

TRAINING RESOURCE GUIDE
FOR SUICIDE PREVENTION
IN PRIMARY CARE SETTINGS

Pain Isn't Always Obvious

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THE SIGNS

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Suicide Is Preventable

TRAINING RESOURCE GUIDE FOR SUICIDE PREVENTION IN PRIMARY CARE SETTINGS

This document and supporting materials may be downloaded from the Resource Center at Your Voice Counts (www.YourVoiceCounts.org) and from the website of the California Integrated Behavioral Health Project (www.ibhp.org).

ABOUT THE FUNDER

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and

communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Proposition 63). Proposition 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

For questions about this document, please contact KnowTheSigns@edc.org.

May 2014

Pain Isn't Always Obvious



Dear Mental Health Director,

Primary care is where many patients come first for most of their health needs, including behavioral health. These needs may include mental health screening, services, or referrals. However, primary care staff often feel unprepared to address mental health concerns, especially when it comes to suicide.

As part of statewide efforts to reduce suicides, the Know the Signs Social Marketing Campaign has developed the enclosed *Training Resource Guide for Suicide Prevention in Primary Care Settings* to help guide your county's efforts to engage primary care in suicide prevention. Information contained in the Training Resource Guide is based on 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). The training is adapted from a model tested in federally qualified health clinics throughout San Diego County by the San Diego County Health and Human Services Agency.

The Training Resource Guide includes:

- Suicide Prevention in Primary Care Settings: A one-hour suicide prevention training (including PowerPoint slides, detailed notes for the presenter, and related handouts) intended for the entire office staff in a primary care setting
- Tips, tools, and templates to support the planning and implementation of the training
- Three copies of the *Suicide Prevention Toolkit for Rural Primary Care Practices*, which can be shared with primary care offices and clinics

By investing a relatively short amount of time, primary care practices can be better prepared to examine their office protocols and procedures to integrate suicide prevention into the primary care culture. We hope that you will disseminate these materials to primary care clinics and contracted health plans in your county and that you will partner with Applied Suicide Intervention Skills Training (ASIST) trainers, your Workforce Education and Training (WET) program, community-based organizations, and others to present the training locally.

We hope that you will find these materials helpful in furthering suicide prevention efforts in the primary care setting. Thank you for your time and support of suicide prevention. Please contact the Know the Signs team with any questions.

The Know the Signs Campaign Team

KnowTheSigns@edc.org



Know the Signs >> Find the Words >> Reach Out

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INTRODUCTION

On average, 45% of suicide victims had contact with primary care providers within one month of suicide. . . . Only one-third of suicide decedents had contact with mental health services within the year of their death, while over 75% had contact with primary care providers.¹

Primary care staff can play an important role in suicide prevention. 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. Additionally, 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.

The one-hour training and supplemental information in the *Training Resource Guide for Suicide Prevention in Primary Care Settings* is intended to support primary care providers and staff in their efforts to identify and appropriately respond to patients who are suicidal.

This Training Resource Guide 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) and (2) a training program created by the San Diego Health and Human Services Agency and the Suicide Prevention Council.²

The Training Resource Guide includes the following:

- **Suicide Prevention in Primary Care Settings:** A one-hour suicide prevention training presentation intended for office staff and providers. The training presentation, detailed notes for the presenter, and handouts are provided on the enclosed CD.
- **Templates and tips to plan, implement, and evaluate the training, including:**
 - A letter to primary care offices introducing the training and materials
 - A flyer to promote the training
 - An evaluation to be handed out to participants at the end of the training
- **Three copies of the *Suicide Prevention Toolkit for Rural Primary Care Practices*.**

1. 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.

2. All of these materials can also be downloaded from the Your Voice Counts Resource Center at www.yourvoicecounts.org. Look under “Other Useful Resources.”

Tips for Planning, Implementing, and Evaluating Suicide Prevention Training in Primary Care Settings

Who should be part of the training?

Different members of a primary care team may be in a position to notice warning signs and risk factors among patients. For example, front office staff may have more information about a patient's financial issues or a pattern of canceled appointments, while medical staff may be more likely to uncover signs during patient screening, such as issues with sleeping or pain management. For this reason, it is important for as many members of a primary care office as possible be trained.

What resources are needed to implement the training?

The training is designed to require only a few resources:

- One hour of training time
- Two to three hours of preparation time for the trainers
- A small cost for printing handouts and obtaining optional additional copies of the *Suicide Prevention Toolkit for Rural Primary Care Practices* and related materials
- Cost of light refreshments if provided
- A room large enough to conduct the training, equipped with a projector for showing the presentation

What additional materials should be included with the training?

All of the materials needed to conduct the training are included in this Training Resource Guide. However, following are some additional resources and materials you may choose to obtain to supplement these materials:

- Additional copies of the *Suicide Prevention Toolkit for Rural Primary Care Practices* for participants of the training and/or for each primary care office that is trained. The toolkit is included on the enclosed CD. It can also be downloaded from <http://www.sprc.org/for-providers/primary-care-tool-kit-tools> or hard copies of the toolkit are available for \$25 through WICHE Mental Health Program. For more information, please contact Tamara Dehay at tdehay@wiche.edu (preferred option) or 303-541-0311.
- State and local data. The training presentation includes two optional slides for state and local level data on deaths, hospitalizations, and emergency room visits for self-inflicted injuries. If the presenter chooses to use one or both of these slides, the data can be obtained from the California

Department of Public Health's EpiCenter website (<http://epicenter.cdph.ca.gov/>). Note that the most current data posted on EpiCenter is usually about two years older than the current calendar year. Another option for obtaining more current local data is to reach out to your county coroner/medical examiner or public health officer.

- Outreach materials, such as tent cards or brochures, from your nearest suicide prevention hotline crisis center that can be distributed at the training. To identify your nearest crisis center, go to the following:
 - Your county's page in the Resources section of www.suicideispreventable.org
 - Suicide Prevention Lifeline website: <http://www.suicidepreventionlifeline.org/getinvolved/locator.aspx>
 - MY3 Suicide Prevention mobile application information sheet, page 2: http://www.my3app.org/wp-content/uploads/2013/11/My3_Guide_C1.pdf
- Information about local resources, such as suicide survivor support programs, substance abuse programs, and mental health warm lines so that primary care providers can choose to refer patients as needed. There is a slide near the end of the training presentation suggesting that the primary care office have available information. You may be able to assist in providing specific local contact information for this slide.

Who will give the training?

Ideally, the training will be conducted by an individual with experience as a trainer as well as expertise in suicide prevention and/or familiarity with the primary care setting. The Training Resource Guide contains enough information so that an individual with either background can familiarize themselves with the contents and conduct the training.

To find a suicide prevention organization in your county or to identify ASIST, safeTALK, and QPR trainers, visit the Reach Out page at www.suicideispreventable.org. Local organizations are listed under each county, and information about training resources is included in the California Statewide and National Resources section.

You may have individuals on your staff who would be good trainers, or you may want to reach out to different community organizations to identify a trainer. Some suggestions include:

- Local suicide prevention organizations or programs, such as a chapter of the American Foundation for Suicide Prevention, Mental Health America, or Yellow Ribbon chapter
- An individual trained in ASIST (Applied Suicide Intervention Skills Training)
- Your nearest suicide prevention crisis hotline

Scheduling the presentation

We recommend that you offer the training during lunch breaks or integrate it into regular staff meetings, keeping the training at no more than one hour in length. Providing lunch and refreshments will go a long way in encouraging participation! You may need to conduct the training more than once to reach all staff.

Evaluation

Measuring effectiveness is a key component of any training and will help the continued development of suicide prevention efforts. A brief evaluation is included for all participants to take at the conclusion of the training. This evaluation will offer immediate feedback to the presenter on how to improve for future presentations.

If you are interested in participating in a follow up evaluation for this training, the Know the Signs project staff would be happy to talk with you. Please e-mail us at KnowTheSigns@edc.org.

Additional Resources

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). This toolkit offers a range of resources, including:

- Safety Planning Guide
- Crisis Support Plan
- Suicidality Treatment Tracking Log
- Assessment and Interventions with Potentially Suicidal Patients: A Pocket Guide for Primary Care Professionals
- Office Protocol Development Guide

It's Up to Us Primary Care Resources (www.MDHelpSD.org): This site, created as part of San Diego County's stigma reduction and suicide prevention campaign, offers a range of tools specifically for primary care providers and settings. On the Resources page, you'll find:

- Tips for talking with patients about their mental health concerns
- Screening and treatment tools
- Helpful fact sheets
- Referrals and resources to provide patients with the guidance they need

Know the Signs (www.suicideispreventable.org): The Know the Signs website is another educational resource:

- Know the Signs—Warning signs of suicide with examples
- Find the Words—How to have a conversation with someone you are concerned about. What to say and what **not** to say.
- Reach Out—Where to find help in your county and the state. Each county has a page with a list of local resources.

National Suicide Prevention Lifeline (<http://www.suicidepreventionlifeline.org/>): The National Suicide Prevention Lifeline is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. By dialing 1-800-273-TALK (8255), the call is routed to the nearest crisis center. Currently, there are 10 crisis centers throughout California that are members of the Lifeline.

It's Up to Us—Outreach to Primary Care Providers in San Diego County

The recommendations, presentation, and supplemental tools in the *Suicide Prevention in Primary Care Settings* training have all been adapted from a primary care outreach effort administered by the San Diego County Health and Human Services Agency (HHSA) as part of San Diego County's It's Up to Us stigma reduction and suicide prevention campaign. For more information visit www.MDHelpSD.org and www.up2SD.org.

Through the efforts of the San Diego County Primary Care Program, 14 federally qualified community clinics and family resource centers received the one-hour suicide prevention training, reaching 216 primary care office staff members, including 44 doctors and clinicians.

Additionally, three out of the five primary care offices that participated in the three-month post-evaluation survey stated that since the training:

- Their office has improved in routinely assessing for suicide risk in patients.
- Their office had utilized the SPRC/WICHE *Suicide Prevention Toolkit for Primary Care Settings*.

And, two out of the five primary care offices indicated that they accessed local suicide prevention resources.

Sample Letter to
Primary Care
Office/Clinic and/or
Local Health Plans

Dear Primary Care Provider,

As you well know, primary care is where patients come for most of their health needs, including behavioral health services, treatment, and/or referrals. Furthermore Luoma (2002) found that 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.

By training your staff to recognize the signs of suicidality and respond appropriately, you may save lives, and we can assist. We are offering a free one-hour presentation for primary care practices on how to recognize the warning signs and risk factors of suicide and how to intervene. It includes detailed information about warning signs and risk factors as well as a brief office intervention that includes assessing and/or screening, as well as safety planning and guidelines for referral to services and supports for individuals in any risk category. It also includes information about developing an Office Plan of Action that can assist your providers and staff to be prepared to assist individuals who may be in a suicide crisis.

This presentation is based on 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) and a training created by the San Diego Health and Human Services Agency and Suicide Prevention Council.

We hope that you will consider partnering with us to implement this training for your staff. By investing a relatively short amount of time, your practice can be better prepared to integrate suicide prevention into the primary care culture.

Thank you for your time and support of suicide prevention,

[Insert closing and contact information here]



Suicide Prevention—One Hour Training

For Primary Care Providers and Staff

GET INFORMED

- Nearly half of the people who die by suicide have seen a primary care provider within a month before their death.
- Although mental illness, such as depression, is highly prevalent among people who die by suicide, relatively few sought mental health specialty services in the weeks preceding their death.
- Primary care is often the place where patients come for their mental health needs; primary care staff are in a position to recognize suicide risk and intervene—if they know what to look for.

TRAINING OVERVIEW

At the conclusion of the session, participants will:

- Understand the scope (prevalence) of the problem of suicide in California
- Know the common warning signs and risk factors for suicide
- Know different strategies to assess risk for suicide in your patients
- Learn about different ways your office can be prepared to respond to patients at different levels of risk for suicide
- Gain knowledge to develop a safety plan for your suicidal patient

TRAINING DETAILS *(add local information)*

To schedule a training for your office, please contact:

Name

Name 2

Phone #

Phone #

E-mail Address

E-mail Address

For more information on suicide prevention visit:

www.suicideispreventable.org

SUICIDE PREVENTION IN PRIMARY CARE SETTINGS TRAINING PRESENTATION

Slide 1

Pain Isn't Always Obvious

KNOW THE SIGNS

Suicide Is Preventable.org

Suicide Prevention in Primary Care Settings

Presenter information

CaMHSA
California Mental Health Services Act

San Diego Health and Human Services Agency

Slide 3

Agenda

1. Key principles in our approach
2. Why focus on primary care settings?
3. Epidemiology of suicide
4. Warning signs and risk factors
5. Suicide risk assessment
6. Office plan of action
7. Resources and Q&A

Know the Signs >> Find the Words >> Reach Out

3

Slide 2

About This Presentation

This presentation is based on information found in:

- *Suicide Prevention Toolkit for Rural Primary Care Practices* by the Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE)
- A training for primary care settings created by the San Diego Health and Human Services Agency and Suicide Prevention Council

Know the Signs >> Find the Words >> Reach Out

2

Slide 4

Key Principles

1. Comprehensive Suicide Prevention
2. Systems Approach: Involve Everyone
3. Asking the Right Questions and Connecting to Help
4. Utilize Community Resources

Know the Signs >> Find the Words >> Reach Out

4

Slide 5

Why focus on suicide prevention in the primary care setting?

1. The 2010 Affordable Care Act created a framework for integrating behavioral health and primary care and strengthening prevention services.
2. Primary care, especially in rural areas, is where people come for most of their health needs (both physical and mental).
3. 70% to 80% of antidepressants are prescribed in primary care.
4. The American College of Preventive Medicine recommends systems of care for depression diagnosis and treatment.
5. Approximately 45% of people who died by suicide were seen by their primary care provider within a month before their death.

Know the Signs >> Find the Words >> Reach Out

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Slide 8

California Statistics

Know the Signs >> Find the Words >> Reach Out

8

Slide 6

Why focus on suicide prevention in the primary care setting? (cont'd)

6. Many warning signs are often seen in a primary care setting: sleep disturbances, pain, anxiety, and depression.
7. There is less stigma associated with visiting primary care than with visiting mental health services.
8. Primary care staff often have ongoing relationships with patients and their families, ideally increasing trust.

Know the Signs >> Find the Words >> Reach Out

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Slide 9

Local Statistics

Know the Signs >> Find the Words >> Reach Out

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Slide 7

Populations at Highest Risk Include:

- Middle-aged and older adults, especially white males
- American Indians and Alaska Natives
- Lesbian, gay, bisexual, and transgendered individuals
- Military veterans

Know the Signs >> Find the Words >> Reach Out

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Slide 10

John Jones

John Jones is a 74-year-old African American male being treated for severe, chronic back pain associated with degenerative changes in the lumbar spine. He was recently widowed. He reports that he holds little hope that his condition will improve.

Know the Signs >> Find the Words >> Reach Out

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Slide 11

Warning Signs and Risk Factors

- Warning signs:
Specific behavioral or emotional clues that may indicate suicidal intent (“red flags”)
- Risk factors:
Conditions or circumstances that may elevate a person’s risk for suicide

Know the Signs >> Find the Words >> Reach Out

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Slide 14

Additional Warning Signs *(cont’d)*

- Withdrawing from friends, family, and society
- 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

Know the Signs >> Find the Words >> Reach Out

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Slide 12

Key Warning Signs

- 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

Know the Signs >> Find the Words >> Reach Out

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Slide 15

Individual Risk Factors

- Previous suicide attempt
- Mental disorders, especially major depression
- Substance abuse disorders or significant changes in substance use

Know the Signs >> Find the Words >> Reach Out

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Slide 13

Additional Warning Signs

- Feeling hopeless
- Feeling rage, uncontrolled anger, or seeking revenge
- Acting reckless or engaging in risky activities
- Feeling trapped
- Increasing alcohol or drug use

Know the Signs >> Find the Words >> Reach Out

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Slide 16

Individual Risk Factors *(cont’d)*

- Major physical illnesses, especially with chronic pain
- Central nervous system disorders, including traumatic brain injury (TBI)
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Family history of suicide

Know the Signs >> Find the Words >> Reach Out

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Slide 17

Social/Environmental Risk Factors

- Chaotic family history (divorce, change in living situation, incarceration)
- Lack of social support and increasing isolation
- Easy access to lethal means
- Local clusters of suicides, contagion
- Legal difficulties, incarceration
- Barriers to accessing health and behavioral health care

Know the Signs >> Find the Words >> Reach Out

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Slide 20

Key Components of a Suicide Risk Assessment

1. Assess risk factors
2. Ask about suicidal thoughts, plan, and intent
3. Assess protective factors
4. Apply clinical judgment
5. Document

Know the Signs >> Find the Words >> Reach Out

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Slide 18

Precipitating Events

RISK
FACTORS + EVENT = ↑ RISK of suicide

∴ Screen, assess and treat

Know the Signs >> Find the Words >> Reach Out

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Slide 21

Assessing Risk Factors

- Use of screening tools
- Observation or knowledge of patient history
- Interviewing the patient

Know the Signs >> Find the Words >> Reach Out

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Slide 19

When to Conduct a Risk Assessment

A suicide risk assessment is warranted:

- If any suicide warning signs are evident
- If significant risk factors are present

Generally, the more warning signs and risk factors present, the greater the individual's risk.

Know the Signs >> Find the Words >> Reach Out

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Slide 22

Using Screening Tools to Identify Risk Factors

- PHQ-2, PHQ-9, other screening tools
 - Go to www.phqscreeners.com
- Who should review the results?
- What systems do you have in place to ensure that a screening is reviewed after it is completed?

Know the Signs >> Find the Words >> Reach Out

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Starting the Conversation

Some questions to 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?

Assessing Suicide Planning

- 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?

Assessing Suicide Intent

Guiding questions:

- 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?

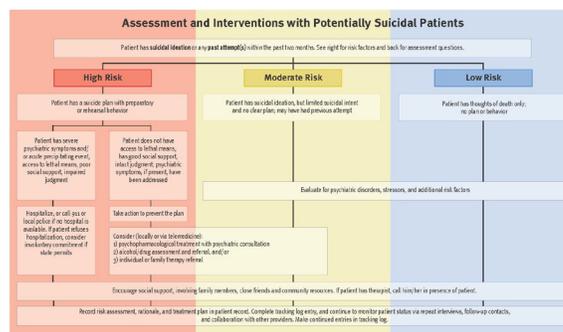
Assessing Protective Factors

- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness
- Coping/problem-solving skills
- Strong therapeutic relationship
- Religious faith

Considerations

- Interviewing with empathetic concern
 - What are your thoughts?

Clinical Judgment



Slide 29

Safety Planning and Support

1. Recognizing the signs of crisis
2. Identifying coping strategies
3. Having social contacts who may distract from the crisis
4. Contacting friends and family for crisis support
5. Contacting health professionals, including 911 or crisis hotlines
6. Reducing access to lethal means

Know the Signs >> Find the Words >> Reach Out

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Slide 32

Office Plan of Action

Who will do what?

- Who will review screenings?
- Who will provide assessments?
- Who will notify the hospital if immediate hospitalization is required?

Know the Signs >> Find the Words >> Reach Out

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Slide 30

Brief Office Intervention

1. Follow-up visits
2. Referrals and warm handoff
3. Crisis support and safety planning (pocket safety plan guide, crisis support form)
4. Documentation

Know the Signs >> Find the Words >> Reach Out

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Slide 33

Suicide Prevention Resources

- **Know the Signs**
 - www.suicideispreventable.org
- **National Suicide Prevention Lifeline**
 - 1-800-273-8255 (TALK)
 - www.suicidepreventionlifeline.org
- **www.MDHelpSD.org**
- **Counseling on Access to Lethal Means training course**
 - <http://training.sprc.org/>

Know the Signs >> Find the Words >> Reach Out

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Slide 31

Documentation

- Thoroughly document a suicide risk assessment, rationale, treatment plan, and follow-up actions in the patient's record.
- Refer to the WICHE toolkit (see Resources handout or office copy) for other record-keeping tools.

Know the Signs >> Find the Words >> Reach Out

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Slide 34

MY3 Suicide Prevention Mobile Application



www.MY3app.org

Target audience:
Those at risk for suicide

Purpose:
Getting those at risk for suicide connected to their primary support network when they are in crisis; also provides safety planning and other helpful resources

Know the Signs >> Find the Words >> Reach Out

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Slide 35

Suggestions for Local Resources

- Walk-in counseling clinics
- Mental health warm lines
- Substance abuse programs and services
- Survivor support programs
- *Others?*

Know the Signs >> Find the Words >> Reach Out

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Slide 37

Pain Isn't Always Obvious



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Suicide Is Preventable.org

Please complete the evaluation!

Know the Signs >> Find the Words >> Reach Out

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Slide 36

Contact Information

- Insert presenter and/or other contact information

Know the Signs >> Find the Words >> Reach Out

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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 synopsise 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

HANDOUTS

Provide handouts to participants all at once in a packet or distribute each handout at the appropriate place during the presentation.

List of handouts

Handout	Where to Obtain	When to Distribute
A. Warning Signs of Suicide	Included on CD	Slide 11
B. Assessment and Interventions with Potentially Suicidal Patients: A Pocket Guide for Primary Care Professionals		
C. Safety Planning Guide	Included on CD	Slide 29
D. Sample Safety Plan		
Outreach materials from local crisis center (optional)	Contacting local crisis center. Locate crisis centers at http://www.suicidepreventionlifeline.org/getinvolved/locator.aspx Also see Handout G: MY3 Mobile App Flier for a list of California crisis centers.	Slide 30
E. Office Protocol Development Guide	Included on CD	Slide 32
F. Resources	Included on CD	Slide 33
G. MY3 Mobile App Flier	Included on CD	Slide 34
H. Training Evaluation	Included on CD	Slide 37

HANDOUT A: Warning Signs of Suicide

Key Warning Signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person

Additional Warning Signs:

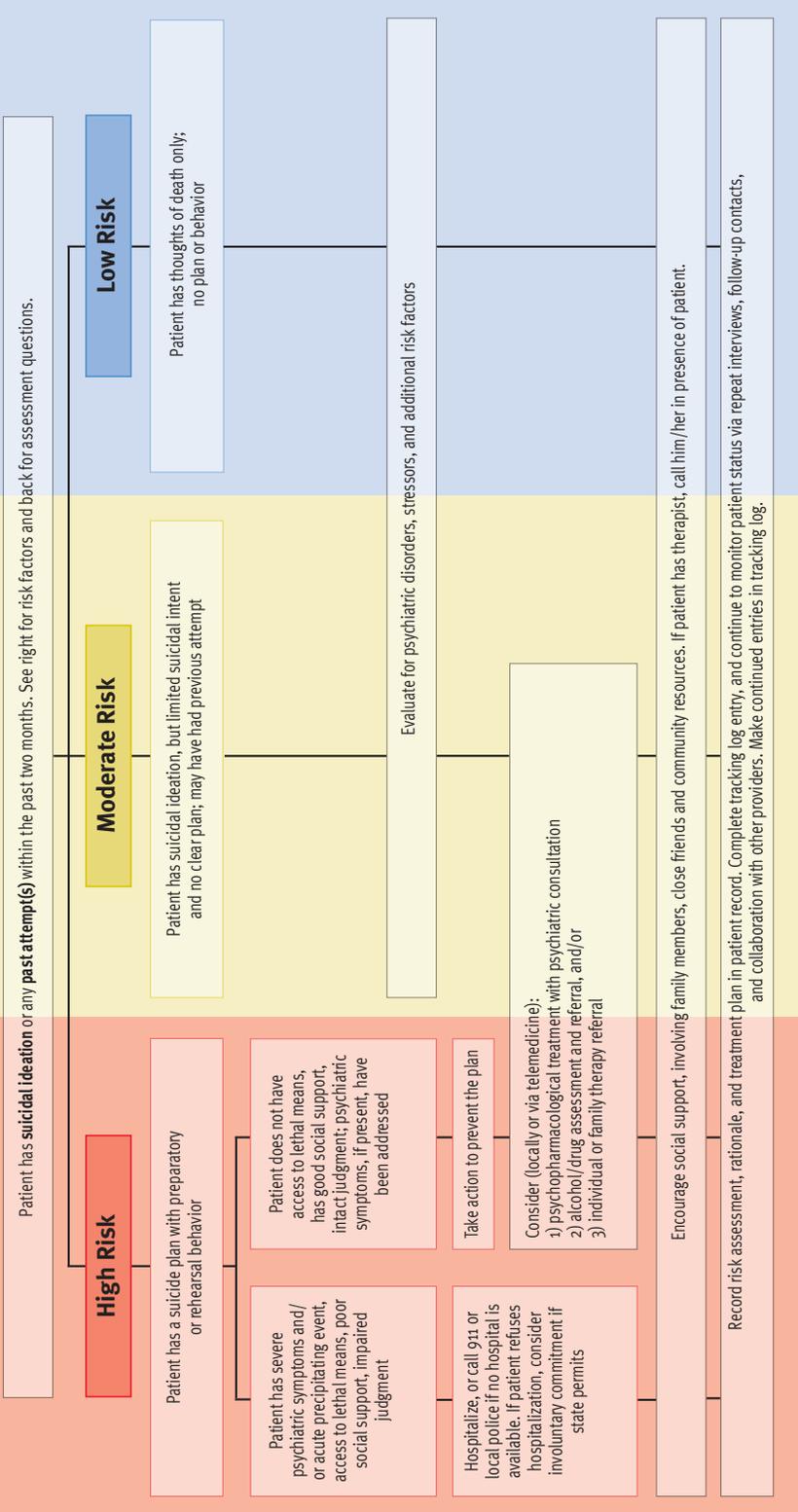
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, 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

HANDOUT B: Assessment and Interventions with Potentially Suicidal Patients: A Pocket Guide for Primary Care Professionals



Assessment and Interventions with Potentially Suicidal Patients A Guide for Primary Care Professionals

Assessment and Interventions with Potentially Suicidal Patients



Suicide Risk and Protective Factors¹

RISK FACTORS

- ▲ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- ▲ **Family history:** of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- ▲ **Current/past psychiatric disorders:** especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
- ▲ **Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.**

Screening: uncovering suicidality²

- ▲ Other people with similar problems sometimes lose hope; have you?
- ▲ With this much stress, have you thought [are you thinking] of hurting yourself?
- ▲ Have you ever thought [are you thinking] about killing yourself?
- ▲ Have you ever tried to kill yourself or attempted suicide?

- ▲ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, and conduct problems.
- ▲ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- ▲ **Chronic medical illness** (esp. CNS disorders, pain).
- ▲ **History of or current abuse or neglect.**

PROTECTIVE FACTORS

- ▲ Protective factors, even if present, may not counteract significant acute risk.
- ▲ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance.
- ▲ **External:** responsibility to children or pets, positive therapeutic relationships, social supports.

Assess suicide ideation and plans³

- ▲ Assess suicidal ideation – frequency, duration, and intensity
 - When did you begin having suicidal thoughts?
 - Did any event (stressor) precipitate the suicidal thoughts?
 - How often do you have thoughts of suicide?
 - How long do they last?
 - How strong are the thoughts of suicide?
 - What is the worst they have ever been?
 - What do you do when you have suicidal thoughts?
 - What did you do when they were the strongest ever?
- ▲ Assess suicide plans
 - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
 - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
 - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent

- ▲ What would it accomplish if you were to end your life?
- ▲ Do you feel as if you're a burden to others?
- ▲ How confident are you that your plan would actually end your life?
- ▲ What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- ▲ Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- ▲ What makes you feel better (e.g., contact with family, use of substances)?
- ▲ What makes you feel worse (e.g., being alone, thinking about a situation)?
- ▲ How likely do you think you are to carry out your plan?
- ▲ What stops you from killing yourself?

Endnotes:

¹SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n.d).

²Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

³Gitatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.



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- ▶ For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- ▶ Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

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This Safety Planning Guide was adapted from content developed by Drs. Barbara Stanley and Greg Brown and the Department of Veterans Affairs.

Safety Planning Guide

A Quick Guide for Clinicians may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.



Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- ▶ Ask: “How will you know when the safety plan should be used?”
- ▶ Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
- ▶ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient’s own words.

Step 2: Internal Coping Strategies

- ▶ Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- ▶ Assess likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
- ▶ If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- ▶ Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- ▶ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- ▶ Ask: “Who or what social settings help you take your mind off your problems at least for a little while?” “Who helps you feel better when you socialize with them?”
- ▶ Ask for safe places they can go to be around people (i.e. coffee shop).
- ▶ Ask patient to list several people and social settings in case the first option is unavailable.
- ▶ Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- ▶ Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- ▶ Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- ▶ Ask: “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
- ▶ Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- ▶ Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- ▶ Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- ▶ Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- ▶ Ask: “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- ▶ List names, numbers and/or locations of clinicians, local urgent care services.
- ▶ Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- ▶ Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- ▶ Ask patients which means they would consider using during a suicidal crisis.
- ▶ Ask: “Do you own a firearm, such as a gun or rifle?” and “What other means do you have access to and may use to attempt to kill yourself?”
- ▶ Collaboratively identify ways to secure or limit access to lethal means: Ask: “How can we go about developing a plan to limit your access to these means?”

HANDOUT D: Sample Safety Plan

Sample Safety Plan

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 technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 6: Making the environment safe:

1. _____
2. _____

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

Office Protocol Development Guide for Suicidal Patients

The purpose of an Office Protocol for Suicidal Patients 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 when needing to arrange a safe environment for a patient who is assessed to be at high risk for suicide. Initial assessment of a potentially suicidal patient can be conducted by a member of the office staff or by an external consultant. Having a posted office protocol will simplify the process of further assessing and potentially hospitalizing a high risk patient.

Some important questions to answer in developing your office protocol are:

- 1. Who will conduct the initial assessment of a potentially suicidal patient (e.g., physician, nurse, mobile crisis team, in-house mental health professional)?**
- 2. Who may be called/paged to provide consultation or assist with assessing a potentially suicidal patient (e.g., psychiatrist, mental health professional, telemental health consultation)?**
- 3. Where will all necessary forms for hospitalizing suicidal patients be kept (it is assumed that the patient’s physician will fill out all necessary paperwork for hospitalization.)**
- 4. What emergency department is nearest to your clinic/facility? How do they handle potentially suicidal patients?**
- 5. Who will call the ambulance, family member, police, mobile crisis team, or other means of transportation to the emergency department?**
- 6. Who will call the emergency department to alert them that the patient is coming via ambulance or other means? What written information can be sent with the patient to give to ED clinicians? It is important that the ED clinicians have access to the information that led the provider to believe the patient may be high risk. Too often, by the time the patient arrives at the ED, they deny everything they said or did that caused concern.**
- 7. Who will sit with the patient who is waiting for transport to the emergency department when necessary?**
- 8. How will the office initiate follow up contact on a suicidal patient after discharge or in the event that the patient is not hospitalized? Who will initiate the follow-up?**
- 9. What procedures will be used to flag the charts of patients at risk of suicide (e.g., a system similar to denoting medication allergies or diabetes)?**
- 10. How soon should a patient be seen back in your clinic after being evaluated by the emergency department and/or hospitalized. How frequently should they be seen? For what duration should more intensive contact with the primary care provider occur?**

The office protocol is an essential component of a comprehensive office strategy for suicide prevention, and may be developed during staff meetings. Once the protocol is developed, it may be useful for the office to implement a “dry run” with a mock patient in order to ensure that the protocol can be followed seamlessly. Suicide prevention trainings, including warning signs to look for, inquiring about suicidal ideation, and how to respond to suicidal individuals, can be provided to all office staff as an in-service. See

the Prevention module of the Primer section of this Toolkit for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies require an investment of time and money, they may save lives.

Consider involving the office staff in suicide prevention efforts. Staff members are frequently in positions to observe changes in behavior or hear patients express suicidal ideation that the patient may be reluctant to share with the provider. Office staff can play a crucial role by detecting concerning behaviors and alerting the patient's provider.

Locate specific information about your state's involuntary treatment laws and post this in the office along with contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the national Suicide Prevention Lifeline, 1-800-273-TALK (8255). The Lifeline offers free materials, including posters and cards with the lifeline number.

HANDOUT F: Resources

Know the Signs Website—<http://www.suicideispreventable.org>

- A review of warning signs/risk factors as well as further information about local resources. Under “Reach Out,” a page exists for each county in California.

Suicide Prevention Toolkit for Rural Primary Care Practices (Suicide Prevention Resource Center and the Western Interstate Commission for Higher Education)

- Additional copies can be downloaded at no cost from <http://www.sprc.org/webform/primary-care-toolkit>.
- Hard copies of the toolkit are available for \$25 through WICHE Mental Health Program. Please contact MentalHealthEmail@wiche.edu or call 303-541-0311.

Patient Health Questionnaires (PHQ) Screening Tools

- The PHQ-9 and other screening tools offer clinicians concise, self-administered screening and diagnostic tools for mental health disorders that have been field-tested in office practice. <http://www.phqscreeners.com>

MY3 Suicide Prevention Mobile App

- 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 as well as marketing materials that providers can use with patients. www.MY3app.org

California Department of Public Health EpiCenter

- State- and county-level data on deaths, hospitalizations, and emergency room visits for self-inflicted injuries. <http://epicenter.cdph.ca.gov/>

www.MDHelpSD.org

- This site is designed to help primary care physicians recognize symptoms of mental disorders in their patients. Resources include tips for talking with patients about their concerns, information on recognizing warning signs of mental illness, helpful fact sheets, and more.

Zero Suicide in Health and Behavioral Health Care

- Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies. <http://zerosuicide.actionallianceforsuicideprevention.org>

National Suicide Prevention Lifeline

- A 24-hour, toll free, confidential suicide prevention hotline available to anyone in a suicidal crisis or emotional distress. Calls to 1-800-273-8255 (TALK) are routed to the nearest crisis center in a national network of local crisis centers that provide crisis counseling and mental health referrals day and night. There are Lifeline crisis centers throughout California.
 - Press 1 if you are a veteran or concerned about a veteran; chat and text services are also available.
 - 24/7 Spanish language Lifeline network can be reached by calling 1-888-628-9454. Teleinterpreter services support 150 additional languages.
 - <http://www.suicidepreventionlifeline.org>

Additional Primary Care Resources and Training Options

Counseling on Access to Lethal Means is a 1.5–2 hour workshop designed to help providers implement counseling strategies to help clients at risk for suicide and their families reduce access to lethal means. Suicide Prevention Resource Center Training Institute online course: <http://training.sprc.org/course/description.php>

Kognito At-Risk in Primary Care is a 1-hour interactive training simulation that prepares primary care providers to recognize when a patient's physical ailments may be masking underlying trauma-related mental health disorders, including PTSD and depression, and how to build a treatment plan. Contact ron@kognito.com or visit www.kognito.com.

Partnership for Male Youth: Health Provider Toolkit for Adolescent and Young Adult Males. This clinical toolkit is for health care providers who serve adolescent and young adult (AYA) males between the ages of 10 and 26. It is designed to address AYA males' unique health care needs. <http://www.ayamalehealth.org/>

Behavioral Health in Primary Care: Clinical Strategies and Program Models for Working with High-Risk Youth. This page hosts a series of video presentations for health care providers interested in the integration of mental health services into medical settings. The presentations cover specific clinical skills for medical staff to help them identify, assess, treat, and refer high-risk youth and systems-level interventions that have supported the health care integration at county and state levels. www.sprc.org/training-institute/behavioral-health-primary-care-clinical-strategies-and-program-models-working-high-risk-youth



STAY CONNECTED TO YOUR NETWORK WHEN YOU ARE HAVING THOUGHTS OF SUICIDE.

CREATE YOUR SUPPORT SYSTEM: Simply add the contact information for people who know and care about you and can help you when you are experiencing thoughts of suicide. These contacts can include your friends, family, professional caregivers and a local crisis hotline. Always tell your contacts that you have included them on MY3 and that you may contact them if you ever start having thoughts of suicide. In any situation, the National Suicide Prevention Lifeline (**1.800.273.TALK [8255]**) and **911** are there to help you. These numbers come pre-loaded on MY3.

The National Suicide Prevention Lifeline is free, and connects you to your nearest crisis center staffed by trained crisis counselors. It is available any time, day or night, every single day.

BUILD YOUR SAFETY PLAN: Customize your safety plan by identifying your warning signs, coping strategies, distractions and personal networks so you can help yourself stay safe. Need help creating your safety plan? Talk to your mental health care provider. Also, you can always call the National Suicide Prevention Lifeline (**1.800.273.TALK [8255]**) and a trained crisis counselor can help you set up your safety plan.

ACCESS IMPORTANT RESOURCES: Personalize MY3 by adding other suicide prevention resources and websites that help you feel better and stay safe. A number of different resources are listed in MY3.

MY3APP.ORG



IPHONE DOWNLOAD INSTRUCTIONS

- 1) Touch the App Store icon on your iPhone
- 2) Search for "MY3 – Support Network"
- 3) To install the app on your device touch "Free"
- 4) Then touch "Install"
- 5) You should now see the MY3 app icon on your iPhone

ANDROID DOWNLOAD INSTRUCTIONS

- 1) Touch the Google Play Store
- 2) Search for "MY3 – Support Network"
- 3) To install the app on your device touch "Install"
- 4) Tap "Accept" to accept the app's permissions
- 5) You should now see the MY3 app icon on your device



FIND YOUR NEAREST CALIFORNIA CRISIS HOTLINE

California has a number of crisis centers with hotlines to serve you 24 hours a day, 7 days a week. Choose your closest crisis center and add their number as one of your primary contacts on MY3. Crisis hotline staff will be glad to assist you, and can connect you to other local services.

SUPERIOR REGION (NORTH OF SAN FRANCISCO BAY AREA)

Wellspace Health Suicide Crisis Line
1.916.368.3111 or 1.800.273.8255

Suicide Prevention & Crisis Services of Yolo County
1.530.756.5000

SAN FRANCISCO BAY AREA

Family Services Agency of Marin North Bay Suicide Prevention Hotline
1.855.587.6373

San Francisco Suicide Prevention Crisis Line
1.415.781.0500

Contra Costa Crisis Center Hotline
1.800.833.2900

Crisis Support Services of Alameda County Crisis Hotline
1.800.309.2131

Santa Clara County Suicide & Crisis Hotline
1.855.278.4204

Star Vista Crisis Hotline
1.650.579.0350

CENTRAL COAST

Transitions Mental Health Association San Luis Obispo Hotline
1.800.783.0607

Family Services Agency of the Central Coast Crisis Line
1.877.663.5433

CENTRAL VALLEY

Kingsview Central Valley Suicide Prevention Hotline
1.888.506.5991

Kern County Mental Health Department Crisis Services
1.800.991.5272

SOUTHERN CALIFORNIA

Didi Hirsch Suicide Crisis Line
1.877.727.4747

OptumHealth San Diego Access & Crisis Line
1.888.724.7240

SERVING CALIFORNIA

Institute on Aging Friendship Line (for older adults)
1.800.971.0016

Trevor Lifeline (for Lesbian, Gay, Bisexual, Transgender, or Questioning Youth)
1.866.488.7386

HANDOUT H: Training Evaluation

Clinic Name: _____ Date: _____

PLEASE RATE/COMMENT ON THE FOLLOWING:

What is your role in the primary care setting/clinic?

Comments: _____

This training offered new and useful information.

Disagree (1) _____ | _____ | _____ | _____ Agree (5)

Comments: _____

After this training, I feel more prepared to recognize suicide risk and to intervene.

Disagree (1) _____ | _____ | _____ | _____ Agree (5)

Comments: _____

Of the different information and tools you learned about today, which one(s) are you most likely to use in your day-to-day work?

Comments: _____

Please provide us with any comments and suggestions for improvement.

Comments: _____



suicideispreventable.org