SUICIDE SAFER CARE

A Toolkit for Primary Care Providers Working with Geriatric Patients

ACU ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED

CENTENE® Corporation

Community HealthChoices

pa health & wellness™

5538632_NA5PCADGDEE
Internal Approved 11142025

Table of Contents

Suicide Safer Care

A Toolkit for Primary Care Providers Serving Geriatric Patients

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 healthcare 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 primary healthcare. The task force found three common characteristics among successful suicide prevention programs in healthcare settings. Healthcare 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]**

This Guide Focuses on Four Core Components:

1. **Screening and identifying patients of all ages at risk for suicide starting at school age**
2. **Assessing patients at risk**
3. **Restricting access to lethal means and safety planning**
4. **Caring for patients at risk for suicide**

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

In each section of this guide, you will find:

- **Summarized information for providers, including helpful provider communication tips.**
- **A list of recommended trainings and resources to learn more.**
- **Leadership actions organizations may take 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 practical tools and tips for primary care providers working with geriatric patients to use during a primary care visit.

---

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

Background: Why Primary Care Should Make Suicide Care a Priority

Geriatric Suicide – The Problem and the Opportunity

The Rate of Suicide Deaths Is Increasing

Suicide is a leading cause of death in the United States, cited as the cause of death for more than 47,000 Americans in 2019.[2] The total age-adjusted suicide rate in the U.S. increased by 35% from 1999 through 2019.[3] According to the State Health Access Data Assistance Center, suicide rates increased in 28 states from firearm methods, and in all but four states from non-firearm methods between 2000 and 2018.[4]

Geriatric Suicide

According to the Centers for Disease Control and Prevention, suicide accounted for 9,137 deaths — 25 every day—among adults over 65-years-old in 2020.[5] In 2018, suicides by firearms were the third leading cause of injury deaths among adults over 65-years-old.[6] There are a number of unique suicide risk factors among geriatric individuals, including grief over lost loved ones, loss of self-sufficiency, chronic illness and pain, cognitive impairment, financial troubles, and social isolation and loneliness. The transition from middle age to old age brings rapid changes to an individuals' social, environmental, and personal circumstances.

Geriatric individuals are at the greatest risk for completed suicide.[7] Compared to other age groups, people who are geriatric have an increased risk of self-harm repetition and suicide, with previous history of self-harm, previous and current psychiatric treatment, being single, and living alone strongly associated with repeated incidents of self-harm.[8] Incidents of self-harm are also generally more lethal because of greater use of deadlier methods such as firearms and poorer physical health.[9] Rural older adults are at particularly high risk of suicide, as there is less access to healthcare

---

[2]CDC. (2019). WISQARS. 10 Leading Causes of Death, U.S. Retrieved from www.cdc.gov/injury/wisqars/LeadingCauses.html.

[3]Hedegaard, H., et al. (2021). Suicide mortality in the United States, 1999-2019 (2021). NCHS Data Brief 398: February 2021. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db398-H.pdf.

[4]Planalp, C., & Hest, R., & Au-Yeung, C. (2020). Suicide Rates on the Rise: [National/State] Trends and Demographics in Suicide Deaths from 2000 to 2018 [PDF file]. Retrieved from https://www.shadac.org/2020SuicideBriefs

[5]CDC. (2020). WISQARS. Fatal Injury Reports, National, Regional and State, 1981-2020. Retrieved from https://wisqars.cdc.gov/fatal-reports.

[6]CDC. (2020). Fatal and non-fatal injury data. Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved

[7]Steele, I. H., et al. (2017). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, Assessment & Management. Journal of Forensic Sciences, 63(1), 162–171. https://doi.org/10.1111/1556-4029.13519

[8]Troya, M., et al. (2019). Self-harm in older adults: Systematic review. from https://www.cdc.gov/injury/wisqars/index.html. British Journal of Psychiatry, 214(4), 186-200. https://doi.org/10.1192/bjp.2019.11

[9]Hedegaard, H., et al. (2018) Suicide rates in the United States continue to increase. NCHS Data Brief 309, pp. 1-8 www.cdc.gov/nchs/data/databriefs/db309.pdf.

and higher firearm ownership than in urban areas.[10] Additionally, significant racial disparities exist in geriatric suicidality: suicide rates by firearms for white men aged 75 years or older were over three times higher than their African American counterparts.[11]

In general, there is an under-identification and treatment of geriatric depression and suicide risk in primary care.[12] While depression is highly associated with suicide risk, 69% of older men and 50% of older women who died by suicide did not have a known mental illness, according to the National Violent Death Reporting System.[13] Individuals with physical illnesses, such as cancers and liver diseases, were at higher risk of dying by suicide: men diagnosed with liver disease within three years were 2.7 times more likely to die by suicide, and 4 times more likely for women. Men with gastrointestinal cancer were 2.5 times more likely to die by suicide, whereas women with brain cancer were 3.5 times more likely to die by suicide.[14]

It is also important to consider significant gender disparities in suicide rates:

- **From 1999 through 2018, the suicide rate for men was 3.5-4.5 times the rate for women in the U.S., and suicide rates for both men and women increased.[15]**
- **Although men are at higher risk for suicide, the suicide rate for women increased 55%**
- **from 1999 to 2018, compared to a 28% increase for men.[16]**
- **Men over age 75 are at one of the highest risks for suicide, with a suicide rate of 40.5 per 100,000.[17]**

Geriatric Primary Care Providers Are Uniquely Positioned to Identify Risk and Intervene

Primary care providers have a unique opportunity to incorporate suicide prevention into established health risk assessment and patient safety practices.[18] **Approximately 45 percent of individuals who died by suicide visited a primary care provider in the month before their death.[19,20] Many had appointments within 30 days of their death.** Suicide is a public health

---

[10]Ivey-Stephenson, A.Z., et al. (2017). Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death—United States, 2001–2015. MMWR Surveill Summ 66 (18), 1-16. https://doi.org/10.15585/mmwr.ss6618a1

[11]Riddell, C. A., et al. (2018). Comparison of rates of firearm and non fire arm homicide and suicide in black and White Non-Hispanic men, by U.S. state. Annals of Internal Medicine, 168(10), 712. https://doi.org/10.7326/m17-2976

[12]Simons, K., et al. (2019). Age differences in suicide risk screening and management prior to suicide attempts Am J Geriatr Psychiatry 27 (6), 604-608. https://doi.org/10.1016/j.jagp.2019.01.017

[13]Schmutte, T. J., & Wilkinson, S. T. (2020). Suicide in older adults with and without known mental illness: Results from the National Violent Death Reporting System, 2003–2016. American Journal of Preventive Medicine, 58(4), 584–590. https://doi.org/10.1016/j.amepre.2019.11.001

[14]Erlangsen, A., et al. (2015). Physical diseases as predictors of suicide in older adults: A nationwide, Register-based Cohort Study. Social Psychiatry and Psychiatric Epidemiology, 50(9), 1427–1439. https://doi.org/10.1007/s00127-015-1051-0

[15]NCHS Vital Statistics System for Numbers of Deaths. (2022). Bureau of Census for Population Estimates. Accessed at wisqars-viz.cdc.gov/.

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

[17]Garnett MF, Curtin SC, Stone DM. (2022). Suicide mortality in the United States, 2000–2020. NCHS Data Brief, no 433. Hyattsville, MD: National Center for Health Statistics. https://dx.doi.org/10.15620/cdc:11421.

[18]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.

[19] 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.

[20]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).

problem, and suicide prevention can be integrated into routine primary care services, along with other preventive screenings and interventions. Suicide can be prevented, and primary care can play a pivotal role. Primary care clinicians do play a key role in addressing suicide risk with patients, but all members of the care team participate in preventing suicide and providing care to those at risk.

Providing Suicide Safer Care is now a nationwide effort, involving primary care providers, professional associations, and state government agencies.

> ***"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*

How Teams Can Act

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 during a primary care visit can reduce suicide deaths.

Getting Started with Key Action Steps:

- **Establish protocols for routine suicide screening, assessment, intervention, and referral**
- **Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling**
- **Work with your local healthcare delivery system partners to enhance continuity of care by sharing patient health information with emergency care and behavioral care providers to create seamless care transitions**
- **Provide information on 988 (formerly the National Suicide Prevention Lifeline)**

Common Risk Factors & 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.[21,22] These risk factors are likely common among patients served in primary care practices and 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.

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 the most significant 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
- Suicide

If any of the following behaviors/conditions are present:

- 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
- Displaying severe/overwhelming emotional pain or distress.
- Withdrawing from activities
- Sleeping too much or too little
- Giving away prized possessions
- Fatigue
- Family history of suicide
- Local suicide epidemic
- Previous suicide attempts
- Loss of spouse/partner

If a patient describes or evidences feelings of:

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

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

[22]Ibid.

Routine Screening and Assessment in Geriatric Settings

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.[23]

In 2016, when it issued its Sentinel Event alert, the Joint Commission, an independent agency that accredits and certifies healthcare 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:[24]

1. **Review each patient's personal and family medical history for suicide risk factors.**
2. **Screen all patients for suicide ideation,** [25] **using a brief, standardized, evidence-based screening tool.**
3. **Review screening questionnaires before the patient leaves the appointment or is discharged.**

Linking Suicide and Depression Screening Health Settings

Primary care clinicians are making great strides in integrating behavioral health and primary care to better address the needs of patients. In 2015, an estimated 57.5% of patients aged 65-74 and 47.9% of patients over the age of 75 received a screening for depression from their healthcare provider.[26] Routine implementation of depression screenings offer a foundation to screen for suicide. In geriatric individuals, utilizing suicide screeners may be increasingly important because older adults are less likely to directly or spontaneously report thoughts of suicide.[27]

In a 2011 study of U.S. primary care providers, suicide was discussed in only 11% of encounters with patients who had screened positive for depression, unbeknownst to their providers.[28] Additionally, an estimated 13.8% of geriatric individuals have subsyndromal depression, a risk factor for subsequent[29] Amajor depressive disorder and suicide that may not always be identified by primary care providers. significant body of research shows that the universal implementation of a brief screening tool can identify individuals at risk for suicide reliably, without leaving the identification up to a clinician's personal judgment.[30]

---

[23] In2014, the U.S. Preventive Services Task Force reviewed current evidence and concluded, "Limited evidence suggests that primary care - feasible screening instruments maybe able to identify adults at increased risk of suicide, and psycho therapy targeting suicide prevention can be an effective treatment in adults. Evidence was more limited in older adults and adolescents...research is needed."

[24] Sentinel Event Alert 56. Detecting and treating suicide ideation in all settings. (2016). The Joint Commission. Accessed at https://cams-care.com/wp-content/uploads/2018/04/Sentinel-Event-Alert-56-Suicide.pdf

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

[26] Kato, E., et al. (2018). Missed opportunities for depression screening and treatment in the United States. The Journal of the American Board of Family Medicine, 31(3), 389–397. https://doi.org/10.3122/jabfm.2018.03.170406

[27] Heisel, M. J., et al. (2010). Screening for suicide ideation among older primary care patients. Journal of the American Board of Family Medicine : JABFM, 23(2), 260–269. https://doi.org/10.3122/jabfm.2010.02.080163

[28] Vannoy, S. D., & Robins, L. S. (2011). Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps. A mixed methods analysis. BMJ open, 1(2), e000198. https://doi.org/10.1136/bmjopen-2011-000198.

[29] Diggle-Fox, B. S. (2016). Assessing suicide risk in older adults. The Nurse Practitioner, 41(10), 28–35. https://doi.org/10.1097/01.npr.0000499551.10701.a3.

[30] Dueweke, A. R., & Bridges, A. J. (2018). Suicide interventions in primary care: A selective review of the evidence. Families, Systems, & Health, 36(3), 289–302. https://doi.org/10.1037/fsh0000349.

Screening Best Practices

- Most practices screen yearly—it is best to use PHQ-9 to directly ask about suicide.
- Rescreen patients who are pregnant/post-partum.
- Screen patients experiencing transitions in care.
- Move routine screening for patients with HIV, substance, or alcohol use.

Review of Screening Protocols 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 ages 18 and up using a basic Patient Health Questionnaire (PHQ-9).** Many primary care settings rely on the PHQ-9[31] 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 and make accommodations for geriatric patients who may have difficulty due to hearing, vision, or memory impairments.** Seniors may be more prone to difficulty seeing the questions on the standard form or a tablet and may have difficulty hearing questions being read by screening staff, so considerations should be made to the screening process for seniors. Additionally, some seniors may struggle with memory loss: it is helpful to use local events or holidays to help establish a timeline for the past two weeks.

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. Organizations that choose the geriatric depression screening tool should ask about suicide directly using the CSSRS.

Resources

Establish a policy to screen all patients over the age of 12 using a standardized screening tool.	• Patient Health Questionnaire–9(PHQ-9) • Columbia Suicide Severity Rating Scale (see Appendix)

Screening and Assessment

- ASQ NIMH Toolkit
- PHQ-9
- Geriatric Depression Scale Short Form (GDS-S)
- Columbia Suicide Severity Rating Scale
- Safety Plan Intervention

[31] Spitzer, R.L, Williams, J.B.W., Kroenke, K, et al. (2001). Patient health questionnaire-9 (PHQ-9). Retrieved from https://www.phqscreeners.com/images/sites/g/files/g10060481/f/201412/PHQ-9_English.pdf

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 _____ + _____ + _____ + _____

= 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.
No permission required to reproduce, translate, display or distribute.

Geriatric Depression Scale: Short Form (GDS-S)

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: http://www.stanford.edu/~yesavage/GDS.html
This scale is in the public domain.

Help from Your EHR

One tool that 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 into 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.

Add Suicide to Your EHR Problem List:

Suicide, suicidal (attempted) (by) X83.8
- blunt object X79
- burning, burns X76
  - fluid NEC X77.2
  - specified NEC X77.8
  - cold, extreme X83.2
- collision of motor vehicle w/
  - motor vehicle X82.0
  - specified NEC X82.8
  - train X82.1
  - tree X82.2

Instrument X78.9
- Knife X78.1
- Specified NEC X78.8

Drowning (in) X71.9
- Bathtub X71.0

electrocution X83.1

explosive X75 (s) (material)
- fire, flames X76
- firearm X74.9
  - handgun X72
  - hunting rifle X73.1
  - specific NEC X73.8
  - shotgun X73.0

hanging X83.8

jumping before moving object X81.8
- motor vehicle X81.0
  - subway train X81.1
  - train X81.1
  - from high place X80

lying before moving object, train, vehicle X81.8

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) 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"
- Review the PHQ-9 responses, reviewing each one working to question 9

"I see that you are having trouble sleeping, and you report that most days. I also see you are having trouble concentrating some days. These are likely related. I also see you are having thoughts of being better off dead, some days. Thank you for sharing you are thinking about suicide. Your life matters to me, and I would like to ask you a few more questions about suicide."

Caring and Clear Provider-Patient Communication

During a primary care visit focused on suicide risk assessment, providers can offer some information and resources to help 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 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.

Columbia-Suicide Severity Rating Scale: Primary Care Screen with Triage Points

Ask questions that are in bold.

Ask Questions 1 and 2	YES	NO
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, whe or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had some intention 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: Lethal Means Restriction & Safety
- Item 3: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4 and Item 5: 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

Advantages to Using the C-SSRS

- Well scripted for use by non-mental health professionals
- Online training available
- Includes triage guidelines
- Can double as both a screening tool and a risk assessment tool

Resources: Routine Screening and Assessment in Primary Care

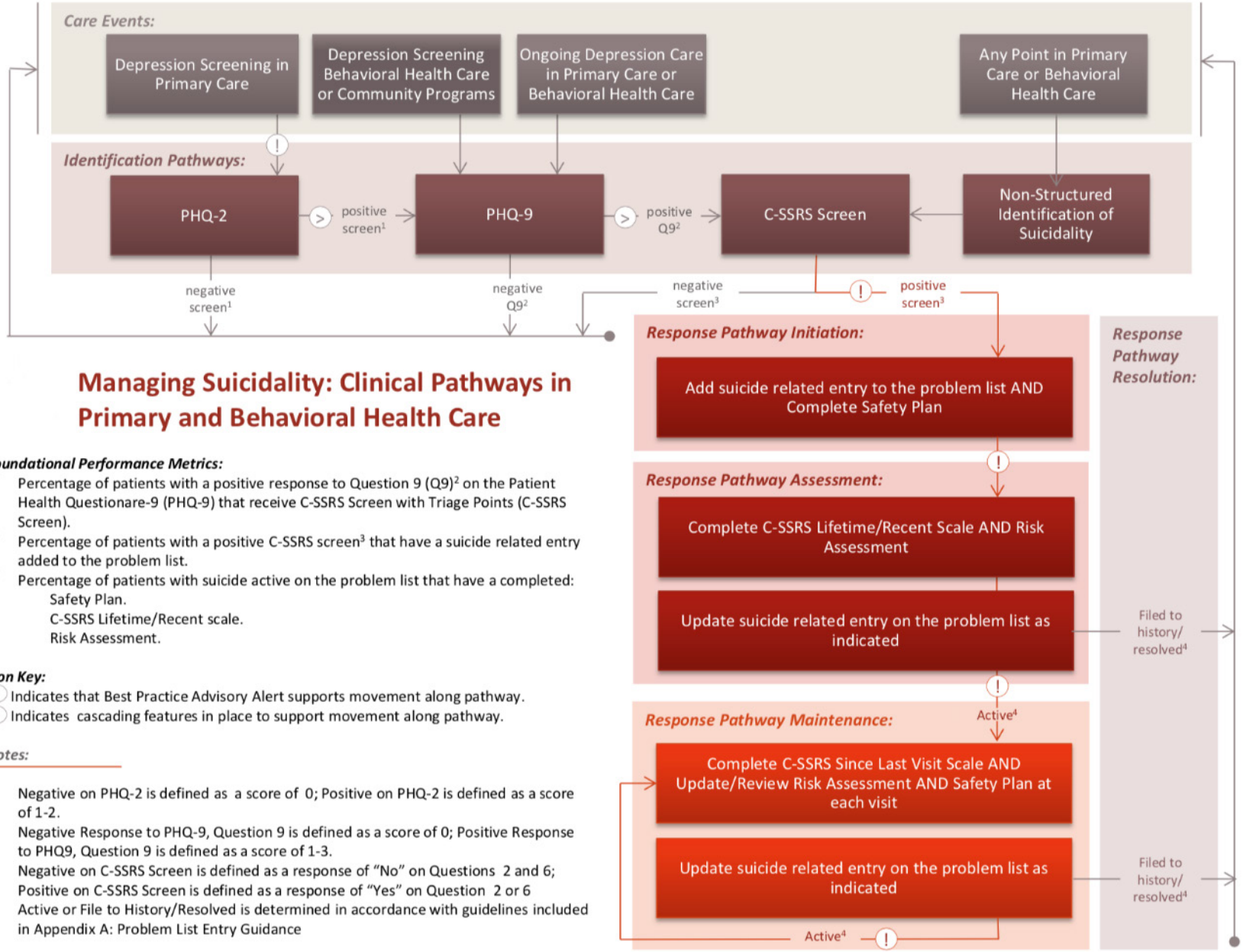
Action Steps	Trainings and Resources
Training for Nonclinical Team Members	• SafeTALK curriculum • Mental Health First Aid
Regulatory	• Joint Commission Alert with Eight Steps on How to Prevent Suicide: Mental Health First Aid

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.

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 Suicide Safer Care**
- **Completion of CSSRS to assess for risk and intent**
- **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**

Example Suicide Safer Care Pathway



Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:

- ✓ Percentage of patients with a positive response to Question 9 (Q9)[2] on the Patient Health Questionare-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
- ✓ Percentage of patients with a positive C-SSRS screen[3] that have a suicide related entry added to the problem list.
- ✓ Percentage of patients with suicide active on the problem list that have a completed:
  - Safety Plan.
  - C-SSRS Lifetime/Recent scale.
  - Risk Assessment.

Icon Key:

(!) Indicates that Best Practice Advisory Alert supports movement along pathway.
(>) Indicates cascading features in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of "No" on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of "Yes" on Question 2 or 6
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance

Brief Evidence-Based Interventions

Working with Geriatric Populations

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 healthcare. These brief interventions may also assist care teams to begin offering Suicide Safer 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.[32] Primary care clinicians and care team members can use these brief interventions as part of a care management plan.

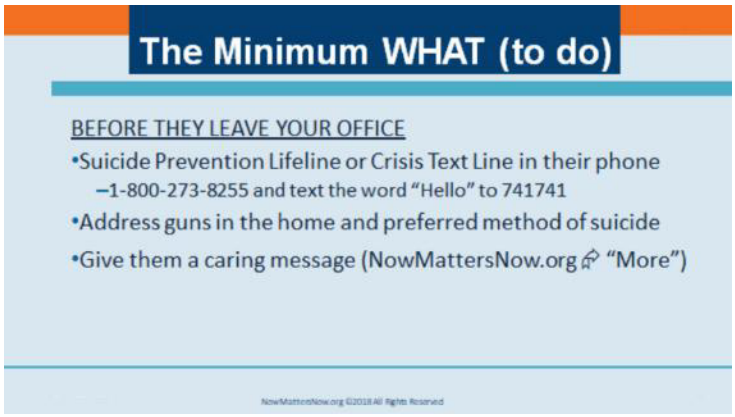
1. Make a Safety Plan

Complete a safety plan:

- Using Electronic Health Records to Assess Suicide Risk

Train staff and providers on helping patients at risk to make a Safety Plan:

- Safety Plan Template: Brown-Stanley
- Safety Planning Intervention for Suicide Prevention



"I didn't realize how do-able and important doing safety plans are. Like asthma action plans, they are really helpful resources for patients at risk."
—PCP, Maine

[32] 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://actionalliance forsuicideprevention.org/sites/actionalliance forsuicideprevention.org/files/Evidence-Based%20Psychotherapies%20for.pdf

"All of our Primary Care Providers, Nurses and Behavioral Health Specialists are trained to do Safety Plans."
—Medical Director, Nebraska

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.[33]

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**

TIP: Program 988 into your phone, and have patients program it into their phone during visits.

Provide the local crisis center phone number or the 988 suicide and crisis lifeline (formerly the National Suicide Prevention Lifeline at 1-800-273-8255) number to every patient as part of the safety plan. Patients may call or text 988.

A Suicide Safer Care approach requires primary care organizations to put systems in place to address both identifying patients at risk **AND** providing routine primary care to patients at risk.

"I have patients call the Lifeline from their phone while I step out for another patient. Then I know what happens."
—PCP in Bronx, NY

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

NowMattersNow.org Safety Plan

NowMattersNow.org Emotional Fire Safety Plan

Select those that fit you, cross out those that don't, add your own. Based on research, and advice from those who've been there.
Visit nowmattersnow.org/get-involved for most recent version, last updated 18.09.11 ©2018

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— Shut it down —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— No Important Decisions —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— Make Eye Contact —
A difficult but powerful pain reliever. Look in their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

☐ Visit NowMattersNow.org (guided strategies)	☐ Opposite Action (act exactly opposite to an urge)
☐ Ice-Water and Paced Breathing (exhale longer)	☐ Mindfulness (choose what to pay attention to)
☐ Call/Text Crisis Line or A-Team Member (see below)	☐ Mindfulness of Current Emotion (feel emotions in body)
☐ "It makes sense I'm stressed and/or in pain"	☐ "I can manage this pain for this moment"
☐ "I want to feel better, not suicide or use opioids"	☐ Notice thoughts, but don't get in bed with them
☐ Distraction:	☐

FIRE PREVENTION

Put Crisis Resources in Phone (take photo of this safety plan with phone and practice calling/texting)

☐ Suicide Prevention Lifeline 1-800-273-8255, Press 1 for Veteran and 2 for Spanish	
☐ Crisis Text Line 741741 Help	☐ Trevor Lifeline (LGBT youth) 1-866-488-7386
☐ See nowmattersnow.org/help-line	☐ Trans Lifeline (transgender) 1-877-565-8860
☐ My3 safety plan app	☐ 911, ask for mobile crisis unit
☐ WarmLine.org	☐

Keeping Myself Safe (address if relevant, as best as possible, as part of collaborative conversation)

☐ Guns locked up w/out key or combo (__NA)	☐ Suffocation and overdose thoughts addressed (__NA)
☐ Guns stored separately from ammunition (__NA)	☐ Preferred suicide methods reviewed and addressed
☐ Guns stored outside of home (__NA)	☐ Remove opioids from home (__NA)
☐ A-Team supports these safety steps (__NA)	☐ No one with or using opioids allowed in home
☐ Confirm steps with another person	☐ Remove or store prescription medications safely

The reason(s) I want to live or not use drugs_____

☐ Visible reminder (e.g., note to self or photo of loved one: phone background, gun case, med cabinet, car dashboard, wallet even after suicidal crisis has passed)

The #1 thing leading to suicidal thoughts or urges to use_____

Create an A-Team (people I can talk to about suicide, drug or alcohol or mental health struggles)
Can be healthcare provider, peer support, friend, family member or other

☐ Choose A-Team member(s)_____
☐ Message or call A-Team members, individually or as a group to let them know they are A-Team
☐ Discuss in advance what would be helpful in crisis ("I believe in you", support this plan, just listen, hospitalization or not)
☐ Decide how to ask for help effectively (be willing to take help, try to communicate before a crisis)

Watch Out for These	**Things I'd Be Willing to Try**
☐ Not sleeping	☐ Regular sleep for a week (8 hours nightly)
☐ Feeling really anxious or irritable	☐ Validate yourself, "my emotions make sense"
☐ Increased alcohol or drug use or relapse	☐ Talk to someone in recovery
☐ Being in frustrating and painful situations	☐ Make plans to get out of these situations
☐ Stop taking medication without support	☐ Go to scheduled appointments or schedule one
☐ Avoiding calls or messages	☐ Message an A-Team member a caring message
☐ Suicidal thoughts or images	☐

NowMattersNow.org Emotional Fire Safety Plan (Additional Notes)

Select those that fit you, cross out those that don't, add your own. Based on research, and advice from those who've been there.
Visit nowmattersnow.org/get-involved for most recent version, last updated 18.09.11 ©2018

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— Shut it down —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— No Important Decisions —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— Make Eye Contact —
A difficult but powerful pain reliever. Look in their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use

Visit NowMattersNow.org	

FIRE PREVENTION

Put Crisis Resources in Phone

☐Suicide Prevention Lifeline 1-800-273-8255, Press 1 for veterans, 2 for Spanish	
☐Crisis Text Line 741741 Help	

The reason(s) I want to live and not use drugs_____

The #1 thing leading to suicidal thoughts or urges to use_____

Keeping Myself Safe

Create an A-Team (healthcare provider, peer support, friend, family member or other)

Possible A-Team members_____

Watch Out for These	**Things I'd Be Willing to Try**

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:

Basic Sections Can Include:

- What are your warning signs?
- What are your coping strategies?
- People and social settings that provide distraction (remember, are they accessible all times of day and year?)
- People I can ask for help and contact info (are they always available?)
- Professionals I can contact during a crisis and their contact info
- Steps to make my environment safe
- Reasons for living

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.[34]

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.[35]

Online Training

- CALM – Counseling Access to Lethal Means
- CSSRS

Access to Lethal Means Handouts

- Information for Families
- Guidelines for Clinicians

Action Steps	Trainings and Resources
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) • Sample Policies and Procedures for Securing Weapons for Suicidal/Homicidal Clients • Recommendations from the Harvard T. H. Chan School of Public Health, Means Matter Campaign for clinicians regarding guns and medications

[34] Harvard T.H. Chan School of Public Heal (2016). Means Matter. Retrieved from https://www.hsph.harvard.edu/means-matter/

[35] SuicidePreventionResourceCenter.CounselingonAccesstoLethalMeans(CALM). https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/.

Medication and drug overdose are the most common means of suicide attempts. Because medications may be needed by the patient or other family members, large quantities should be secured in a locked box such as a steel toolbox with a padlock. Parents should dispense medication prescribed to the patient. Over the counter medications should be secured as well and replaced with small quantities if needed in the home. Special attention should be paid to high-risk medications such as antidepressants, sedatives and opiates. Pharmacists can also dispense smaller quantities of high-risk medications.

Center SPR. 2018. CALM: Counseling on Access to Lethal Means. Educational Development Center. https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/.

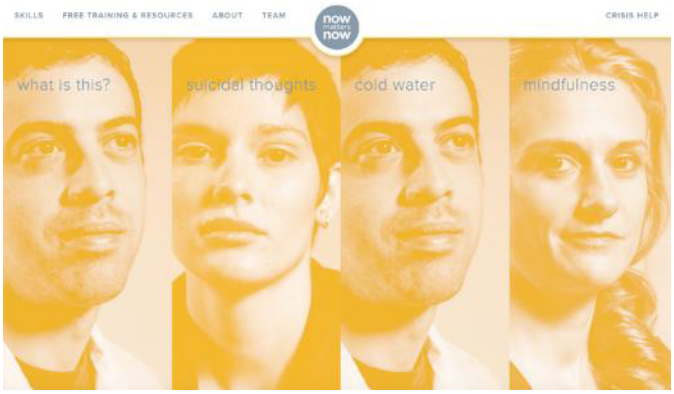
A Helpful Resource for Parents, Caregivers, Friends, and Family

It is essential that patients have access to a crisis line, such as 988 (formerly 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 a phone? I'd like you to enter 988 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 include NowMattersNow. This website can be given to patients or even pulled up during your primary care visit. The website offers resources and tips for providers.



Other Resources to Consider

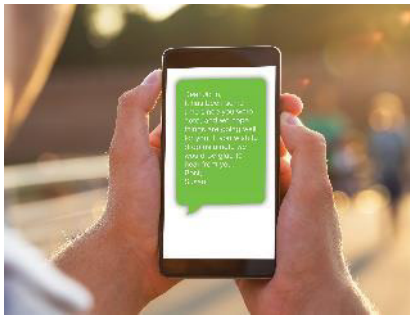
- 988 Suicide & Crisis Lifeline
  - Formerly the National Suicide Prevention Lifeline (1-800-273-TALK (8255))
  - Spanish/Español: 1-888-628-9454
- Crisis Text Line
  - Text HOME to 741-741
- Suicide Prevention Resource Center
- National Institute of Mental Health
- Substance Abuse and Mental Health Services Administration

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. Healthcare professionals' contact with patients at risk of suicide have been found effective in suicide prevention.[36,37] 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.

[36] MottoJ.A.,Bostrom A.G.(2001).A randomized controlled trial of post crisis suicide prevention.Psychiatr Serv.52(6):823-33.

[37] Berrouiguet S. , G ravey M. , L e Galudec M. , Alavi Z., W alter M . (2014). P ost-acute crisis tex t messaging outreach for suicide prevention: a pilot s tudy. Psychiatry R es. 217(3):154-7.

Alternative Levels of Care

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 is 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.

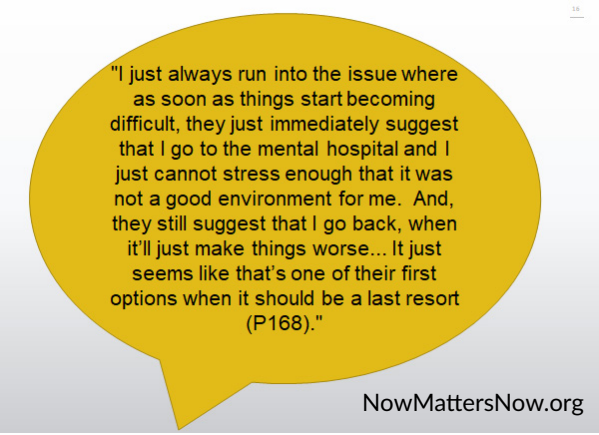
Multi-disciplinary or integrated care teams can deliver care management focused on patient engagement in care plans, care coordination, risk monitoring, and evidence-based clinical interventions to address medical and behavioral health conditions. Increased patient engagement and effective care management 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. An article in the *American Journal of Preventive Medicine* (2014) recommends a "stepped care treatment pathway" for intervention[38].

The Stepped Care Model Includes Six Levels of Care for Suicide Risk:

1. Crisis center hot line support and follow-up – have the patient put the lifeline number in their phone
2. Brief intervention and follow-up (see more detail in Part Three below)
3. Suicide-specific out patient care
4. Emergency respite care
5. Partial hospitalization, with suicide-specific treatment
6. Inpatient psychiatric hospitalization, with suicide-specific treatment

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."[39]



[38] Ahmedani, B.K., & Vannoy, S.(2014). National pathways for suicide prevention and health services research. American Journal of Preventive Medicine,47(3 Suppl2),S222–S228.Retrievedfromhttp://actionallianceforsuicideprevention.org.

[39] SentinelEventAlert, The Joint Commission,Issue56,February24,2016

Care Transitions

Effective care coordination and care transition services are an important component of Suicide Safer Care. Care transitions are a time of great vulnerability for individuals at risk for suicide.[40] 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. Healthcare 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, for both medical and psychiatric admissions.**
- **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.**
- **Patients transitioning from incarceration.**
- **Patients ending substance use treatment.**

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, including referrals for specialty care such as cardiology.**

Action Steps	Trainings and Resources
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

Does your organization use CPT codes 99495/99496 to help track transition of care?

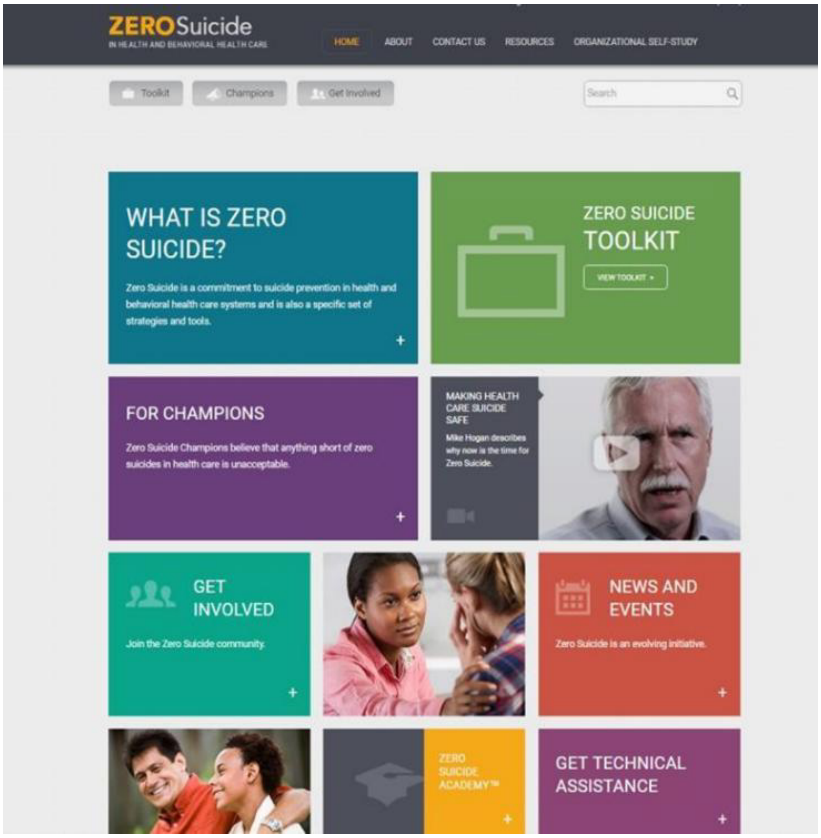
[40] Bickley, H., Hunt, I. M., Windfuhr, K., Shaw, J., Appleby, L., & Kapur, N. (2013). Suicide within two weeks of discharge from psychiatric inpatient care: A case-control study. Psychiatric Services, 64(7), 653–659. Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201200026

Other Considerations

Recommendation for Monitoring Through the Quality Improvement Program

Incorporating all aspects of Suicide Safer Care into clinical workflow and quality assurance 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 processes that work to implement suicide care in practice and evaluates performance towards 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. The Zero Suicide Toolkit offers a Data Elements Worksheet that defines key measures that organizations may want to consider.[41]



[41] 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.

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[42] 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.

Action Steps	Trainings and Resources
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
Review best practices in documentation.	• Legal and Liability Issues in Suicide Care

[42] Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines. https://www.researchgate.net/publication/240314951

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
Assess staff skills and training needs related to suicide care on a routine basis.	Zero Suicide Workforce Survey
Establish a suicide care training plan for all staff in the organization.	Suicide Care Training Options

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. The Zero Suicide Toolkit offers a comprehensive list of Suicide Care Training Options.[43] Primary care organizations can reassess staff training needs throughout the implementation of the suicide care approach.

[43] Zero Suicide Toolkit, Suicide Care Training Options. Retrieved from: http://zerosuicide.sprc.org/

Example Training Grids

Action Steps	Length	Trainings and Resources
Assessment of Suicidal Risk Using C-SSRS	45 min. (online)	https://zerosuicide.edc.org/resources/resource-database/assessment-suicidal-risk-using-columbia-suicide-severity-rating-scale
Safety Planning Intervention for Suicide Prevention	45 min. (online)	https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention
Counseling on Access to Lethal Means (CALM)	2 hrs. (online)	https://zerosuicidetraining.edc.org/enrol/index.php?id=20
Assessing and Managing Suicide Risk (AMSR)	1 day (in-person)	https://solutions.edc.org/solutions/zero-suicide-institute/amsr
Structured Follow-up and Monitoring	45 min. (online)	http://zerosuicideinstitute.com
SafeTALK	3 hrs. (in-person)	https://www.livingworks.net/
Suicide Care at the Institute for Family Health	4 hrs (in-person)	https://institute.org/

Job Title	Required Suicide Prevention Trainings
• Associate Director • Associate Director of Psychiatry • Associate Regional Director • Behavioral Health Faculty • Care Management Coordinator • Care Manager • Director Clincial Quality & Compliance • Director Of Technology Implementation • Director Of Psychiatry • Mental Health Clinician • Nurse Care Manager • Program Director • Director Of Family Programs • Psychiatric Provider • Rn Care Coordinator • Social Worker • Substance Abuse Director	• Assessment of Suicidal Risk Using C-SSRS • Safety Planning Intervention for Suicide Prevention • Counseling on Access to Lethal Means • Assessing and Managing Suicide Risk • Structured Follow-up and Monitoring • Suicide Care at the Institute for Family Health
• Care Coordinator • Case Manager • Community Health Worker • Family Assessment Worker • Medical Assistant • Outreach And Assessment Coordinator • Patient Navigator • Retention & Adherence Specialist - Bachelors • Director, Process Improvement & Analytics • Health Education & Access Coordinator • Lead Patient Services Rep • Billing + Referral Coordinator • Mental Health Billing Director • Nutritionist • Outreach Worker • Patient Service Representative • Practice Administrator	• Safety Planning Intervention for Suicide Prevention • Counseling on Access to Lethal Means • Structured Follow-up and Monitoring • safeTALK