care and behavioral health care providers to create seamless care transitions, and**
- **Provide information on the National Suicide Prevention Lifeline crisis line and services.**

Case Study: The Institute for Family Health shows reducing suicide is feasible in a community health center setting

The Institute for Family Health, a not-for-profit community health center network located in New York, launched a two-prong approach striving for a zero suicide rate in the populations it serves. In 2008, the Institute implemented a policy mandating suicide prevention training for every employee.

The Institute's second initiative was implementation of the Electronic Health Record (EHR) system Epic for the identification and assessment of patients at risk for suicide. While the Institute implemented Epic, it simultaneously launched a depression identification and treatment program, making it the first organization to build the PHQ-9 depression screening tool into their EHR, scoring it as a lab value. When the PHQ-9 score is a 10 or above, it is added as an abnormal lab value in the EHR, which then alerts providers to the patient's potential risk. While electronic health technology and the use of the PHQ-9 has advanced since that time, the Institute maintains one of the country's highest screening rates at almost 90%.

Now, the Institute requires that all patients who respond positively to the PHQ-9 suicide screening question have "suicide ideation" put on their problem list, which means it is visible to all providers who see the patient regardless of discipline, and it is "blown in" to each provider's note, automatically bringing immediate attention to the patient's risk for suicide. Staff are required to ask the patient if they are at risk. Then, they must develop and review the safety plan and, if necessary, seek mental health support if they are not a mental health provider.

PART ONE:
Routine Screening and Assessment in Primary Care

Screening for suicide improves patient safety and represents a huge opportunity for primary care providers and care teams to improve patient safety, but there are still many unknowns and the evidence and recommendations continue to evolve.[20]

In 2016 when it issued its Sentinel Event alert, the Joint Commission, an independent agency that accredits and certifies health care organizations in the United States, urged that all primary, emergency, and behavioral health clinicians take eight steps to prevent suicide, including steps 1-3 related to screening[21]:

1. **Review each patient's personal and family medical history for suicide risk factors.**
2. **Screen all patients for suicide ideation[22], using a brief, standardized, evidence-based screening tool.**
3. **Review screening questionnaires before the patient leaves the appointment or is discharged.**

A. Linking suicide and depression screening in primary care

Primary care clinicians working in underserved practice settings are making great strides in integrating behavioral health and primary care to better address the needs of patients. In 2016, 60.3 percent of patients over the age of 12 received a routine screening for depression and had a follow-up care plan as appropriate[23]. Primary care clinicians can use these routine screening practices as a foundation and include within these processes a specific focus on suicide screening.

In a 2011 study of U.S. primary care providers, suicide was discussed in only 11 percent of encounters with patients who had screened positive for suicidal ideation, unbeknownst to their providers[24]. A significant body of research shows that a brief screening tool can identify individuals at risk for suicide more reliably than leaving the identification up to a clinician's personal judgment[25].

[20] In 2014, the U.S. Preventive Services Task Force reviewed current evidence and concluded,"Limited evidence suggests that primary care-feasible screening instruments may be able to identify adults at increased risk of suicide, and psychotherapy targeting suicide prevention can be an effective treatment in adults. Evidence was more limited in older adults and adolescents; additional research is urgently needed."

[21] https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

[22] Suicidal thoughts, or suicidal ideation, means thinking about or planning suicide.

[23] Health Resources and Services Administration. National Uniform Data System (UDS) reporting. Accessed online: https://bphc.hrsa.gov/uds/datacenter.aspx

[24] Vannoy SD, Robins LS. Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps A mixed methods analysis. BMJ. 2011;1(2):e000198. [PubMed] [Reference list]

[25] 26. Simon GE, et al: Do PHQ depression questionnaires completed during outpatient visits predict subsequent suicide attempt or suicide death? Psychiatric Services, December 1, 2013;64(12):1195–1202. 27. Shaffer D, et al. The Columbia Suicide Screen: Validity and reliability of a screen for youth suicide and depression. Journal of the American Academy of Child and Adolescent Psychiatry, 2004;43:71-79. 28. Cauffman E. A statewide screening of mental health symptoms among juvenile offenders in detention. Journal of the American Academy of Child and Adolescent Psychiatry, 2004;43:430-439. 29. Joiner TE Jr, et al. A brief screening tool for suicidal symptoms in adolescents and young adults in general health settings: Reliability and validity data from the Australian National General Practice Youth Suicide Prevention Project. Behaviour Research and Therapy, 2002;40:471-481. 30.

Part 1

B. Know common risk factors and warning signs

In addition to integrating routine suicide screening into primary care, it is important for primary care teams to understand the risk factors, warning signs, and the difference between the two. Knowing the risk factors can help primary care teams identify patients that may require further assessment for suicide and responsive care through brief interventions.

Primary care clinicians and leaders must also work to dispel myths that suicide is directly linked to mental illness. Suicide is rarely caused by any single factor, rather determined by multiple factors. Diagnosed depression or other mental health conditions are only one of many risk factors for suicide[26, 27] (see a complete list risk factors at the end of this section). Given that these risk factors are likely common among patients served in underserved primary care practices, integrating routine screening can help identify patients at greater risk. Routine screening is not intended to predict suicide but rather to plan effective suicide care.

The American Foundation for Suicide Prevention lists the following warning signs and risk factors[28].

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of sharpest concern if the new or changed behavior is related to a painful event, loss, or change.

If a person talks about:

- → **Feeling hopeless**
- → **Feeling trapped**
- → **Having no reason to live**
- → **Being a burden to others**
- → **Experiencing unbearable pain**

Behaviors that may signal risk, especially if related to a painful event, loss or change:

- → **Increased use of alcohol or drugs**
- → **Looking for a way to end their lives, such as searching online for methods**
- → **Isolating from family and friends**
- → **Visiting or calling people to say goodbye**
- → **Aggression**
- → **Withdrawing from activities**
- → **Sleeping too much or too little**
- → **Giving away prized possessions**
- → **Fatigue**

People who are considering suicide often display one or more of the following moods:

- → **Depression**
- → **Rage**
- → **Humiliation**
- → **Impulsivity**
- → **Sudden sense of peacefulness**
- → **Loss of interest**
- → **Irritability**
- → **Anxiety**
- → **Despair**

Scott M, et al. The Columbia suicide screen: Does screening identify new teens at risk? Presented at the American Academy of Child and Adolescent Psychiatry; October 21, 2004; Washington, D.C. 31. Simon GE, et al: Does response on the PHQ-9 depression questionnaire predict subsequent suicide attempt or suicide death? Psychiatric Services, December 2013;64(12):1195-1201.

[26] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1

[27] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1

[28] https://afsp.org/about-suicide/risk-factors-and-warning-signs/

C. Review of screening protocol and tools

The Suicide Prevention Resource Center and the Joint Commission have studied best practices in screening for suicide and make the following recommendations.

1. **Screen all patients using a basic patient health questionnaire.**
   Many primary care settings rely on the PHQ-9[29] for screening all patients over age 12 for depression. This screening tool includes item 9, which asks specifically about suicidal thoughts, "Over the past two weeks, have you been bothered by… thoughts that you would be better off dead or of hurting yourself in some way."

2. **Consider adding some additional questions to the PHQ-9.**
   Some suicidal patients won't answer yes to item 9, but may still be suicidal. More direct questions can include:

   Over the past two weeks have you been bothered by:

   - → **Little interest or pleasure in doing things?**
   - → **Feeling down, depressed or hopeless?**
   - → **Thoughts that you want to kill yourself or have you attempted suicide?**

3. **If the PHQ-2 is used for routine screening, consider adding in question 9.**
   The PHQ-2 screens for depression but does not ask specifically about suicide. Some clinicians start with the PHQ-2 and move on to the PHQ-9 if the patient responds "yes" to questions about depression. One concern about this approach is that a patient could answer "no" to the questions and still be having suicidal thoughts that go undetected. Organizations may consider adding a question specific to suicide to the brief screening tool.

Help from your EHR

One tool that primary care practices can use to support this protocol is the electronic health record (EHR). Embedding prompts for each of the steps described above can help clinicians and staff to adhere to the protocol and elevate the standard of care for patients at risk of suicide.

- → **EHR systems that have built in templates may allow entry of the patient's overall score. Some systems allow entry of the patient's answer to question 9 on the PHQ-9. Entry of a "yes" answer then prompts an assessment protocol. Suicide risk should be put on the problem list.**
- → **Some EHR systems can be configured to record safety and contingency plans, a list of referrals made and why, and a plan for follow-up with the patient and other caregivers. If your EHR doesn't have a place for safety plans, consider scanning them in to the patient record.**
- → **An alert should be added on the record of patients who are being monitored and treated for suicide risk so that each time a patient is seen EHR alerts or banners can serve as a reminder that the patient's suicide status must be addressed.**

[29] Spitzer, R. L., Williams, J. B. W., Kroenke, K., et al. (2001) Patient health questionnaire-9 (PHQ-9). Retrieved from http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

D. Suicide risk assessment

Once screening shows some risk for suicide, additional instruments can then be deployed to get more detail and a better assessment of risk.

If the patient answers yes to any of these questions in the PHQ-9 (item 9 and or additional questions) or the provider has other reasons to suspect suicide may be a concern, a complete assessment of thinking, behavior, and risk should be done immediately. There are a few tools available to further assess suicide risk. The Columbia-Suicide Severity Rating Scale (C-SSRS) is one example of an assessment tool primary care practices could use for this purpose. The C-SSRS guides the provider through a series of questions, including whether the patient has been thinking about a method, whether there is some intent behind their thoughts of suicide, whether they have a plan, and any suicidal behavior.

Provider Communication Tip

- → **Be sure to orient your patients before moving into the C-SSRS.**
- → **Ask matter of fact questions.**
- → **Orient ahead of time that you are going to follow up on these questions but you have to ask the most important questions first.**
- → **Sample introduction to the assessment: "At our organization we feel that it is really important we ask you about suicide. As a provider, I know that suicidal thoughts are not unusual, and at the same time they are a good measure of how much people are suffering"**

All staff in the primary care organization can benefit from training on effective communication practices when working with someone at heightened risk for suicide. There are a number of evidence-based trainings emerging that are appropriate for all staff within health care organizations.

Resources: Routine Screening and Assessment in Primary Care

Action Steps	Trainings and Resources
Establish a training plan to support all staff in adopting suicide safe communication strategies.	SafeTALK curriculum (https://www.livingworks.net/)
	Mental Health First Aid (https://www.mentalhealthfirstaid.org/)
Identify comprehensive screening tools like the PHQ-9 and a more comprehensive assessment tool like the C-SSRS.	Screening and Assessment for Suicide in Health Care Settings (http://zerosuicide.sprc.org/webinar/screening-and-assessment-suicide-health-care-settings) Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/cssrs_web/course.htm)
Establish a policy to screen all patients over the age of 12 using a standardized screening tool.	Patient Health Questionnaire – 9 (PHQ-9) (http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf)
	Columbia Suicide Severity Rating Scale -- see Appendix
Establish a protocol for responding to positive depression screens and/or answers of "yes" to question 9 on the PHQ-9.	Joint Commission Alert with eight steps on how to prevent suicide. See https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf
If possible, update your organization's EHR to reflect the steps outlined in the "Help from your EHR" listing on page 8.	Engage Patients at Risk for Suicide in a Care Plan: Using the Electronic Health Record (http://zerosuicide.sprc.org/toolkit/engage/using-electronic-health-record)
Train staff on the protocol for administering the screening and documenting patient responses in the patient record.	Assessment of Suicidal Risk Using C-SSRS (http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm)

The American Foundation for Suicide Prevention lists the following risk factors for increased risk of suicide:

Health Conditions:

- Mental health conditions
- Substance abuse disorders
- Alcohol abuse disorders
- Serious or chronic health conditions
- Chronic pain
- Limited access to healthcare
- Sleeping difficulties

Identifiable Stressors:

- Relationship loss or challenges such as a death, **divorce**, separation
- Job loss
- Harassment, bullying, relationship problems
- Financial or school difficulties

Environmental Factors:

- Access to lethal means including firearms and drugs
- Exposure to suicide in the media or community

Past Suicidal Behavior:

- Previous suicide attempts
- Family history of suicide attempts
- History of self-harm
- Recent hospitalization
- Cultural beliefs that support suicide

Patient Health Questionnaire - 9 (PHQ-9)

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

For office coding **0** + _____ + _____ + _____

= Total Score: _____

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

Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult ○

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an education grant from Pfizer Inc.
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Part 1

Columbia-Suicide Severity Rating Scale

Primary Care Screen with Triage Points

Ask questions that are in bold.

	Past Month YES	Past Month NO
Ask Questions 1 and 2		
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual thoughts of killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "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.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Response Protocol to C-SSRS Screening

- Item 1 and Item 2: Behavioral Health Referral
- Item 3: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4 and Item 5: Behavioral Health Consultation and Patient Safety Precautions
- Item 6: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precaution
- Item 6: 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Developed by Columbia University, the University of Pennsylvania, and the University of Pittsburgh — supported by the National Institute of Mental Health (NIMH).

PART TWO:
Suicide Care Management and Referral Process

Every patient who is identified as being at risk for suicide must be closely followed through a Suicide Care Management Plan. It is essential to continuously assess risk, engage patients in their treatment and safety plan, and re-engage patients at every encounter, no matter the reason for the visit. These steps cannot just fall on one provider—they are the responsibility of a whole care team and organization committed to reducing suicide.

Ideally, part of care management will include referrals to qualified behavioral health providers as appropriate. However, primary care teams can provide high quality care to patients at risk of suicide.

A. Care management plan

The Suicide Care Management Plan includes a package of evidence-based protocols and interventions to mitigate the risk of suicide. Key components include:

- The screening tool and criteria to indicate that the patient should be engaged in a Suicide Care Management Plan
- Same-day access to a behavioral health professional for formulation of a clinical judgment of risk using a standard risk formulation framework
- Requirements and protocols for safety planning, crisis support planning, and, when needed lethal means reduction (see additional details in the Part Three below)
- Frequency of visits for a patient with a Suicide Care Management Plan and actions to be taken when the patient misses appointments or drops out of care
- Process for communicating with a patient about diagnosis, treatment expectations, and what it means to have a Suicide Care Management Plan
- Requirements for continued contact with and support for the patient, especially during transitions in care
- Referral process to suicide-specific, evidence-based treatment
- How documentation of progress and symptom reduction will take place
- Criteria and protocols for closing out a patient's Suicide Care Management Plan

B. Brief evidence-based interventions

Primary care providers can help support patients at risk for suicide using brief interventions. These can be utilized during the period between assessment and referral to follow-up behavioral health care. These brief interventions may also assist care teams to begin offering safer suicide care in areas where access to behavioral health care is limited. Brief interventions include:

1. Creating a safety plan with the patient
2. Reducing access to lethal means
3. Using clear and caring provider-patient communications
4. Implementing Caring Contacts

Treating suicidal ideation specifically and directly, independent of any diagnosed mental health or substance abuse problem, in the least restrictive setting demonstrates promising results in reducing suicide attempts[30]. Primary care clinicians and care team members can use these brief interventions as part of a care management plan.

1. Make a safety plan

Apart from those needing emergency hospitalization, most patients at risk of suicide will benefit from establishing a Safety Plan with their primary care provider. Establishing a safety plan is an evidence-based best practice[31]. The Safety Plan should:

- Be brief, in the patient's own words, and easy to read
- Involve family members as full partners in the collaborative process, especially to establish their role in responding to patient crises
- Include a plan to restrict access to lethal means, which is also balanced with respect to legal and ethical requirements under federal and state laws
- Be updated whenever warranted
- Be in the patient's possession when she or he is released from care

Provide the local crisis center phone number or the National Suicide Prevention Lifeline number (800) 273-TALK (8255) to every patient as part of the safety plan.

Basic sections can include:

- What are your warning signs?
- What are your coping strategies?
- People and social settings that provide distraction
- People I can ask for help and contact info
- Professionals I can contact during a crisis and their contact info
- Steps to make my environment safe
- Reasons for living

[30] Brown G. K., & Jager-Hyman S. (2014). Evidence-based psychotherapies for suicide prevention: Future directions. American Journal of Preventive Medicine, 47(3 Suppl 2), S186–194. Retrieved from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Evidence-Based%20Psychotherapies%20for.pdf

[31] Stanley, B, Brown GK. (2011). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice. 19(2):256-264.

2. Reduce access to lethal means
Every safety plan should address specific steps for reducing access to any lethal means that are available to the patient. This may include limiting access to medications and chemicals and removing or locking up firearms. Studies have demonstrated that the overall rate of suicide drops when access to commonly-used, highly lethal suicide methods is reduced[32].

Reducing access to possible methods of suicide may be one of the most challenging tasks a clinician faces with a patient. Zero Suicide recommends all clinical and in some cases non clinical staff take the Counseling on Access to Lethal Means (CALM) online training. This training is offered online free of charge by the Suicide Prevention Resource Center[33].

3. Caring and clear provider-patient communication
During a primary care visit focused on suicide risk assessment, providers can offer some information and resources to support patients cope with their suicidal thoughts. Providers and care team members can use effective communication approaches to increase the likelihood that the patient will recall and use the information presented in the encounter.

Provider Communication Tip: Brief Interventions

- → **Thank you for sharing your suicidal thoughts**
- → **I won't be asking for the details now, but they are important**
- → **Suicidal thoughts are not unusual, but they are a good indication of how bad things are**
- → **It is hard to think clearly when our brains are so overwhelmed with emotions – and others don't understand this**
- → **Some people in despair imagine suicide because their brain wants a way out of the intense pain**
- → **It would really help me out if you removed the gun from your home, at least temporarily**
- → **What you do with the suicidal thought makes all the difference: Acknowledge them, but direct your attention away from them by focusing your attention on something else**

[32] Harvard T.H. Chan School of Public Health. (2016). Means Matter. Retrieved from https://www.hsph.harvard.edu/means-matter/
[33] Suicide Prevention Resource Center. Counseling on Access to Lethal Means (CALM). http://training.sprc.org/enrol/index.php?id=3

It is essential that patients have access to a crisis line, such as the National Suicide Prevention Lifeline. This should be noted in the Safety Plan as well. Providers and care team members can help make the crisis line readily available to patients.

Provider Communication Tip: Connecting Patients to Crisis Support Services

- → **Do you have your phone? I'd like you to enter 1-800-253-8255 in your phone right now. You may never need it, but you want to have it in case someone you care about is suicidal.**
- → **Next, let's open a website called NowMattersNow.org and look at a 40-second video by Marsha on suicidal thoughts. I want you to go to the website after our visit.**

Examples of resources that providers can share with patients includes Now Matters Now (www.nowmattersnow.org). This website can be given to patients or even pulled up during your primary care visit. The website also offers resources and tips for providers.

4. Follow-up with caring contacts
Caring contacts are brief communications with patients during care transitions such as discharge from treatment or when patients miss appointments or drop out of care. Health care professionals' contact with patients at risk of suicide have been found effective in suicide prevention[34, 35]. Through these contacts care teams continue to show support for a patient, promote a patient's feeling connection to treatment, and increase patient engagement in care. Caring contacts may be especially helpful for patients who have barriers to accessing outpatient care or are less likely to access care.

Examples of caring contacts include:

- → **Postcards, letters, patient portal emails, and text messages.**
- → **Some EHR systems may have automated patient engagement systems that can be used.**
- → **Phone calls made by care management staff, patient navigators, or peer providers.**
- → **Home visits.**

Organizations can explore developing partnerships with local crisis centers that can provide follow-up caring contacts with patients during transitions in care.

[34] Motto J.A., Bostrom A.G. (2001). A randomized controlled trial of postcrisis suicide prevention. Psychiatr Serv. 52(6):823-33.
[35] Berrouiguet S., Gravey M., Le Galudec M., Alavi Z., Walter M. (2014). Post-acute crisis text messaging outreach for suicide prevention: a pilot study. Psychiatry Res. 217(3):154-7.

C. Referrals and the Stepped Care Models

The process of making safety plans in collaboration with the patients can help the provider determine what kind of referral may be appropriate. The patient's level of engagement in creating these plans will also be a factor in determining the level of ongoing follow-up the patient will need. While risk stratification for patients at risk for suicide are not yet well developed, new models of care suggest that treatment and care for patients at risk for suicide should be provided in the least restrictive setting.

An article in the American Journal of Preventive Medicine (2014) recommends a "stepped care treatment pathway" for intervention[36].

The Stepped Care Model includes six levels of care for suicide risk:

1. **Crisis center hotline support and follow-up**
2. **Brief intervention and follow-up (see more detail in Part Three below)**
3. **Suicide-specific outpatient care**
4. **Emergency respite care**
5. **Partial hospitalization, with suicide-specific treatment**
6. **Inpatient psychiatric hospitalization, with suicide-specific treatment**

Multi-disciplinary or integrated care teams can deliver care management focused on patient engagement in care plans, care coordination, risk monitoring, evidence-based clinical interventions to address medical and behavioral health conditions. Increased patient engagement and effective care management supports may help reduce suicide risk. Patients with a moderate to high risk score on assessments and who have symptoms of mental illness may require referral to a behavioral health provider for evaluation and treatment. Patients who continue to be an imminent danger to themselves even after intervention efforts may require hospitalization, however emerging evidence suggests that hospitalization should be avoided if at all possible.

A reminder about HIPAA

When suicidal ideation (SI) is present, contact family or friends when possible. According to the Joint Commission, "For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others."[37]

[36] Ahmedani, B. K., & Vannoy, S. (2014). National pathways for suicide prevention and health services research. American Journal of Preventive Medicine, 47(3 Suppl 2), S222–S228. Retrieved from http://actionallianceforsuicideprevention.org.
[37] Sentinel Event Alert, The Joint Commission, Issue 56, February 24, 2016

D. Care transitions

Effective care coordination and care transition services are an important component of suicide safer health care. Care transitions are a time of great vulnerability for individuals at risk for suicide[38]. Caregivers and clinicians must address suicide risk at every visit, including when transitioning a patient within an organization between the primary care provider and behavioral health staff in integrated care settings. Primary care teams must also support care transitions between care settings such as inpatient, emergency department, or primary care, and behavioral health care. Examples of care transition supports include:

- **For patients who are admitted for inpatient care, make a follow-up appointment for a patient before discharge. Ideally follow-up care should be scheduled within 48 hours of discharge.**
- **Involve family, friends, and other loved ones in the plan for care transition.**
- **Make follow-up contacts (e.g., by email, text or phone) with patients after inpatient hospitalizations.**

Organizations can establish policies that provide guidance for successful care transitions and specify the contacts and supports needed throughout the process to manage any care transition.

Providers and care team members should follow organization policies on obtaining patient consent to share patient health information.

Again, a little help from the EHR

The electronic health record (EHR) plays a key role in assuring the following:

- **Patient appointments inside or outside an organization are recorded.**
- **No-shows are flagged and actions are taken to locate the person, ensure their safety, and reschedule the appointment or link them to a higher level of care if necessary.**
- **Patient information—especially information about suicide risk and previous care—is transmitted to the receiving provider.**

[38] Bickley, H., Hunt, I. M., Windfuhr, K., Shaw, J., Appleby, L., & Kapur, N. (2013). Suicide within two weeks of discharge from psychiatric inpatient care: A case-control study. Psychiatric Services, 64(7), 653–659. Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201200026

Resources: Care Management and Referral Processes

Action Steps	Trainings and Resources
Review the education material at Now Matters Now with patients at risk of suicide during visits	Now Matters Now (https://www.nowmattersnow.org/)
Train staff and providers on helping patients at risk to make a Safety Plan.	Safety Plan Template, Brown Stanley (https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf)
	Safety Planning Intervention for Suicide Prevention (http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm)
Develop organizational policies that clearly state what clinicians and care teams can do to counsel patients on lethal means, including the protocol to follow in the event a patient brings a weapon or other lethal means to the clinical setting.	Reducing Access to Lethal Means (CALM) (http://training.sprc.org/enrol/index.php?id=3)
	Sample Policies and Procedures for Securing Weapons for Suicidal/Homicidal Clients (http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Centerstone%20Clinical%20and%20Administrative%20Policies%20and%20Procedures%20Securing%20Weapons%20for%20Suicidal%20Homicidal%20Clients_0.pdf)
	Recommendations from the Harvard T. H. Chan School of Public Health, Means Matter Campaign for clinicians regarding guns and medications (https://www.hsph.harvard.edu/means-matter/)
Monitor to ensure that care transitions are documented and flagged for action in an electronic health record or a paper record.	Structured Follow-up and Monitoring for Suicidal Individuals (http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/monitor_suicidal_individuals/course.htm)
Develop internal written policies and procedures—and contracts or memoranda of understanding with outside organizations, including local crisis centers— for safe care transitions	A sample MOU with an emergency department can be found here: http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Centerstone%20MOU%20ED%20enhanced%20follow%20up%20template%202016.08.22.pdf

Patient Safety Plan Template

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 techniques, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 6: Making the environment safe:

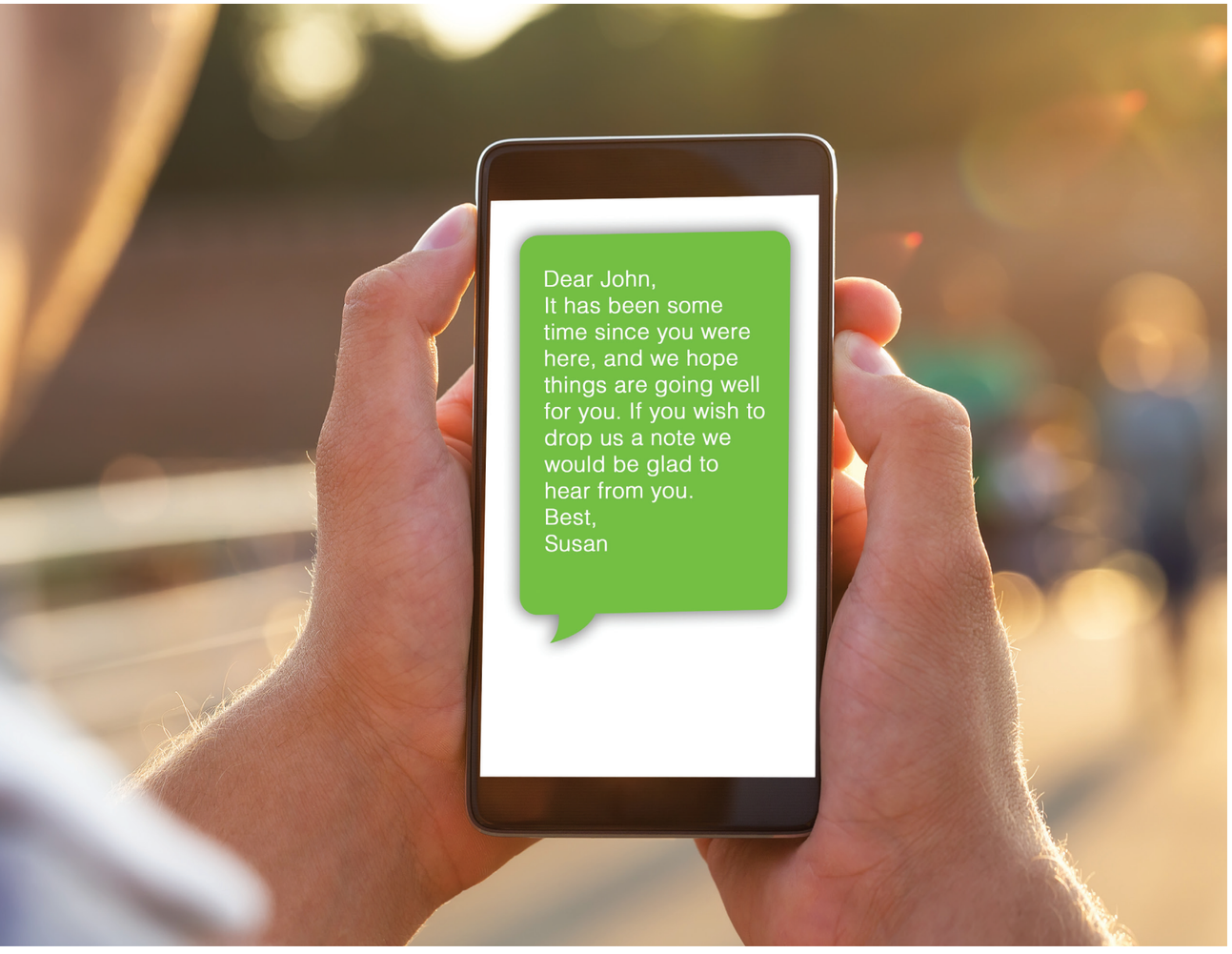
1. _____
2. _____

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

_____

Stanley, B, Brown GK. (2011). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice. 19(2):256-264.

Sample of a Caring Contacts Letter



PART THREE: Other Considerations

A. Recommendation for monitoring through the Quality Improvement program

Incorporating all aspects of suicide care into clinical workflow and quality assurances processes will support primary care teams in delivering high quality care. A data-driven quality improvement approach can help to monitor the systems, care strategies, and patient care outcomes.

Primary care leaders can establish a Zero Suicide team that works to implement suicide care in practice and evaluates performance towards patient care goals. The team can complete a Zero Suicide Organizational Self-Study to assess what components of suicide safer care are in place and use the results to set patient care goals. The team can create a plan to collect and review data regularly. The team can also present feedback to senior leadership and staff on progress of the organization in adopting a Zero Suicide approach. The Zero Suicide Toolkit offers a Data Elements Worksheet that defines key measures that organizations may want to consider[39].

Case Study on One Health Center's Use of the EHR to drive Improvement in Suicide Care

After a safety planning template was embedded into the electronic health record (EHR) system for the Institute for Family Health, all providers received training on how to use the tool with patients. Using the EHR the health center routinely monitored safety plan usage. Safety plan usage by primary care providers for patients with a positive suicide screen increased from 38 percent to 84 percent over two years[40].

[39] Zero Suicide Toolkit, Zero Suicide Data Elements Worksheet. Retrieved from: http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS%20Data%2Elements%20Worksheet.TS_.pdf.
[40] Hogan, M.F., Goldstein Grumet, J. (2016). Suicide Prevention: An Emerging Priority for Health Care. Health Aff. Jun 1;35(6):1084-90. doi: 10.1377/hlthaff.2015.1672.

B. Don't let liability concerns deter your organization from addressing suicide

Primary care organizations and providers implementing suicide prevention practices often have concerns about liability and legal issues. Patients at risk for suicide present a special challenge. Providers want to provide quality care without putting themselves or their practices at risk. By following some basic guidelines, providers can reduce risk in situations where the worst-case scenario happens. Universal screening and adequate documentation are critical.

The following list was developed based on actual court cases[41] and offers strategies for proper documentation:

- **Get a good medical history and document clinical/family history, if relevant, when making notes about concerns about suicide and when formulating a diagnosis.**
- **Be knowledgeable on the necessary conditions for involuntary hospitalization. Be aware of the rule of the "least restrictive environment."**
- **Take greater precautions if patient demonstrates an active suicide plan.**
- **Make arrangements for follow-up appointments and care continuity, especially if you plan to be absent.**
- **Use the care management plan to record care team action plan and follow-up.**
- **Inform/involve the family. Be knowledgeable on the standard of care (provide a translator to inform both the patient and the family of important information). Take appropriate action to inform the family of patient's status.**

Proper documentation of all conversations and contact with the patient, as well as reasons for the provider's decisions is key.

C. Resources and tools for workforce development

When a primary care organization makes a commitment to preventing suicide through adoption of a comprehensive approach, it is essential that all staff members have the necessary skills to provide high quality care and feel confident in their ability to deliver effective care to patients with suicide risk. Primary care leaders can assess staff for the beliefs, training and skills needed to care for individuals at risk of suicide. Based on needs identified, a training plan can be established.

There are many training workshops currently available online and through live training offerings. Zero Suicide Toolkit offers a comprehensive list of Suicide Care Training Options[42]. Primary care organizations can reassess staff training needs throughout the implementation of the suicide care approach.

[41] Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines. https://www.researchgate.net/publication/240314951.
[42] Zero Suicide Toolkit, Suicide Care Training Options. Retrieved from: http://zerosuicide.sprc.org/

Resources: Other Considerations

Action Steps	Trainings and Resources
Assess what core elements of suicide safer care your organization has in place.	Zero Suicide Organizational Self-Study (http://zerosuicide.sprc.org/what-organizational-self-study)
Assess staff skills and training needs related to suicide care on a routine basis.	Zero Suicide Workforce Survey (http://zerosuicide.sprc.org/resources/zero-suicide-workforce-survey-resources)
Establish a suicide care training plan for all staff in the organization.	Suicide Care Training Options (http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/2018.03.23%20-%20Suicide%20Care%20Training%20-%20Final%20Draft.pdf)
Create a plan to collect and review patient care goals and evaluate outcomes.	Zero Suicide Data Elements Worksheet (http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS%20Data%20Elements%20Worksheet.TS_.pdf)
Get a brief sense of case law and successful malpractice and negligence cases involving suicide.	Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines (https://www.researchgate.net/publication/240314951_Avoiding_Malpractice_Lawsuits_by_Following_Risk_Assessment_and_Suicide_Prevention_Guidelines)
Review best practices in documentation.	Legal and Liability Issues in Suicide Care (https://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Legal%20and%20Liability%20Issues%20in%20Suicide%20Care%205-27-16_0.pdf)