Recommended Standard Care for People with Suicide Risk:

MAKING HEALTH CARE SUICIDE SAFE

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

This report advances goals 8 and 9 of the National Strategy for Suicide Prevention (National Strategy):

- Goal 8: Promote suicide prevention as a core component of health care services.
- Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

To download a copy of the National Strategy, please visit www.actionallianceforsuicideprevention.org

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NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION:

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NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

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Introduction

This guide has been produced by health care and suicide prevention experts working with the National Action Alliance for Suicide Prevention (Action Alliance). The information is for health care organizations that wish to better identify and support people who are at increased risk of suicide and for advocates who will work with hospitals and clinics to make them safer. In this guide, we:

- Describe why improving suicide care is urgently needed
- Identify gaps in health care that contribute to suicide deaths
- Summarize the evidence-based solutions that should be adopted
- Provide information on resources that are available to make care safer and better

Why Do We Need Recommendations for Standard Care for People with Suicide Risk in Health Care Organizations?

Suicide is an important health care issue. Suicide is the 10th leading cause of death overall in the United States and the 2nd leading cause of death among 15 to 34 year olds (Centers for Disease Control and Prevention [CDC], 2015a). Despite improvements in overall health and health care, the national suicide rate has risen about 27 percent in the last 15 years (CDC, 2015b).

Health care organizations have a unique opportunity to help prevent suicide. People at risk of suicide are often seen in health care settings; in a study within large health systems, over 80 percent of those who died by suicide had been seen by a professional in the prior year; most did not have a mental health diagnosis. Almost 40 percent of those who died by suicide had an emergency department visit without a mental health diagnosis (Ahmedani et al., 2014). In another review (Luoma, Martin, & Pearson, 2002). close to one-half of those who died by suicide visited a primary care provider in the month before their death In response, and due to advances in research and the development of new tools to assist in addressing suicide, health care organizations have begun to prioritize suicide prevention.

Frequently, when someone dies by suicide, we hear "he fell through the cracks." Health care organizations are well-positioned to help prevent this from happening. But care for people with suicide risk is highly variable, common gaps in care for individuals at risk of suicide do exist, and recommendations are needed to close these gaps. Health care organizations have already recommended guidelines or standards to improve care to address other urgent medical conditions, such as heart attack, stroke, and serious injury from an accident. Similar action is overdue and now needed for suicide.

The field of Lean Production ("lean"), now widely applied in health care, seeks to improve care by first identifying and implementing "standard work" for a particular task and then incrementally improving quality. We apply this process to suicide care by identifying low-cost, high-value, evidence-based approaches that should be implemented as standard care in health care organizations—inpatient and outpatient mental health and substance use settings, emergency departments, and primary care offices and clinics. While there are a number of additional promising and desirable approaches for suicide care (for example, direct treatment of individuals with suicide risk by clinicians using evidence-based psychotherapies), this guide is focused solely on those basic elements of suicide care that should be standard in health care settings. All the recommended approaches have been research tested and implemented successfully in health care organizations.

If we want to turn the tide of suicide deaths, change is needed now. By promoting elements of care that should be standard, and helping health care organizations to implement them, people at risk of suicide can be identified, supported, and kept safe. The recommended standard care approaches we propose were developed by experts, researchers, clinicians, and consumers based on both research and experience caring for suicidal patients in

real-world health care settings. We hope that, with this guidance, health care organizations across the country will step up to make the care that they provide "suicide safe." And we hope that advocates are engaged to encourage and support this needed change.

Background: Why Do We Need Standard Care Recommendations for Health Care Organizations?

Statistics from the CDC provide context for the nation's need for suicide care:

- Suicide is the 10th leading cause of death in the United States, with more than 44,000 deaths in 2015 (CDC, 2015a).
- Among 15 to 34 year olds, suicide is the 2nd leading cause of death (CDC, 2015a).
- The number and rate of suicide deaths rose significantly between 2000 and 2015 (CDC, 2015b):
  - 2000: 29,350 suicide deaths (a rate of 10.44 deaths per 100,000 population)
  - 2015: 44,193 deaths (13.26 deaths per 100,000 population)

Mental health, primary care and emergency department providers are likely to encounter patients at risk of suicide in their practices, as noted by Ahmedani et al. (2014) and Luoma et al. (2002):

- The majority of individuals who have died by suicide visited a primary care provider in the year before their death.
- Close to one-half of individuals who died by suicide visited a primary care provider in the month before their death.
- Almost 40 percent of individuals who died by suicide had an emergency department visit, but not a mental health diagnosis.

But many clinical training programs do not fully prepare health care professionals to provide suicide care (Bolster, Holliday, & Shaw, 2015; Schmitz et al., 2012; Sudak et al., 2007). There are two main reasons for this gap. First, many evidence-based approaches to identifying and working with people at risk of suicide are relatively new. Second, until recently, suicide care was not seen as a core responsibility of most health care organizations, and managing patients at risk of suicide was left to mental health crisis care and inpatient psychiatric units (Hogan & Goldstein Grumet, 2016).

But attention to suicide prevention in health care is accelerating. In 2012, the revised *National Strategy for Suicide Prevention* included a new national goal: **Promote suicide prevention as a core component of health care services** (U.S. Department of Health and Human Services Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Based on new research and successful implementation of suicide prevention in health care—beginning with the ground breaking Perfect Depression Care initiative at the Henry Ford Health System (Coffey, 2007)—the Zero Suicide model for suicide care was developed and is now being implemented in hundreds of health care organizations, including behavioral health programs, general and psychiatric hospitals, primary care settings, and health plans (Suicide Prevention Resource Center, n.d.-b).

In 2015 and 2016, national health care accrediting bodies improved their focus on suicide care:

- 2015: The Council on Accreditation (2015) released updated standards.
- Early 2016: The Joint Commission (2016) released an updated Sentinel Event Alert on suicide prevention, advising all outpatient and inpatient health care settings to improve their ability to detect suicidality and assure care for patients at risk.
- Late 2016: The Commission on Accreditation of Rehabilitation Facilities (2016) released a new accreditation product on suicide prevention to its member organizations.

Although these recent actions reflect new momentum, they do not fully close the common gaps in care for patients who are at risk for suicide. Also, the new recom-

mendations by the aforementioned accrediting bodies are generally advisory, not mandatory. There is very little accountability for suicide prevention in health care. For example, suicide rates in health systems are not routinely measured. As a result, patients at risk of suicide often "fall through the cracks" of a distracted and an often unprepared health care system.

The Gaps in Care That Suicidal Individuals Fall through, and the Evidence-Based Solutions

Although the work to make health care *suicide safe* is challenging, we now have evidence and long-standing clinical best practices showing how to fill the gaps in care—gaps that are too often fatal. It is time to apply this knowledge.

To address these gaps, we focus on three key questions:

1. What are the gaps in health care that contribute to suicide deaths?
2. What is the clinical evidence to close these gaps?
3. Are the solutions feasible for ordinary health care settings?

In the following sections, we identify the typical gaps in usual care that often make health care settings unsafe for people at risk of suicide, as well as the evidence and solutions for closing these gaps.

Gap: Not Proactively Identifying Intense Suicide Risk

Approximately half the people who die by suicide had a recent health care visit (Luoma et al., 2002). It is probable not enough was done during that visit to identify suicide risk, leading to a failure to keep the patient safe. Just as we expect signs of serious heart disease risk to be uncovered and lead to action, we should expect signs of suicide risk to be uncovered and acted on.

Several key barriers contribute to this gap. First, until recently, suicide care has not been seen as a core responsibility of health care organizations (Hogan & Goldstein Grumet, 2016). This unfortunate and unacceptable trend is rationalized in many ways, such as "of course suicide is a tragedy, but there's really nothing we can do." Second, myths about suicide have been accepted as true in health care settings. For instance, one widespread myth is that asking people about suicide encourages them to complete it. This myth contributes to a failure to ask about suicide risk. Third, most health care professionals are not aware of newly developed brief interventions for suicide, leading to the assumption that they should not ask about suicide because there is nothing practical that can be done in ordinary health care settings.

Evidence about Closing This Gap

Asking patients about thoughts of suicide or self-harm does not increase a person's risk of suicide (Dazzi, Gribble, Wessely, & Fear, 2014; Mathias et al., 2012). But it is a simple and effective way to uncover most suicide risk. In one of the largest studies to assess this issue, Simon et al. (2013) found that the widely used Patient Health Questionnaire-9 (PHQ-9) depression screening questionnaire was effective at identifying patients with an increased risk of suicide, noting there was a tenfold increase in suicide among patients who reported thoughts of death or self-harm "more than half the days" or "nearly every day" in the past two weeks. This suggests that routine screening could detect suicidal individuals who could then be treated.

It is important to note that these and other results do not show that "predicting suicide" with certainty is possible. It is not necessary to predict suicide with certainty to intervene effectively. Rather, the evidence is clear that it is possible to identify most individuals with greatly elevated risk, allowing us to provide targeted, effective supports during the period where their risk remains high. This is similar to identifying risk factors for heart disease so that something can be done about it (e.g. prescribing a statin, stopping smoking). As with suicide, health care organizations do not have a way to predict exactly *who*

will have a heart attack and *when* it will occur. But also as with suicide, we can identify people whose risk is high and prescribe treatments to greatly reduce this risk.

We should treat suicide prevention in health care systems as we treat heart attack prevention, with an emphasis on targeted preventive interventions for individuals with elevated risk. Most individuals with high cholesterol get a statin; most individuals with suicide risk should get brief interventions like safety planning and caring contacts.

> ***"We should treat suicide prevention in health care systems as we treat heart attack prevention."***

Is Identifying Suicide Risk Feasible?

The feasibility of identifying suicide risk has now been demonstrated in many behavioral health care, primary care, and emergency department settings. For example, one question such as "Within the last two weeks, have you had thoughts of killing yourself, or that you would be better off dead?" can identify most people with elevated risk (Simon et al., 2013). However, to assess if the risk is substantial and to guide action, we need a more thoughtful assessment of risk that is workable in the health care setting. Where feasible, this is done by a behavioral health professional using a standardized suicide risk assessment tool. Identification and assessment tools that do not require specialized mental health training are also available and in use. We provide information on some tools in Appendix A.

Implementing an identification and assessment protocol means we must think through what to do with individuals found to be at elevated risk. So the second major implication of an identification and assessment protocol is putting in place expectations for the care of people who have significantly elevated risk. This is where new tools and resources are available

Gap: Not Acting Effectively for Safety

Current practice for people who acknowledge suicidal thoughts or feelings often revolves around a decision of whether to hospitalize them or send them home, perhaps with a future appointment for mental health treatment. Unfortunately, neither of these options often adequately addresses the risks of suicide or the needs of suicidal people. Inpatient care may keep people safe for the few days they are hospitalized. However, very brief stays are not long enough to get many suicidal people through their period of elevated risk, and they are often discharged while still in a state of elevated risk (Crawford, 2004; Olfson et al., 2016; Qin & Nordentoft, 2005).

Additionally, hospital treatment (like other mental health care) usually does not directly address suicidal thought patterns, relying on the hope that treatment for other behavioral health diagnoses problems is sufficient. We now understand that this may not be true. As a result, suicide rates for the days and weeks immediately after hospitalization are extremely high (Crawford, 2004; Olfson et al., 2016; Qin & Nordentoft, 2005). We will discuss improved follow-up after emergency department visits and inpatient care, for individuals with elevated risk, as an essential intervention.

The other frequent choice in usual suicide care—to send people home with a future appointment—is also often not good enough. As many as half of initial mental health appointments are not completed (Bickley et al., 2013), while the risk of suicide is highest in the few days after discharge and well before scheduled outpatient visits (Crawford, 2004; Olfson et al., 2016; Qin & Nordentoft, 2005). Fortunately, practical brief interventions to address these problems are demonstrated effective.

Evidence about Closing This Gap

Two closely linked and relatively simple interventions that have been shown to reduce attempts and deaths for people at high risk for suicide are safety planning and lethal means reduction.

Safety planning (see Appendix B) is a brief intervention to help a patient develop a plan to recognize suicidal thoughts and manage them safely. Action steps may include calming activities, identifying supportive people to talk to and providing contact information for crisis call or text lines. Safety planning has been adopted by the Veterans Health Administration as part of its suicide prevention protocol (U.S. Department of Veterans Affairs, 2008), and it is recommended in the Sentinel Event Alert (The Joint Commission, 2016).

Lethal means reduction is a crucial part of safety planning. It involves identifying possible means of self-harm that are available to the individual (especially ones they may have considered, such as use of a weapon or overdosing on medications) and reducing access by taking specific steps, such as self-storage. Reducing access to lethal means has repeatedly been shown effective in community-wide suicide prevention and has been cited as a crucial factor in the success of suicide prevention efforts at the Henry Ford Health System (Coffey & Coffey, 2016).

Is Safety Planning with Lethal Means Reduction Feasible?

Safety planning with means reduction has now been embedded in the suicide care protocols of hundreds of health care organizations. As a brief intervention (e.g., 30 minutes) tied to a specific risk, safety planning is comparable to many other brief health interventions, such as counseling on smoking cessation or recommendations to modify diet or exercise. Different safety planning formats are available in the public domain and have been embedded in various electronic medical records systems.

Information on well-tested approaches to safety planning is included in Appendix B. High-quality online training modules on both safety planning and lethal means reduction may be accessed at www.zerosuicide.com.

Gap: Not Providing Supportive Contacts for People at Risk of Suicide

Isolation is both a risk factor and possible precipitant of suicide. Therefore, it is not surprising that brief supportive contacts—by phone, text, or even postcards or letters—are shown to reduce suicide and suicide attempts during high-risk periods, such as after hospitalization or emergency department visits (Luxton, June, & Comtois, 2013). Despite the research supporting "caring contacts," they are used infrequently in our health care systems, which tend to rely on scheduled visits. However, brief follow-up contacts are commonly used for other medical conditions (e.g., after outpatient surgery) and should be standard for individuals who are at risk of suicide.

> *"Safety planning with means reduction has now been embedded in the suicide care protocols of hundreds of health care organizations."*

Evidence about Closing This Gap

Timely supportive contacts (such as calls, texts, letters, and visits) should be standard for people with significant suicide risk after acute care episodes or when ongoing services are interrupted (e.g., a scheduled visit is missed). These caring contacts with high-risk individuals have been demonstrated to be effective in reducing self-

harm and suicide (Luxton et al., 2013). Caring contacts can be done by staff in any program that has provided acute care (e.g., emergency department or inpatient programs), by outpatient programs that provide ongoing care (during high risk periods or when an appointment is missed), or by crisis centers that can conduct follow-up under contract with other services. The evidence supporting caring contacts found that various methods of supportive contacts can be effective (Luxton et al., 2013).

> ***"Brief follow-up contacts are commonly used for other medical conditions (e.g., after outpatient surgery) and should be standard for individuals who are at risk of suicide."***

Feasibility of Caring Contacts

Routine caring contacts have been implemented effectively in community mental health, hospital, and integrated primary care settings. Crisis call centers that are part of the National Suicide Prevention Lifeline also have experience making caring contacts, both with callers who may not be engaged in care or as part of a follow-up protocol of inpatient programs.

Major barriers against caring contacts include the relative novelty of the approach, a lack of familiarity with the billing codes that may be used, and that they may not be reimbursable in some settings.

Framework for Recommended Standard Care for People with Suicide Risk

The recommended standard care elements outlined in Table 1 are based on research results, real world experience and expert judgement by a working group of health care and behavioral health care experts, including clinicians, researchers, health system and suicide prevention leaders, and people with lived experience perspectives. The standard care elements for emergency department care were selected from *Caring for Patients with Suicide Risk: A Consensus Guide for Emergency Departments*, which was developed through a careful process involving dozens of experts and stakeholders (Suicide Prevention Resource Center, n.d.-a).

For each setting, the recommended standard care elements describe actions that will have a high value in reducing suicide associated with health care organizations and that are feasible for implementation in settings of various sizes and scopes. For each setting (outpatient and inpatient behavioral health, emergency departments, and primary care), the recommended standard care elements build on or supplement care standards set by accrediting and certifying agencies such as The Joint Commission and the Centers for Medicare and Medicaid Services (CMS).

For each setting, the description summarizes the mission of the setting as it relates to suicide prevention, and describes the standard care actions providers should take to keep suicidal patients from "falling through the cracks." Recommended standard care elements applicable to the setting are also listed.

Table 1: Summary of Recommended Standard Care Elements by Major Care Setting

Setting	Emphasis	Identification and Assessment	Safety Planning	Means Reduction	Caring Contacts
Primary Care	Identify suicide risk among patients with MI/SUD* conditions or treatment. Enhance safety for those with risk. Refer to specialized care. Provide caring contacts	Identify suicidality in all patients with MI/SUD conditions or treatment (e.g., psychiatric meds) using a standardized scale. If risk is identified, proceed with active referral for hospital or outpatient care as judged appropriate.	Complete the brief Safety Planning Intervention during the visit where risk is identified. With consent, discuss the safety plan with the family to gain support for safety activities.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit or the next business day.
Outpatient BH* Care (Mental health and substance use treatment)	Provide treatment and support for individuals who may have elevated suicide risk.	Identify and assess suicide risk at admission and whenever patients are seen by using a standardized scale. Do not assess more than 1x per day. Use judgement if patients are seen daily.	Complete the brief Safety Planning Intervention during the visit where risk is identified Update the safety plan at each visit as long as risk remains high.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Initiate caring contacts during care transitions or if appointments are missed.
Emergency Department	Identify suicide risk among patients who have harmed/injured themselves or have MI/SUD conditions or treatment. Carry out the brief Safety Planning Intervention to enhance safety for those with risk. Refer to specialized care. Provide two caring contacts.	Identify and assess patients who have harmed themselves or have MI/SUD conditions or treatment (e.g., psychiatric meds) using a standardized scale. If risk is found, proceed with active referral for hospital or outpatient care as judged appropriate. If immediate transfer is not possible, provide a space for the patient that is "safe, monitored, and clear of items that the patient could use to harm himself or herself or others" (The Joint Commission, 2016).	Complete the brief Safety Planning Intervention during the visit where risk is identified. With consent, discuss the safety plan with the family to gain support for safety activities	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit. Make the second caring contact within 7 days of visit.
BH Inpatient Care (Hospital level psychiatric or addiction treatment)	Usually brief hospital treatment for individuals who may have high risk of suicide. Sometimes admission is precipitated by suicide attempt. Emphasis is on keeping patient safe while in the hospital and immediately following discharge.	Identify and assess suicide risk at admission and daily during stay—or more frequently as indicated by level of risk—using a standardized scale. In addition to other safety and treatment expectations during inpatient care, work with patient on a safety plan for their environment immediately post-discharge.	In addition to safety activities oriented at the hospital stay, complete the brief Safety Planning Intervention prior to discharge, aimed at safety in the patient's post-discharge environment. Discuss the safety plan with the family to gain support for safety activities.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible prior to discharge.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit. Make the second caring contact within 7 days of visit.

*Abbreviation key: BH – behavioral health | MI/SUD – Mental illness/substance use disorder

Recommended Standard Care Elements for People with Suicide Risk: Outpatient Mental Health and Substance Use Settings

Background

Outpatient behavioral health (BH) settings include clinics, mental health centers, day treatment or partial hospital programs, and group private practices (and as feasible, the elements of standard care are recommended for solo private practice therapists). These settings care for many individuals with suicidal thoughts and feelings and who may have been referred specifically because of their suicidality or a co-occurring substance use disorder, which increases suicide risk. While inpatient care is designed to initiate treatment, mitigate immediate risk and prepare patients for continuing care post-hospitalization, outpatient BH settings have a longer-term, ongoing role in treating individuals who may be or have been suicidal. Therefore, the ability to provide suicide safe care should be a core responsibility of outpatient BH settings, and competence and confidence in working with these individuals are essential.

Ideally, in addition to the recommended standard care elements defined in the following sections, outpatient programs or clinics should have available clinicians who can provide evidence-based treatments for suicidality, including Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention (CT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Brief Cognitive Behavioral Therapy (BCBT).

Overview of Recommended Standard Care Elements for People with Suicide Risk: Outpatient Behavioral Health Settings

The recommended standard care elements are the essential evidence-based and expert activities and competencies that should be in place in outpatient BH settings.

They include the following:

- On intake and periodically, assess all patients for suicide risk using a standardized instrument or scale (see Appendix A for a partial list of such scales).
- Stratify all patients according to the level of risk.
- For all patients with elevated risk:
  - ◇ As part of the treatment plan, complete a collaborative safety plan during the same visit (see Appendix B for a list of recognized approaches).
  - ◇ As part of safety planning, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means, including asking family members and significant others to assist.
  - ◇ Engage the patient in treatment with a licensed professional, preferably one who has training in suicide, including risk assessment and safety planning (visit the Zero Suicide website for training resources recommended by suicide prevention professionals: www.zerosuicide.com).
  - ◇ Reassess risk and review and/or update the patient's safety plan at every visit until the risk is reduced.

Recommended Standard Care Elements for People with Suicide Risk: Inpatient Mental Health and Substance Use Settings

Background

Minimum standards for inpatient BH care were established by The Joint Commission's 1996 Sentinel Event Alert on suicide risk reduction, and they have evolved since then. This 1996 Sentinel Event Alert was replaced with The Joint Commission's 2016 updated Sentinel Event Alert: Detecting and Treating Suicide Ideation in All Settings (The Joint Commission, 2016). The recommended standard elements we discuss here build on The

Joint Commission's and other regulatory requirements related to preventing inpatient suicide. These serve as a baseline for suicide safe care; they do not sufficiently address new findings about treating and managing suicidality. Accreditation and federal certification requirements (from CMS) set basic expectations for hospital care—expectations about assessment, treatment, and safe environments—that are applicable to all patients. The recommended standard care elements outlined below reflect "condition specific" expectations relevant to suicide.

Overview of Recommended Standard Care Elements for People with Suicide Risk: Inpatient Behavioral Health Settings

The following recommendations for standard care are expectations specific to patients who are suicidal. As with outpatient programs, there are additional measures to improve the quality of care that inpatient programs should establish, including staff training and providing treatments that are specifically focused on managing suicidality. However, the recommendations for standard care that follow define *essential* steps.

These standards may go beyond current practice in several ways. Most notably, the expectations for safety planning and caring contacts for the post-discharge environment may be new. These expectations are based on data showing that suicide rates are very high in the period immediately after discharge, in data showing that about half of all discharged patients do not complete a first outpatient visit within seven days after discharge, and in research showing the effectiveness of caring contacts. Therefore, these recommended standard care elements are fundamental to patient safety:

- Assess all patients for suicide risk using a standardized instrument or scale at intake and then daily during a patient's stay—or more frequently if indicated by the level of risk.
- Stratify all patients according to the level of risk.
- For all patients identified as having an elevated risk:
  - ◇ Complete collaborative safety planning:
    - To assure safety on the unit, complete hospital safety plan on admission (with updates as needed).
    - Prior to discharge, and to assure safety immediately post-discharge, develop a collaborative safety plan for the living environment or setting that the patient will return to. Include in the planning family members and/or other support individuals who may be involved with the patient post-discharge.
    - As part of the discharge safety plan, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means, asking family members and significant others to assist.
- For all patients, regardless of level of risk:
  - ◇ Following discharge, engage the patient in treatment with a licensed behavioral health professional, ideally one who has been trained in suicide care. Make sure to share all appropriate clinical information with that provider.
  - ◇ Complete caring contacts with patient (by phone, text, e-mail or face-to-face), preferably in the manner preferred by the patient:
    - Make the first contact within 24 hours of discharge.
    - Make the second contact within 7 days of discharge.

Recommended Standard Care Elements for People with Suicide Risk: Emergency Department Settings

Overview of Recommended Standard Care Elements for People with Suicide Risk: Emergency Department Settings

These standards are in large measure extracted from *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments* (http://www.sprc.org/ed-guide).

- Identify and assess suicide risk in all patients with poisoning (including overdoses), with an injury that may be self-inflicted, and who have behavioral health diagnoses or other clinical risk factors for suicide. For patients with an external injury, assessing and recording the cause of injury (e.g. accidental or self inflicted) may be essential in determining appropriate care.
- For patients with elevated risk, stratify risk and determine need for inpatient admission or discharge with support:
  - ◇ Secure inpatient admission if judged necessary.
  - ◇ Provide a space that is "safe, monitored, and clear of items that the patient could use to harm himself or herself or others" (The Joint Commission, 2016).
  - ◇ For patients with elevated risk who will be discharged with support:
    - Provide information on telephone crisis lines, including the National Suicide Prevention Lifeline number (1-800-273-TALK).
    - Complete a collaborative safety plan during the same visit.
    - As part of the safety plan, carry out steps to reduce access to lethal means, including asking assistance from family members and significant others.
    - Following discharge, engage the patient in treatment with a licensed behavioral health professional who has training in suicide.
    - Complete caring contacts with patient (by phone, text, e-mail or face-to-face) preferably in the manner preferred by the patient:
      - » Make the first contact within 24 hours of discharge.
      - » Make the second contact within 7 days of discharge.

Recommended Standard Care Elements for People with Suicide Risk: Primary Care Settings

Background

More individuals with behavioral health conditions are treated and more individuals with suicidality are seen in primary care settings than in specialty behavioral health settings (Luoma et al., 2002). Additionally, data show that almost half the individuals who completed suicide were seen in a primary care setting in the 30 days before they died. While universal screening for suicide in primary care settings has not yet been recommended by health authorities (U.S. Preventive Services Task Force, 2016), we conclude it is essential to explicitly consider suicide risk among all patients who present key risk factors for suicide—including having a diagnosed mental illness or substance use disorder—or who are being treated with a psychiatric medication.

Importantly, establishing limited and discrete suicide care activities in primary care is reasonable since there is now evidence on several brief and limited suicide prevention actions that are feasible in medical offices. These include: 1) a brief (e.g., 30-minute) safety plan intervention that can be completed by a physician, nurse, physician assistant, or other trained individual, and 2) completing two brief follow-up caring contacts within the week after the visit. Both of these activities are consistent with other health care activities carried out in primary care settings.

Traditional care patterns with patients at risk for suicide have allowed many to fall through gaps in care. For example, the fear that asking about suicidal thoughts can precipitate suicidal action is persistent, but a myth. It is more dangerous to not ask patients about suicide who have risk factors, such mental illness. Traditional approaches with patients who might be suicidal (e.g., referral to a mental health specialist, mental health hospitalization) make more sense, but gaps in psychiatric care—including that only about half the patients discharged from psychiatric units complete the recommended mental health outpatient visit within a week of discharge—make this approach incomplete.

Recommended standard care elements for suicide include the following:

- Identify and assess suicide risk in all patients who have a mental illness, misuse substances, have a substance use disorder or who have been prescribed a psychiatric medication. Assess degree of suicide risk for patients with any risk by using a standardized instrument or scale. Stratify patients by risk.
- For those with elevated suicide risk:
  - ◇ Complete a collaborative safety plan during the same visit:
    - As part of the safety plan, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means, including asking assistance from family members and significant others.
  - ◇ Engage the patient in treatment with a behavioral health professional, if possible with one who has training in suicide.
  - ◇ Complete a follow-up caring contact with the patient (by phone, text, e-mail or face-to-face), preferably in the manner preferred by the patient, within 24 hours of discharge or on the next business day.

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Appendix A: Suicide Screening and Risk Assessment Instruments

The following are some of the more widely used suicide screening and assessment instruments. This is not an exhaustive list – there are hundreds of screening and assessment tools available – nor should it be taken as a prioritized list. However, the following tools are commonly used by health care systems.

More information on the instruments can be found on the website listed in each summary and in the following comprehensive reviews:

- Brown, G. (2003). *A review of suicide assessment measures for intervention research with adults and older adults.* Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Brown2003
- Goldston, D. B. (2000). *Assessment of suicidal behaviors and risk about children and adolescents*. Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Goldston2000
- Range, L. M. (2005). The family of instruments that assess suicide risk. *Journal of Psychopathology and Behavioral Assessment, 6*, 127–139.

Some instruments are available in languages other than English. Unless otherwise noted, the instruments listed are free to use.

Screening Tools

Ask Suicide-Screening Questions (ASQ) National Institute of Mental Health
ASQ is a four-item suicide-screening tool designed to be used for people ages 10–24 in emergency departments, inpatient units, and primary care facilities. A Brief Suicide Safety Assessment is available to be used when patients screen positive for suicide risk on the ASQ. ASQ was developed by a team from the National Institute for Mental Health (NIMH). https://www.nimh.nih.gov/news/science-news/ask-suicide-screening-questions-asq.shtml

Behavioral Health Measure-10® (BHM-10®)
The BHM-10 is a 10-item tool that assesses patient depression, anxiety, and overall life functioning. The paper version is free. The BHM-10 was created by CelestHealthSolutions (www.celesthealth.com/), which has also developed 20- and 45-item assessment instruments that can be administered electronically, although these require a licensing fee. https://www.pointnclick.com/sites/default/files/files/CelestHealth%20Behavioral%20Health%20Measure-10%2001-29-2010.pdf

Behavioral Health Screen (BHS)
The BHS is the screening tool delivered by the BH-Works browser-based web software. The BHS screens across 16 domains of mental health and psychosocial risk factors. It assesses risk for depression, anxiety, substance misuse, traumatic stress, eating disor¬ders, psychosis, and suicidality. The BHS also measures psychosocial risk factors such as family environment, bullying, physical or sexual abuse, sexual behavior, gender identity, exercise, and safety. Versions for health care systems include: Child (ages 6-11); Adolescent Primary Care (ages 12-24); Primary Care (ages 24 and up); and Emergency Department (ages 12 and up). There is a licensing fee for this instrument. https://bh-works.com/

Brief Symptom Inventory 18® (BSI 18®)
The BSI 18 is an 18-item instrument designed to measure psychological distress and psychiatric disorders in individuals age 18 and older. It includes one suicide-specific question. The BSI 18 can be administered with paper and pencil, via computer, or online and takes approximately 4 minutes to complete. Manuals and trainings are available. There is a licensing fee for this instrument. http://www.pearsonclinical.com/psychology/products/100000638/brief-symptom-inventory-18-bsi18.html

Columbia-Suicide Severity Rating Scale (C-SSRS)
The C-SSRS features questions that help determine whether an individual is at risk for suicide. There are brief versions of the C-SSRS often used as a screening tool (first two questions) that, based on patient response, can lead to the administration of the longer C-SSRS to triage patients. http://www.cssrs.columbia.edu/

Outcome Questionnaire 45.2® (OQ-45.2®)
The OQ 45.2 helps mental health professionals assess symptom distress (depression and anxiety), interpersonal relationships (loneliness, conflicts with others, and marriage and family difficulties), and social role (difficulties in the workplace, school, or home). It includes explicit questions about suicide and is for use with adults. There is a licensing fee for this instrument. http://www.oqmeasures.com/

Patient Health Questionnaire-9 (PHQ-9) Depression Scale
The PHQ-9 is a widely used nine-item tool used to diagnose and monitor the severity of depression. Question 9 screens for the presence and duration of suicide ideation. This screening tool and an instruction manual are available at no cost. http://www.phqscreeners.com

Suicide Behavior Questionnaire-Revised (SBQ-R)
The SBQ-R is 4 item self-report questionnaire that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones, and includes a question about lifetime suicidal ideation, plans to commit suicide, and actual attempts. https://www.integration.samhsa.gov/images/res/SBQ.pdf

Assessment tools

Columbia-Suicide Severity Rating Scale (C-SSRS)
The C-SSRS is frequently used as a secondary suicide assessment tool following the use of one of the screening tools listed above. The Columbia Lighthouse Project offers a variety of C-SSRS tools for use by family, friends and neighbors, first responders, researchers, and health care providers, among others. C-SSRS tools for health care providers include screens to assess whether suicide risk has been evident over the patient's lifetime, more recently, or since the patient's last health care contact. Tools are available for screening children, people with cognitive impairments, and patients at discharge and in emergency departments. A variety of training webinars and online trainings are also available. There is no charge for C-SSRS tools or trainings. http://www.cssrs.columbia.edu/

M-3 Checklist™
The M3 website encourages individuals to complete the M3 Screen, a private, self-rated checklist for potential mood and anxiety symptoms. The checklist responses trigger a feedback page indicating each individual's relative risk for Depression, an Anxiety Disorder, Bipolar Disorder and PTSD. The Screen responses and the resulting M3 analysis of risk may be printed, emailed, or securely accessed online by a designated health care professional, at the discretion of the user. The M3 is not designed to diagnose illness on its own. Rather, it is meant to elicit symptoms that may indicate a psychiatric illness. Physicians must use the symptoms checklist responses and the risk assessment provided as a basis for formulating a diagnosis and treatment. The M3 website does provide physicians with supplemental information that guides them through this formulation, including relevant follow-up questions to ask. There is a fee for providers to purchase a license to use this with patients. https://whatsmym3.com/

Reasons for Living (RFL)
The RFL is a self-report questionnaire that measures clients' expectancies about the consequences of living versus killing oneself and assesses the importance of various reasons for living. The measure has six subscales: Survival and Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections. http://depts.washington.edu/uwbrtc/resources/assessment-instruments/

Appendix B: Safety and Stabilization Planning

Aeschi Approach

The Aeschi Approach (Michel & Jobes, 2010) advocates building a therapeutic alliance with suicidal patients from a place of empathy. Once risk is identified in a patient, the patient is then given space to share their narrative and plan for safety in collaboration with the clinician. http://www.aeschiconference.unibe.ch/Guidelines_for_clinicians.htm

https://www.amazon.com/Building-Therapeutic-Alliance-Suicidal-Patient/dp/1433809079\

http://www.aeschiconference.unibe.ch/

Counseling on Access to Lethal Means (CALM)

CALM is a free online course for providers on how to ask patients about their access to lethal means. http://zerosuicide.sprc.org/resources/counseling-access-lethal-means-calm

CAMS Stabilization Plan

Collaborative Assessment and Management of Suicidality (CAMS) is a clinical philosophy of care and a flexible clinical framework developed by David Jobes (2009). Stabilization planning is a core component of CAMS, and it includes identifying warning signs, brainstorming short-term problem-solving skills, identifying contact information of support persons and emergency contact numbers, formulating a plan to reduce access to lethal means, and developing strategies for reducing barriers to treatment.

Jobes, D. A. (2009). The CAMS approach to suicide risk: Philosophy and clinical procedures. *Suicidologi, 14, 3–7.*

Crisis Response Safety Plan

The Crisis Response Safety Plan (Rudd, Joiner, & Rajab, 2006) is a written, collaborative document that focuses on strength-based and calming skills building. Each of the seven steps of the safety plan are phrased from the perspective of the patient (e.g., "Step 1: I will try to identify specifically what's upsetting me."). https://dbhdid.ky.gov/dbh/documents/cmc/2015/McFarland1.pdf

http://www.ccsme.org/userfiles/files/NoSuicideContracts.pdf

Stanley and Brown's 2012 Safety Plan Intervention

Stanley and Brown's Safety Plan Intervention (2012) is a five-step safety plan that helps clinicians work with patients so both develop a better understanding of patients' warning signs, internal coping strategies, external and social coping strategies, people they can go to for help, and professional agencies to contact during a crisis. It also includes a space to plan ways to make a patient's environment safer. http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog___Beh_Practice.pdf

Appendix C: Other Resources

Crisis Text Line

The Crisis Text Line provides free, 24/7 support via text messaging for those in crisis. Individuals can text 741741 from anywhere in the United States and connect to a trained volunteer crisis counselor. https://www.crisistextline.org/

National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline (1-800-273-TALK [8255]) provides free, 24/7 access by phone to a trained volunteer crisis counselor. https://suicidepreventionlifeline.org

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