PRESENTATION NOTES

Instructions for the presenter are in italics. Suggested remarks for each slide are in regular type. Estimates of how long each slide should take are included in the notes to assist with keeping the presentation within 1 hour.

Slide 1—Title Slide (2 minutes)

Insert presenter contact information in text box prior to presentation.

Introduce yourself and ask participants to give their names and roles in the clinic/office.

State that the presentation will take approximately 1 hour.

The Know the Signs Social Marketing Campaign for Suicide Prevention is part of statewide efforts to prevent suicide, reduce the stigma and discrimination related to mental illness, and promote the mental health and wellness of all people in California.

These initiatives are funded by counties through the Mental Health Services Act (Proposition 63) and administered by the California Mental Health Services Authority (CalMHSA), an organization of county governments working to improve mental health outcomes for individuals, families, and communities.

Slide 2—About This Presentation (1 minute)

This presentation is based on two sources of information:

1. The *Suicide Prevention Toolkit for Rural Primary Care Practices*, created in collaboration by the Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE)
2. A training created by the San Diego Health and Human Services Agency and Suicide Prevention Council

Let participants know where they can obtain copies of the SPRC/WICHE toolkit, and whether a copy of the toolkit is available in the office for referral.

Slide 3—Agenda (1 minute)

1. We will begin by discussing the basic principles of the comprehensive approach to suicide prevention in the primary care setting.
2. We will also discuss the reasons for and value of focusing on suicide prevention in the primary care setting.
3. Next we'll have an overview of the epidemiology of suicide.
4. Then we'll talk about the warning signs of suicide and go over the risk factors associated with suicide, as well as how to assess patients for suicidal risk.
5. We will review suicide risk assessment and follow-up procedures.
6. We will discuss the Office Plan of Action. This is a vital component to ensure the safety and well-being of your patients, and it will streamline response, care, and referral for your patients.
7. And we will conclude with a review of resources and a time for discussion.

Slide 4—Key Principles (3 minutes)

1. Comprehensive suicide prevention involves being proactive and implementing training and procedures broadly in your office **before** a crisis arises.
2. Integrating a systems approach into your office protocols will result in a more thorough and effective plan when a patient may be at risk of suicide.
    a. It is important for every member of your staff to be familiar with not only office protocol but also with recognizing potentially suicidal patients.
    b. For example, front office staff are the first to greet patients when they arrive and the last to see them before they depart. They may be more familiar with a patient's appointment records or financial issues (cancellations, re-schedules, billing issues, collections) and thus may observe warning signs and risk factors not evident during a typical examination.
3. Asking the Right Questions and Connecting to Help
    a. Most people who may be considering suicide will not volunteer this information without prompting, but they may respond to thoughtful questions. This presentation will help you learn to identify when someone might be at risk, their level of risk, and the interventions that can help them stay safe and get help.

b. When inquiring about suicide, it is recommended that you be direct in your questioning. Many people have the misconception that asking someone about suicide might give them the idea or appear to encourage it. However, being direct and comfortable with the subject will help your patient feel more confident to share information.

c. Familiarity with the assessment tools and intervention strategies discussed in this training will increase your staff's confidence as well as the likelihood of gaining pertinent patient information that may elicit suicidal intent or plans.

4. Whether or not your facility, or one in your network, provides behavioral health services, it may be necessary to refer to and utilize additional community resources.

    a. The referral process should be as seamless as possible and follow-up provided to promote continuity of care.

    b. What community resources are available in your area? These could include substance abuse programs, support groups, treatment facilities, as well as others. *Ask participants to name a few resources.*

    c. We will also touch on what additional services and supports beyond behavioral health can be useful.

Slide 5—Why focus on suicide prevention in the primary care setting? (2 minutes)

1. As part of health care reform, behavioral health and primary care are becoming more integrated and prevention more emphasized.

    If asked, suggest they visit the Integrated Behavioral Health Project website at www.ibhp.org *for more information on this subject.*

2. Primary care is often the place where patients come for most, if not all, of their health needs, including mental health concerns. This is especially true in areas with limited access to mental health services.

3. Approximately 70%–80% of antidepressants are prescribed in the primary care setting.

    Refer to the following citation if asked:

    Mojtabai, R., & Olfson, M. (2008). National patterns in antidepressant treatment by psychiatrists and general medical providers: Results from the National Comorbidity Survey replication. *Journal of Clinical Psychiatry, 69*(7), 1064–74.

4. The American College of Preventive Medicine recommends that all primary care practices have systems of care in place to assure accurate diagnosis, effective treatment, and follow-up for depression.

   Refer to the following citation if asked:

   Mitchell, J., Trangle, M., Degnan, B., Gabert, T., Haight, B., Kessler, D., . . . Vincent S. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care.* Updated September 2013. Retrieved from **https://www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf**

5. On average, 45% of people who died by suicide had contact with primary care providers within one month of their death, and over 75% had such contact within a year of their death. This is especially true of older adults who see their primary care providers more frequently than younger adults do. All of this suggests there may have been missed opportunities to identify the patient's suicidality.

   Refer to the following citation if asked:

   Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909–16. Retrieved from **http://www.ncbi.nlm.nih.gov/pubmed/12042175**

Slide 6—Why focus on suicide prevention in the primary care setting? (cont'd) (2 minutes)

6. Primary care staff are in a position to observe many of the warning signs and risk factors of suicide, but only if they know what to look for. They are also in a position to recognize risk factors and life circumstances that may be cause for further assessment and follow-up. Some of these may be somatic complaints, for example, unexplained body aches and pain, changes in sleeping patterns, and stress-related symptoms.
7. Stigma can be a barrier to accessing needed mental health services. Your patients may be more likely to come to you initially for mental health concerns than to risk "exposure" by visiting a mental health clinic.
8. Primary care providers often have ongoing relationships with patients. This relationship can increase opportunities to see changes in risk factors and the emergence of warning signs in patients, and offer the opportunity to "check-in" on the mental health status of patients over time.

Slide 7—Populations at Highest Risk Include . . . (2 minutes)

Suicide impacts people of all races and ethnicities, ages, and genders. However data show that certain populations are at particularly high risk.

- The highest numbers of suicide deaths occur among middle-aged white males.

- There are a number of groups that also have very high rates of suicide (number per 100,000), for example white males age 65 and older, and Native American and Alaska Natives between the ages of 10 and 39.
- Females attempt suicide three to four times more frequently than males.
- People identifying as lesbian, gay, bisexual, transgender, and questioning (LGBTQ) have disproportionately high rates of suicide **attempts** compared to their straight peers. For LGBTQ youth, acceptance or rejection by their families and support networks are major factors affecting their resiliency.
- Military veterans face multiple risk factors for suicide: gender is primarily male, diminished social support, medical and psychiatric conditions that may increase risk (such as posttraumatic stress disorder and traumatic brain injuries), as well as comfort with and access to highly lethal means (i.e., firearms).

Slide 8—California Statistics (optional slide) (1 minute if used)

If you choose to use the slide, visit the California Dept. of Public Health's EpiCenter website (http://epicenter.cdph.ca.gov/) to obtain state-level data on deaths, hospitalizations, and emergency room visits for self-inflicted injuries. Insert that data here.

Note that the most current data posted on EpiCenter is usually two years older than the current calendar year.

Slide 9—Local Statistics (optional slide) (1 minute if used)

If you choose to use the slide, visit http://epicenter.cdph.ca.gov/ to obtain county-level data on deaths, hospitalizations, and emergency room visits for self-inflicted injuries and insert here. Contacting your local behavioral health agency to see if they have more current local data is also a good idea, since the most current data posted on EpiCenter is usually two years older than the current calendar year.

Slide 10—John Jones (5 minutes)

Review scenario. Facilitate a brief discussion about what factors might be a cause for concern.

Questions to pose:

- Would you be worried that this patient might be suicidal?
- If so, what specifically concerns you?
- If not, why not?

Slide 11—Warning Signs and Risk Factors (2 minutes)

Distribute:

- Handout A: Warning Signs of Suicide
- Handout B: Assessment and Interventions with Potentially Suicidal Patients: A Pocket Guide for Primary Care Professionals

Indicate that Handout B, the Pocket Guide, is primarily a tool for clinicians, however these handouts synopsize information that will be provided throughout most of the remaining presentation so they have been provided for everyone to reference.

We will discuss individual warning signs and risk factors in this section; however, keep in mind that every individual and situation is different. What impacts one person profoundly might not have the same effect in another due to a wide variety of factors. Conduct a suicide risk assessment whenever you are concerned that a patient may be at risk for suicide.

Warning Signs

- A suicide warning sign is the earliest detectable sign that indicates a person is at a heightened risk for suicide in the near term (i.e., within minutes, hours, or days). These are observable clues and behaviors, such as talking about death or acquiring lethal means.
- The warning signs of suicide relate to an individual's immediate state. Similar to the warning signs of a heart attack—chest discomfort or shortness of breath—the warning signs of suicide signal the potential for immediate or short-term crisis. Also similarly, it is a cluster of these signs that most strongly signal risk rather than only one or two warning signs.

Risk Factors

- Suicidal behavior is complex and is not caused by a single risk factor or life event. Risk factors tend to be longer term than warning signs and are not, in and of themselves, an indication of immediate suicide risk. Whereas warning signs always refer to an individual's current state, risk factors are often based on population-level data.
- To continue the analogy, risk factors of a heart attack might include older age, family history of heart disease, and lifestyle factors.

Slide 12—Key Warning Signs (1 minute)

- These three key warning signs are the most indicative of a crisis situation:
    - Threatening to hurt or kill oneself, or talking of wanting to hurt or kill oneself
    - Looking for ways to kill oneself (purchasing a gun, stockpiling pills, etc.)
    - Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- If any of these warning signs are present, immediate action is necessary. We will be talking more about how to assess the level of risk and what interventions might be needed later in this presentation.
- Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change in life circumstances.
- If the patient has been accompanied by a family member or friend, that person may be able to offer key insights into the patient's state of mind, recent crises, and behaviors.

Slide 13—Additional Warning Signs (1 minute)

The following warning signs may not indicate an immediate crisis, but they are also cause for concern:

- Feeling hopeless.
- Feeling rage or uncontrolled anger or seeking revenge.
- Acting reckless or engaging in risky activities—seemingly without thinking; these behaviors may actually "mask" thoughts of self-harm.
- Feeling trapped—like there's no way out; statements such as "I just feel trapped" or "what's the point" should be taken seriously and followed up on.
- Increasing alcohol or drug use.

Slide 14—Additional Warning Signs (cont'd) (1 minute)

- Withdrawing from friends, family, and society – Increased withdrawal is often a sign of mental health issues, such as anxiety or depression. Ask the patient if they have been seeing friends or family as they usually would, or if they have become anxious about social interactions and responsibilities.

- Feeling anxious, agitated, or unable to sleep or sleeping all the time.
- Experiencing dramatic mood changes.
- Seeing no reason for living or having no sense of purpose in life.

Slide 15—Individual Risk Factors (1 minute)

- A combination of individual, relational, communal, and societal factors contribute to the risk of suicide.
- Three major factors to be aware of are a prior attempt, major depression, and substance use disorders.
- As many as 90% of people who die by suicide had a **diagnosable** mental health and/or substance abuse condition. Unfortunately, many mental health issues are undiagnosed unless a crisis situation arises. When an individual receives treatment, 70%–90% will have a significant reduction in symptoms and improved quality of life.

  Refer to the following citations if asked:

  Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

  National Institute for Mental Health. (2005, June 6) Mental illness exacts heavy toll-beginning in youth [press release]. Retrieved from http://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml

  National Alliance on Mental Illness (NAMI). (n.d.) What is mental illness: Mental illness facts. Retrieved from http://www.nami.org/template.cfm?section=about_mental_illness

Slide 16—Individual Risk Factors (cont'd) (2 minutes)

- Diagnosis of a serious or chronic illness may cause a person to feel frustration, anxiety, and even hopelessness. They may ponder their reasons for living, and question whether they will become a burden to others. Addressing these concerns can help identify potential thoughts of suicide.
- Central nervous system disorders can also elevate suicide risk. Some studies have found elevated risk of suicide and suicide attempts among people with severe traumatic brain injuries (TBIs).

  Refer to the following citation if asked:

  Simpson, G., & Tate, R. (2007). Suicidality in people surviving a traumatic brain injury: Prevalence, risk factors and implications for clinical management. *Brain Injury, 21*(13–14), 1335–51.

- Impulsive and/or aggressive tendencies
- Exposure to trauma, including death of loved ones to suicide, can increase an individual's risk of suicide. Some studies have shown that posttraumatic stress disorder (PTSD) is significantly associated with suicide ideation and attempts.

  Refer to the following citation if asked:

  Sareen, J., Houlahan, T., Cox, B., & Asmundson, G. J. G. (2005). Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey. *Journal of Nervous and Mental Disease. 193*(7), 450–454.
- Suicide risk can run in families. The Hemingway family is an often-cited example, which had five members dying by suicide over four generations. Factors that may influence this include psychiatric conditions, traits such as impulsivity and aggression, and other factors. The important thing is to note whether or not the patient has had a family member die by suicide; it need not be a recent death.

Slide 17—Social/Environmental Risk Factors (2 minutes)

- Although stressful life events and situations may elevate a person's risk, or precipitate a crisis, most people handle such events without becoming suicidal. But for some people, their inability to effectively cope with the crisis may lead them to feel suicidal.
- A lack of social support, real or perceived, can impact a person's ability to cope with life stressors.
- Ready access to highly lethal means can greatly influence risk.
- Exposure to suicide, whether through death of a friend or loved one or through the media, can elevate a vulnerable person's own suicide risk. The grief of a survivor of suicide loss can be especially complex and traumatic.
- Legal problems, civil or criminal, or recent incarceration can also increase risk.
- Barriers to receiving health care, including behavioral health care, such as cost, and transportation, can elevate risk.

Slide 18—Precipitating Events (1 minute)

Precipitating events that cause overwhelming emotions of humiliation, shame, or despair may also increase risk of suicide. These can include significant health conditions or the loss of a job. When one of these events has occurred, risk factors that have been more long-term or latent can become more significant.

Slide 19—When to Conduct a Suicide Risk Assessment (1 minute)

If any suicide warning signs are evident or if significant risk factors are present, suicide risk assessment is warranted. Generally, the more warning signs and risk factors present, the greater the individual's risk.

Slide 20—Key Components of a Suicide Risk Assessment (1 minute)

Patients will generally not spontaneously report that they are feeling suicidal, but 70% communicate their intentions or wish to die to significant others. When possible, and always with adolescents, seek to confirm the information you obtain from the patient with additional information from a family member, spouse, or close friend.

In the next few slides we will review the five key components of a suicide risk assessment.

Slide 21—Assessing Risk Factors (1 minute)

There are three main ways to assess risk factors: use of screening tools, observation or knowledge of the patient's history, and interviewing the patient.

Many practitioners prefer to use a screening tool. (We will talk more about screening tools on the next slide.)

Observation or knowledge of patient history and interviewing the patient: Follow up on routine questions such as "How have you been sleeping lately?" or "Has there been any change in how many drinks you have per week?" These questions may offer valuable insight into a patient's mental health status. This is especially important when dealing with patients with previously diagnosed mental illnesses such as depression.

Slide 22—Using Screening Tools to Identify Risk Factors (1 minute)

Some offices will incorporate screening tools as a regular part of routine visits and check-ups, while others choose to only utilize screening tools if certain symptoms present.

The Patient Health Questionnaire, or PHQ-9, is a nine-question tool that has been validated across populations and is available in different languages. It is a self-reporting questionnaire that can be an effective and time-efficient way to screen patients. The final item screens specifically for the presence of suicidal ideation. A website where you can access screening tools, including the PHQ-9, in a variety of languages is provided in your Resources handout.

Systems should be in place to ensure results are appropriately reviewed. Your office protocol can identify who is qualified and responsible to review the results, and include follow-up steps for when potential suicide risk is identified.

Slide 23—Starting the Conversation (1 minute)

Even if you aren't using a screening tool, these questions can help start the conversation:

- Sometimes, people in your situation lose hope. I'm wondering if you may have lost hope, too?
- Have you ever thought things would be better if you were dead?
- With this much stress, have you ever thought of hurting yourself?

If thoughts of suicide are suspected, the next step is to follow up with a suicide inquiry to assess suicide intent.

Slide 24—Assessing Suicide Intent (1 minute)

Discussing specifics about suicidal intent can be uncomfortable, but by finding out how thoroughly they have thought through their plan, you can better understand to what extent the patient expects to carry out his or her plan. This information will also help determine if the patient believes the act will be lethal vs. self-injurious.

These questions can guide you when assessing suicidal ideation:

- Are you thinking about suicide? Are you thinking about killing yourself?
- When did you begin thinking about suicide?
- Did any event cause these thoughts?
- How often do you think about suicide?
- How long do these thoughts last?

Slide 25—Considerations (5 minutes)

Facilitate a brief discussion about interviewing potentially suicidal patients with empathetic concern. Solicit input from the audience about how they might use visual, physical, and verbal cues to gently elicit suicidal thoughts from the patient. Ensure most of the following items are covered in the discussion:

Ideas for visual, physical, and verbal tactics the provider can use to communicate empathetic concern:

Visual:

- Maintain eye contact, at eye level if possible.

Physical:

- Use appropriate physical contact (hand on shoulder, back of arm)
- Turn shoulders towards person, give them your full attention
- Avoid crossing your arms across your body and other restrictive body language

Verbal:

- Ask open-ended questions where possible
- Avoid asking leading questions such as “You’re not thinking about suicide, are you?”
- Use a friendly, caring tone of voice (like you would use for a loved one or family member)
- Use reflective listening “one-liners”
- Offer reassuring statements

Other considerations:

- During this questioning, consider the patient’s judgment and level of impulse control.
- Look for disagreement between what you see (objective findings) and what the patient tells you about his or her suicidal state (subjective findings).

Slide 26—Assessing Suicide Planning (1 minute)

After assessing suicide intent, the next step is to inquire about planning.

These are some questions that can help you assess whether the person has a plan and how intent they may be on acting out the plan:

- Do you have a plan? If so, how would you do it? Where would you do it?
- Do you have the _____ (means) that you would use? Where is it right now?
- What have you done to begin carrying out your plan? Have you made other preparations?
- What stops you from carrying out your plan?

Slide 27—Assessing Protective Factors (1 minute)

Assessing protective factors can help figure out the individual's level of risk and are part of the safety planning process (which we will discuss in detail later).

Protective factors can help mitigate risk in a person with moderate to low suicide risk, but may not counteract significant, acute risk.

Review the protective factors on the slide. Ask the participants to suggest some additional protective factors.

Slide 28—Clinical Judgment (2 minutes)

The decision tree you see on the slide is a snapshot from the pocket guide handout (Handout B) you have been provided. This handout also provides a review of warning signs and risk factors, as well as sample questions to assist in suicide inquiries.

Assessing suicide risk is complex, and no screening tool or questionnaire can predict with certainty which patients with suicide risk will go on to make an attempt, either fatal or non-fatal. The pocket guide is a quick reference to help identify and assess levels of suicide risk in your patients.

- **Low Risk:** At the low end of the risk spectrum are patients with thoughts of death or wanting to die, but without immediate suicidal intent or a plan.
- **Moderate Risk:** Suicidal thoughts are present, but limited intent and no clear plan; may have made a previous attempt
- **High Risk:** Those with highly specific suicide plans, preparatory acts, or suicide rehearsals and clearly articulated intent are at the high end. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates risk.

Slide 29—Safety Planning and Support (3 minutes)

Distribute:

- Handout C: Safety Planning Guide
- Handout D: Sample Safety Plan

Point out that the safety planning handouts are primarily a tool for clinicians to use with patients, but that copies are provided to everyone for their reference.

If you cannot obtain copies for this presentation, let participants know that safety planning tools are included with the SPRC/WICHE Toolkit, or where they can access them: the office copy of the toolkit (if provided), the toolkit website, or from **http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf***).*

A safety plan is developed collaboratively with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The safety plan includes, but is not limited to, the following:

- Removal of lethal means
- Contacting the patient's support network
- Listing crisis resources

The plan is developed in six steps:

1. Help the patient to recognize signs that a crisis may be approaching. He or she will be more prepared to avoid crisis situations and also be more aware of when a situation has risen to crisis levels and further action is necessary.
2. Help the patient identify coping strategies that he or she can use to soothe their emotions and avert a crisis.
3. Social contacts and settings can provide a distraction for many patients. Ask the patient about people or social settings that help take their mind off their problems or that help them feel better.
4. The patient's support network is a key component of suicide prevention. Help the patient identify friends and family members that they feel they could talk to about their suicidal thoughts.
5. The patient's social network may also include professional contacts, such as clergy, a therapist, a primary care doctor, or a suicide prevention hotline. Calling the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to the emergency room are possible next steps if a crisis escalates.

   Patients may need assistance with identifying their social supports, especially in the midst of a crisis. Having a predetermined list of supportive individuals and their contact information will increase the likelihood that the patient will seek help before or during a crisis.
6. Reducing access to lethal means is important. Friends and family can help by holding onto excess medications, weapons, and other instruments that could be used in a suicide attempt. Training is available (Counseling on Access to Lethal Means) to learn how to assess and potentially reduce immediate risk. Information on this training is included in your Resources handout.

Slide 30—Brief Office Intervention (3 minutes)

This slide provides an overview of a brief office intervention.

1. Follow-up visits:
    - If a patient presents at risk of suicide, aside from other treatment interventions, it is recommended that follow-up visits be scheduled with the patient to monitor his or her status and level of care. Tracking logs are helpful to ensuring the patient's needs are being met.
2. Referrals and warm handoff:
    - Encouraging social support and involving family members, close friends, and community resources is a good idea regardless of risk levels. If the patient sees a mental health professional, call him or her in the presence of the patient.
    - Facilitate a referral for low- or moderate-risk patients who are not currently in mental health treatment but might benefit from these services.
    - For patients in the moderate- and high-risk categories who have symptoms of a psychiatric disorder, consider a referral to a psychiatrist for a medication evaluation.
    - Some high-risk patients may need to be hospitalized, for example if they have severe psychiatric symptoms, an acute precipitating event, access to lethal means, or poor social support. Patients can be psychiatrically hospitalized voluntarily or involuntarily. Have information about California's involuntary treatment laws available in the office.
    - High-risk patients without these factors may be referred to outpatient treatments or other services.

Provide outreach materials from your local crisis center to participants, if available. Lifeline affiliated crisis centers can be found at http://www.suicidepreventionlifeline.org/getinvolved/locator.aspx *or from* http://www.my3app.org/wp-content/uploads/2013/11/My3_Guide_C1.pdf.

If these materials are not available, Lifeline information is provided here and also included on the Resources slide (slide 33):

- Regardless of risk category, always provide information about the National Suicide Prevention Lifeline, 1(800)273-TALK (8255), to both the patient and his or her family and friends. By calling the Lifeline, patients or caregivers will be connected to the nearest accredited crisis center within California. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 services when indicated. It is also recommended you have materials available in your office about local crisis center services, alcohol and drug services, etc.

3. Crisis Support and Safety Planning was discussed in the previous slide.
4. The next slide will focus on documentation.

Slide 31—Documentation (1 minute)

Be sure to record risk assessment, rationale, and treatment plan in the patient's record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers. Continued entries in the tracking log will assist in the patient's continuity of care.

Slide 32—Office Plan of Action (2 minutes)

Distribute:

- Handout E: Office Protocol Development Guide

The purpose of an office protocol is to anticipate and have an appropriate plan in place **before** a suicidal patient is identified. This "crisis plan" for the office allows providers and office staff to be more prepared **if there is** the need to arrange a safe environment for a patient who is assessed to be at high risk for suicide.

Having the insight of all personnel will aid in answering questions and creating procedures to make the referral, treatment, or hospitalization of a patient more streamlined and effective.

Having an office protocol posted in the office will simplify the process of further assessing and potentially hospitalizing a high-risk patient.

The Office Protocol Development Guide includes questions that will help create your office protocol. These are just a few of the questions to consider when developing office protocols related to suicidal patients.

Review questions on slide.

Slide 33—Suicide Prevention Resources (1 minute)

Distribute:

- Handout F: Resources

By visiting the Know the Signs website, you will have access to a review of warning signs and risk factors as well as additional information about local resources. Under Reach Out, you can access an information page for each county in California.

Local and national crisis lines are also available to you as professionals to further assist you in coordinating care for a person at increased risk of suicide.

MDHelpSD.org: This site is designed to help primary care physicians recognize symptoms of mental disorders in their patients. On the Resources page, you'll find tips for talking with patients about their concerns, information on recognizing warning signs of mental illness, helpful fact sheets, and a host of other resources to provide patients the guidance they need.

Counseling on Access to Lethal Means is a 1.5–2 hour workshop designed to help providers implement counseling strategies to help patients at risk for suicide and their families reduce access to lethal means. You can find out more about the workshop at the SPRC website: **http://training.sprc.org/**

Slide 34—MY3 Suicide Prevention Mobile Application (1 minute)

Distribute:

- Handout G: MY3 Mobile App Flier

Note: The second page of the handout includes information about crisis centers in California.

MY3 was created in partnership with the National Suicide Prevention Lifeline. MY3 is marketed through health care providers, survivor support groups, and crisis centers. The goal of MY3 is to connect individuals who are at risk for suicide to their primary support networks when they are in crisis, and to help them build their safety plan for self-care.

MY3 is available for iPhone and Android systems, in English and Spanish, and is free of charge. More information about MY3 and additional marketing materials, including a brief video and customizable fliers, are available on **www.my3app.org**.

The app is a tool that you can share with your patients as part of the safety planning process. Guidance for safety planning is available on the MY3 website.

Slide 35—Suggestions for Local Resources (1 minute)

It may be useful to have a list of local resources handy to share with patients. Some examples might include:

- Walk-in counseling clinics
- Mental health warm lines

- Substance abuse programs and services
- Survivor support programs—Survivors are individuals who have lost someone to suicide. The grief following a suicide loss is complicated, and many survivors find that only another survivor can really understand their situation and offer some comfort and healing. In a small pilot study, 94% of adult survivors that used suicide grief support services found it moderately or very helpful compared to only 27% that found a general grief support group helpful. The same study found that every survivor who had the opportunity to talk one-on-one with another suicide survivor found it beneficial.

  Refer to the following citation if asked:

  McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008, July). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior, 38*(4), 375–389.

Solicit other resources from participants if you have time.

Slide 36—Contact Information (1 minute)

Add to slide any relevant contact information: presenter, county contact, etc.

Slide 37—Know the Signs logo

If there is time, facilitate a question and answer period.

End by distributing the following handout and encourage participants to fill it out before leaving.

- Handout H: Training Evaluation