

# Suicide Care in Systems Framework

*National Action Alliance: Clinical Care & Intervention Task Force*

In 2011, we set out to identify the best practice toolkit for better suicide care. What we found most compelling were the cultural and system changes that were common in the most innovative suicide intervention programming. This thought paper lays out a logic map model for replication.

# **SUICIDE CARE IN SYSTEMS FRAMEWORK**

A Report to: **National Action Alliance for Suicide Prevention Executive Committee**

From: **Clinical Care and Intervention Task Force**

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## EXECUTIVE SUMMARY

The following report presents the findings and recommendations of the Clinical Care and Intervention Task Force to the National Action Alliance for Suicide Prevention. The Task Force focused its deliberations and recommendations on care in four environments: (1) Emergency Departments and Medical-Surgical Units; (2) Primary Care and General Medical Settings; (3) Behavioral Health Entities; and (4) Crisis Services. And, while much of our concept of care lies in traditional face-to-face service delivery between clinicians and patients, the Task Force recognizes and has incorporated the growing use of technology to deliver care (e.g., telephone lines, e-help, texting, blogs, and social networks).

The Task Force focused its environmental scan on a number of programs that have garnered attention for their novel approaches and positive outcomes. These programs included the following:

- **Air Force Suicide Prevention Program (AFSPP)**; 1996-2002
- **Henry Ford Health System (HFHS)** “Perfect Depression Care;” 2001-present
- **National Suicide Prevention Lifeline (Lifeline)** “Suicide Risk Assessment Standards;” 2007-present
- **Central Arizona Programmatic Suicide Deterrent System Project**; 2009-present

In each of these initiatives, dramatic successes were achieved in reducing suicide attempts, deaths, and in reducing costs associated with unnecessary hospital and emergency department care. Most importantly, these initiatives have demonstrated the capacity to save lives. In reviewing these initiatives, the Task Force found three critical factors common to all that led to their remarkable successes.

- **Core Values** – the belief and commitment that suicide can be eliminated in a population under care (boundaried population), by improving service access and quality and through continuous improvement (rendering suicide a “never event” for these populations);
- **Systems Management** – taking systematic steps across systems of care to create a culture that no longer finds suicide acceptable, set aggressive but achievable goals to eliminate suicide attempts and deaths among members, and organize service delivery and support accordingly; and
- **Evidence-Based Clinical Care Practice** – delivered through the system of care with a focus on productive patient/staff interactions. These methods (e.g., standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up and engagement and education of patients, families and health care professionals) achieve results.

**Core Values: Beliefs and Attitudes – The Foundation for Eliminating Suicide Deaths and Attempts** – The Task Force has identified five critical elements that it believes are instrumental for public and behavioral health organizations to adopt and adapt in order to implement suicide prevention effectively.

1. **Leadership leading to cultural transformation** – Organizational leadership must articulate and infuse the fundamental tenet that a suicide event (attempt or death) is an unacceptable outcome of its care, and build a culture that strives to make suicide a “never event.”
2. **Continuity of Care and Shared Service Responsibility** – Caring for suicidal persons requires that the suicidal risk be addressed directly, not merely as a symptom of an underlying disease. That care will most likely require multiple levels of services in a team environment. Discharge decisions from one level of care (e.g., hospital care) must incorporate linkages to other necessary levels of care (e.g., intensive outpatient, private therapist, pharmacological therapy). Organizations must recognize, accept, and implement shared service responsibilities both among various clinical staff within the organization and among providers in the larger community.
3. **Immediate Access to Care for All Persons in Suicidal Crisis** – Because many persons seek care only when they are in crisis, behavioral health systems must provide 24-hour, 7-day a week availability to individuals trained in assessment, supportive counseling and intervention. Crisis hotlines, online crisis chat/intervention services, self-help tools, crisis outreach teams and other services can ensure that individuals can obtain help when they need it – eliminating barriers related to cost, distance, and stigma.
4. **Productive Interactions between Persons at Risk and Persons Providing Care** – Positive health and behavioral health outcomes are partly dependent on a functional relationship between the person requiring help and the persons delivering help. This assistance should respect the cultural preferences and values of the individuals as much as possible. Trusting therapeutic alliances are fundamental to reducing suicide risk and promoting recovery and wellness. Such alliances are most productive when the care is collaborative, where the client is actively engaged in making choices that will keep him/her safe, and when the clinician feels confident that he/she has the training and skills to support the client’s safety and treat the suicide risk.
5. **Evaluate Performance and Use for Quality Improvement** – Setting a goal of zero suicides and managing a system of care to achieve that goal requires organizations to evaluate performance rigorously and to use untoward events as opportunities to improve their capacity to save lives at risk.

**Systems Management: Implementation and Action for Care Excellence** – To achieve the goal of zero suicides will require countless managerial decisions – both the major policy shifts and the details of patient care management. In this context, the Task Force recommends three major managerial areas to guide the organization of effective service delivery.

1. **Policies and Procedures** – All health and behavioral health organizations should have specific written policies and procedures focused on the detection and response to persons presenting for care with suicide risk. Staff must be trained on how to employ the policies and procedures, with regular (e.g., annual) scheduled refreshers.
2. **Collaboration and Communication** – Responding to suicide risk should be premised on collaborative care characterized by direct and open communication with persons at risk of suicide and timely and effective communication patterns with all personnel who are collaborating in the person’s care.
3. **Trained and Skilled Work Force** – Public health and behavioral health organizations should assure that staff working with persons with suicide risk have been appropriately trained and possess requisite skills.

***Evidence-Based Clinical Care Practice: Comprehensive Quality Care to Save Lives*** – While research has shown that over 90 percent of persons who die by suicide had a diagnosable mental health disorder and/or substance use disorder, empirical research has shown that it is insufficient to treat only the mental disorder. In contrast, the extant literature does show that targeting and treating suicidal ideation and behaviors, independent of diagnosis, hold the greatest promise for care of suicidal risk. It is vital that direct intervention and treatment be provided for potential suicidality. Care for persons at risk of suicide should be person-centered, where their personal needs, wishes, values, and resources become the foundation of developing a plan for their continuing care and safety. Where appropriate and practical, families and significant others should be engaged and empowered as well. Cultural values and preferences should be respected as much as possible. The Task Force has identified the following four components of care.

1. **Screening and Suicide Risk Assessment** – Universal screening for suicide risk should be routine in all Primary Care, Hospital Care (especially emergency department care), Behavioral Health Care, and Crisis Response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.
2. **Intervening to increase coping to ensure safety** – All persons identified as at risk of suicide by primary care practices and clinics, hospitals (esp. emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care. This should include inquiring about means access and planning to restrict access to lethal means (balanced with respect to other obligations, including legal and ethical requirements under federal and state laws).
3. **Treating and caring for persons at-risk of suicide** – Treatment and support of persons with suicide risk should be carried out in the least restrictive setting using research-guided practice techniques.
4. **Follow Up** – Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.

Figure 1 (p. 10) provides a Summary of Care for Suicide Prevention.

**R***ecommendations for Action* – The Task Force has outlined a vision of care; attaining that vision will require organizational change and systematic and ongoing upgrading of clinical knowledge and skills. Because the challenge may be great for some organizations, it will be important to offer strategies to motivate, support and sustain systemic improvements. The following recommendations are offered to facilitate that process.

#### Recommendation 1

- *The U.S. Department of Health and Human Services (DHHS) should spearhead two public-private task forces to catalyze change strategies recommended in this report.*
- *1A: DHHS should convene a task force charged with identifying and implementing strategies to mobilize and facilitate public and behavioral health organizational change, including collaborations among organizations to promote continuity of care for persons at risk of suicide.*
- *1B: DHHS should convene a task force charged with incorporating suicide detection, risk formulation and prevention in the preparatory training of clinicians across the country.*

#### Recommendation 2

- *State suicide prevention lead agencies, other relevant state agencies, and key stakeholders (e.g., health, mental health, addiction services, child serving, aging or social services agencies) should consider incorporating strategies to promote suicide as a never event within state health and behavioral health organizations as one critical element for updating or advancing their state plans.*

#### Recommendation 3

- *All health and behavioral health care accrediting organizations should create guidance to organizations on elevating suicide prevention practice in accredited organizations from clinical settings to health plans. Accredited organizations should set goals of reducing suicide and self harm, and take progressive steps to implement and measure progress, with an ultimate goal of zero deaths among members/patients.*

#### Recommendation 4

- *All health and behavioral health plans and providers should develop plans to reduce suicide and self harm. They should select evidence-based and best practices that are relevant to their mission that can reduce suicide and self harm, and implement and monitor the impact of these efforts.*

#### Recommendation 5

- *National guidance should be created for providing suicide prevention care through technology-based services (e.g., telephone crisis hotlines, on-line crisis chat services).*

#### Recommendation 6

- *The Suicide Prevention Resource Center (SPRC) should build on its current record of success by increasing its capacity to assist local suicide prevention services in two major areas.*
- *6a: Regional Centers of Excellence on Suicide Prevention should be established under the auspices of the national Suicide Prevention Resource Center to deliver training, technical assistance and consultation to communities, providers and practitioners.*
- *6b: The Suicide Prevention Resource Center should establish and facilitate a clinical and research advisory group to translate research into clinical practice guidance, providing an expert forum for advising the work of the Regional Centers of Excellence.*

#### Recommendation 7

- *Suicide prevention should be incorporated in national health care reform implementation. State health and behavioral health agencies should incorporate the recommendations contained in this report in guidance to and expectations for health plans and specialty and mainstream health providers (e.g., hospitals, clinics, group practices, treatment facilities).*

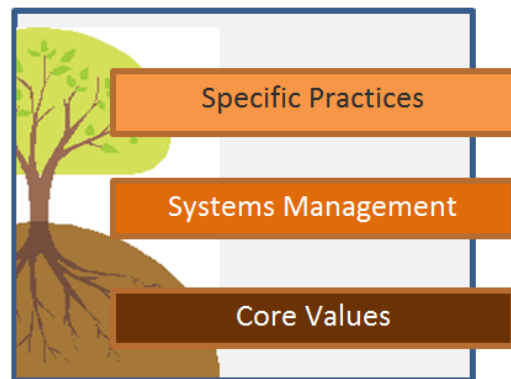
## TASK FORCE CHARGE

The Action Alliance set forth a bold vision of our nation free from the tragedy of suicide. For this vision to be achieved, substantial changes – if not transformation – are necessary in how this nation prevents suicide and intervenes with those at-risk of suicide. The adage, “Suicide is everybody’s business,” must become a reality.

As major contributors to suicide prevention and intervention, public (including primary care, general medical care, emergency services and medical-surgical care) and behavioral health systems must make dramatic changes in how they perceive and address suicide. The Clinical Care and Intervention Task Force focused its deliberations and recommendations on care in four environments: (1) Emergency Departments and Medical-Surgical Units; (2) Primary Care and General Medical Settings; (3) Behavioral Health Entities; and (4) Crisis Services. And, while much of our concept of care lies in traditional face-to-face service delivery between clinicians and patients, the Task Force recognizes and has incorporated the growing practices of nontraditional, technology-based care (e.g., telephone lines, e-help, texting, blogs, and social networks).

The Clinical Care and Intervention Task Force began by looking for better interventions and tools to assist behavioral health clinicians and primary care professionals in engaging those at risk of suicide. What were most compelling in the evaluation of different initiatives were the ***cultural and systems changes that formed the underpinnings of effective approaches***.

Learning from these inspiring models requires a focus on core values; management strategies to effectuate changes reflecting those values; clinical practices based on knowledge of best practice models; and empowerment of clinicians and patients to work together as a team. The Task Force vision is to sink the roots of effective suicide prevention into a framework that will grow into “Perfect Suicide Care” over future iterations of this model.



The purpose of this paper is to provide a potential framework for replication of suicide care in systems. The following is the final report of the Clinical Care and Intervention Task Force.

The report summarizes the results of the investigative process used by the Task Force in studying major advances in suicide prevention in public and behavioral health systems. It articulates key findings from the Task Force investigations and sets forth a vision of care. This vision is based upon current understanding of best practice; it must be continually reevaluated against new findings from research and ensuing innovations in practice. A series of recommendations are proposed for national and state action to move the country toward change.



The Task Force clearly recognizes that these recommendations are being issued in the context of the volatility facing the United States. As the country struggles with a mounting national debt and competing perspectives on how to tame that debt, services for people in need will likely encounter rigorous review and many will face cuts. Yet, millions of Americans are plagued with suicidal thoughts and over a million adults attempt suicide each year. And, as the 10<sup>th</sup> leading cause – and a preventable form – of death of Americans, its effective prevention, and the relief of suffering Americans will not only save lives and untold anguish, but, also lead to savings and increased productivity by those whose lives we save and help by our actions.

## THE TASK FORCE PROCESS

The Task Force focused its environmental scan on a number of programs that have garnered attention for their novel approaches or unique outcomes. These programs included the following:

- **Air Force Suicide Prevention Program (AFSPP); 1996-2002**
- **Henry Ford Health System (HFHS) “Perfect Depression Care;” 2001-present**
- **National Suicide Prevention Lifeline (NSPL) “Suicide Risk Assessment Standards;” 2007-present**
- **Central Arizona Programmatic Suicide Deterrent System Project; 2009-present**

Learning about the Henry Ford Health System (HFHS) “Perfect Depression Care” initiative focused the attention of the Task Force. Launched in 2001, the program achieved steep declines in the suicide rate during the first four years and focused on a broader group than those diagnosed with depression, including persons at risk of suicide. More recently, HFHS has reported ten straight quarters without a suicide death for those enrolled in its Health Maintenance Organization.

The Task Force entered into its dialogue with HFHS focusing on key clinical interventions. However, the HFHS lesson is that culture change focused on a goal of zero errors (deaths) was the essential foundation for improving interventions. HFHS adopted these core values, which, in turn, catalyzed practices that have achieved unprecedented results.

In the weeks following the Henry Ford Health System presentation, the Task Force heard descriptions from the Central Arizona Programmatic Suicide Deterrent System Project, National Suicide Prevention Lifeline, and the Air Force Suicide Prevention Program. Similarly, these initiatives built their services with the foundational precept that suicide deaths were unacceptable outcomes. In each case, services were designed, restructured and implemented to achieve significant successes in the reduction of suicide deaths. Brief summaries of each of these initiatives are found in Appendix A.

The Task Force heard that remarkable successes were achieved when leadership articulated and instituted the value that suicide deaths were preventable in their organizations; when staff embraced that value in their work and cultivated its infusion throughout the organization; and when patients felt empowered to disclose suicide risk and work with staff as a team to lower

that risk and raise protective buffers. Steps were taken to support staff by training in evidence-based or best practices, elevating their skills and confidence. Further, a commitment to accountability, performance measurement and attendant quality improvement were featured in each organization. Employing a systems approach to change, critical to the success of the four initiatives, is replicable in health and behavioral health organizations across the country. The Task Force has selected this construct to convey its recommendations to the National Action Alliance for Suicide Prevention:

- **Core Values** – the belief and commitment that suicide can be eliminated in a population under care (bounded population), by improving service access and quality and through continuous improvement (rendering suicide a “never event” for these populations);
- **Systems Management** – taking systematic steps across systems of care to create a culture that no longer finds suicide acceptable, set aggressive but achievable goals to eliminate suicide attempts and deaths among members, and organize service delivery and support accordingly; and
- **Evidence-Based Clinical Care Practice** – delivered through the system of care with a focus on productive patient/staff interactions. These methods (e.g., standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up and engagement and education of patients, families and healthcare professionals) achieve results.

## CORE VALUES: BELIEFS AND ATTITUDES – THE FOUNDATION FOR ELIMINATING SUICIDE DEATHS AND ATTEMPTS

Regardless of the setting, preventing suicide requires quality care. Therefore, organizations and communities must come together to lay the foundation for effective suicide prevention. Based on the successes of the Air Force, Henry Ford Health Service, National Suicide Prevention Lifeline (the Lifeline), and Central Arizona Programmatic Suicide Deterrent System Project, as well as reviews with nationally and internationally renowned experts in suicide prevention, the Task Force asserts that the following four characteristics are instrumental to successfully reducing suicide deaths.

1. **Leadership leading to cultural transformation** – While individual clinicians may work heroically to attempt to save patients seen as at high risk of suicide, too often the culture of behavioral health organizations may be marked by a deep pessimism regarding the possibility of dramatically reducing or eliminating suicide. This stigma associated with suicide has led to avoidance behavior by far too many organizations and clinicians who could effectively reduce suicide risk and help patients build protective buffers and resilience. Yet, as we have seen with HFHS, the Air Force, Magellan Health Services, and the Lifeline, leadership mobilizing staff to believe that suicide can be prevented has led to dramatic reductions in suicide deaths. While it may sound simple, a major challenge for organizations to effectively eliminate suicide among their members requires them to instill the core belief that suicides can be prevented in their

organization and to systemically manage service delivery around that core belief. In some cases, this may be a complete cultural transformation in the organizational response to suicidal patients.

2. **Continuity of Care and Shared Service Responsibility** – Just as the path to recovery and wellness for a heart attack victim requires multiple levels of care, treatment and patient lifestyle changes, so does the path to recovery and wellness for persons who face possible death by suicide. To help keep suicidal individuals safe, cooperation and communication across these multiple levels of care is critical. Care for suicide risk must be comprehensive and continuous until the risk is eliminated. In the most efficacious chain of care, the person at risk is everyone’s responsibility. Each setting has a critical role in verifying that the subsequent supportive services have the information and resources they can provide, which are pertinent to keeping the individual safe. Treating the physical manifestations of a suicide attempt in an Emergency Department and sending the patient home with a discharge plan to seek therapy, for example, is insufficient care. Persons presenting with suicide risk should be screened and assessed with intervention plans developed. If required, treatment must be provided for the specific suicide risk, itself, as well as for any underlying conditions. A safety plan should be designed collaboratively by the caregiver and patient. Wherever feasible, care providers should seek to engage the individual in follow-up supports to bolster their continued safety, and to reinforce protective buffers by reducing feelings of isolation.

While some organizations may be able to deliver a full continuum of care, collaborative service arrangements will be required for others. The Task Force recognizes that collaborative arrangements with providers or practitioners who can provide face-to-face assessment and intervention may not always be practicable. A growing network of crisis services organizations can provide an effective option for face-to-face care. Many, including the certified crisis centers in the Lifeline network, offer the capacity for trained persons to conduct remote assessments, linkage for care, and follow-up for persons at risk. Effective communication from provider to provider; between provider and patient; among provider, patient and family; and from provider to other critical stakeholders is critical to continuity of care.

Too frequently, suicide risk provokes anxiety and avoidance behavior in clinicians. Promoting a culture of shared responsibility and team care will mitigate clinicians’ anxiety, allowing them to address suicide risk appropriately. The Henry Ford Health Service has implemented universal screening in its primary care clinics, but not without initial resistance from primary care physicians concerned about what to do for a patient they might detect with suicide risk. To overcome that fear and resistance, HFHS made a promise to those physicians that they would be able to get a psychiatric consult within 24 hours for any patient they were concerned about. In other words, they promised their physicians that “their backs would be covered.” Collaboration and teamwork should be a value embraced by health and behavioral health organizations, incorporated into the management and performance measurement of each.

3. **Immediate Access to Care for All Persons in Suicidal Crisis** – As noted by the Georgia Crisis and Access Line, “A Crisis has no schedule.” Therefore, effective treatment and support services to reduce suicidality must be made available to persons in crisis, how

and when they need them. In restructuring its behavioral health care system, HFHS now offers same-day drop-in care for persons in crisis. Other behavioral health organizations should make this option available. Explicit guidance from accrediting organizations and payment from health plans would encourage implementation of this practice.

Research indicates that 66 percent of persons who take their own lives were not receiving treatment for their suicide risk at the time of their death. Unfortunately, stigma, cost barriers, distance, and lack of service availability (especially in rural areas) impede access to care. While face-to-face therapy may be indicated for many persons in suicidal crisis, the aforementioned barriers may limit access to that care. Virtual or remote care enables persons in crisis to access help 24-hours a day, 7-days a week. Examples include telephone connections to crisis hotlines, telecounseling, short message services (SMS), and texting; and online access, using video counseling, crisis chat, self-assessment, and self-help. Typically, this type of care is available at low or no-cost for persons seeking help. And, it provides immediate access, convenience, and a higher level of anonymity for persons reluctant to engage in face-to-face therapy arrangements. Access to such resources is critical for augmenting clinic-based care and private-practice offices, which usually have limited hours that may make services unavailable during a time of crisis. They also provide alternatives to emergency departments, which are often less appropriate, expensive, and may have inhospitable waits.

4. **Productive Interactions between Persons at Risk and Persons Providing Care –** The Planned or Chronic Care model asserts that improved patient outcomes are partly dependent upon productive interactions between informed, activated patients and prepared, proactive practice teams. The Task Force recommends broadening this construct to include any person seeking help and persons in a position to intervene to provide help, including clinicians, trained hotline staff and volunteers, and trained on-line staff and volunteers. Persons contacting a potential helper must feel comfortable to disclose their desire to die and their thoughts of suicide. They must feel confident that the potential caregiver will be accepting and in a position to offer nonjudgmental help. Similarly, the person who may be doing the intervention must be willing to engage persons in a helping alliance around suicide risk, and they must be confident in their ability to help. This confidence must arise from education and training in suicide risk management, including screening, risk assessment, safety planning, and, for those delivering care, treatment.
5. **Evaluate Performance and Use for Quality Improvement –** As the Task Force heard stories of remarkable successes in reducing suicide deaths and suicidality, a consistently important element was creating a climate of continuous performance improvement. Deaths by suicide and suicide attempts represent adverse outcomes for health and behavioral health providers. Applying a zero defect standard of care will mean that practitioners must review adverse outcomes related to suicide and adjust performance accordingly. Robust performance improvement focused on the goal of zero suicides must become a central ingredient to managing practice and systems of care. The Task Force is keenly aware that in the aftermath of suicide deaths there may be clinician survivors who will be in need of compassionate understanding and care themselves. The delicate balance between relentlessly striving for zero suicides and creating a caring

climate for those suffering from suicide loss, including clinicians themselves, will require careful management. Nonetheless, the Task Force believes that a caring climate and quality improvement are symbiotic; they should not be sources of conflict.

## SYSTEMS MANAGEMENT: IMPLEMENTATION AND ACTION FOR CARE EXCELLENCE

Health and behavioral health organizations face daily challenges in organizing staff and other resources, directing patient flow, maintaining fiscal health, assessing system performance, balancing quantity of service with quality of care, etc. Successfully embedding effective suicide prevention care into the organization must be carefully aligned with existing management structures and processes. The Task Force recognizes that this will include many detailed decisions and close monitoring of operations. Nonetheless, there are three broad areas that will be essential for managing a system of care around suicide prevention.

1. **Policies and Procedures – *All health and behavioral health organizations should have specific written policies and procedures focused on the detection and response to persons presenting for care with suicide risk.*** Embedding suicide prevention responsibilities into the organization culture must be carefully planned and staff must clearly understand how to engage and respond to patients with suicide risk within the scope of their roles. It is critical that organizations develop written policies and procedures to guide how staff responds to suicide risk. The Task Force recommends that policies and procedures be based on a goal of suicide as a “never event.” The policies and procedures should guide staff in every step of appropriately responding and helping persons with suicide risk in the context of their roles within the organization. Procedures should stipulate tools to be employed if screening or assessing risk, and should articulate communication protocols with other members of the organization and with resources external to the organization. Policies and procedures must clearly stipulate how to respond in the event of an emergency suicide situation.

Staff must be carefully trained on policies and procedures. Every person in the organization, who may work in any capacity with a person at risk of suicide, must understand his or her role and know how to respond appropriately. Refresher training should be offered regularly – at a minimum, annually.

Systems of care with multiple sites should establish uniform guidelines across these sites to assure that persons at risk are accorded similar care and treatment, with respect to what is appropriate for that site’s level of care. One example of such a policy implemented on a broad scale, across multiple sites, is the National Suicide Prevention Lifeline’s Policy for Helping Callers at Imminent Risk of Suicide.

2. **Collaboration and Communication – *Responding to suicide risk should be premised on collaborative care characterized by direct and open communication with persons at risk of suicide and timely and effective communication patterns with all personnel who are collaborating in the person’s care.*** Clinical staff working in isolation may avoid asking about suicidal thinking as they may not know what to do if the answer is “yes” or may not have adequate community resources to support care for suicidal patients. Team care fosters connectedness, which is a potent protective buffer against fear of

working with persons who may be at risk of suicide, just as connectedness acts as a protective buffer for persons having thoughts of suicide. As was demonstrated so clearly in the Henry Ford Health Services experience, medical staff who were guaranteed psychiatric backup when they felt it was needed were far less resistant to screening patients for suicidality and taking appropriate actions in response to positive screens. Thus, it is important for management practice to emphasize collaborative care.

Effective collaborative care requires effective communication. All persons addressing suicidality among patients at risk must have full knowledge of screening and assessment results, and knowledge of steps taken to work with the patient. To the degree possible, care decisions should be made in a team environment with shared decision making and shared responsibility for care. The team must include the patient and his or her family, whenever possible and appropriate.

3. **Trained and Skilled Work Force – *Public and behavioral health organizations should assure that staff working with persons with suicide risk have been appropriately trained and possess requisite skills.*** Too many clinical staff lack the knowledge and skills to provide appropriate and effective responses to suicide. Even expertly trained mental health professionals who have not been trained in suicide risk assessment and treatment are likely to assess and treat for “underlying” disorders and avoid the essential tasks of directly assessing and treating the person’s suicidality. Lacking specific training in suicide care undermines clinical confidence in addressing suicidality. That lack of clinical confidence contributes heavily to avoidance behavior.

Developing clinical competence was an important part of the success stories the Task Force heard. For example, HFHS trained its clinical staff in Cognitive Behavioral Therapy, while Magellan trained its staff in ASIST. In each case, clinician confidence soared. Clinicians felt empowered to care for persons presenting with suicide risk, which contributed substantially to dramatic reductions in suicide attempts and deaths seen in those systems. Additional information on these two programs as well as other evidence-based and best practice programs can be found on the SPRC Best Practices Registry ([www.sprc.org](http://www.sprc.org)).

## EVIDENCE-BASED CLINICAL CARE PRACTICE: COMPREHENSIVE QUALITY CARE TO SAVE LIVES

Because the stakes are sometimes life or death, suicide risk management demands comprehensive care using services and supports marked by excellence. Unfortunately, across health and behavioral health organizations, the quality of care for suicide is marred by inconsistency and wide variability. At both the organizational and practitioner levels, too often, we find the landscape of care clouded by fear, avoidance and inappropriate interactions with persons at risk of suicide. Stigmatization overshadows suicide in much the same way it does with chemical abuse and mental illness.

Some organizations avoid suicidal patients due to a fatalistic misperception that if someone has a desire to take his or her life, the outcome is inevitable, when the opposite is true: effective and compassionate interventions can alter that course and bring renewed desires

for life. Similarly, clinicians too often lack the knowledge, skills and confidence to address suicidality. This breeds a culture of avoidance, resulting in unnecessary emergency care, and inappropriate referrals for inpatient services. When care is provided, lack of skills in suicide-specific treatment may lead to care for underlying conditions such as depression, without directly treating the suicidality. In some helping organizations, a history of prior suicide attempts and/or current suicidal ideations, unnecessarily rules out admission or continuing care.

Caring for someone with disclosed risk of suicide requires knowledge and skills to manage risk appropriately. Further, it requires mastering the emotional trepidation of helping someone who may kill him- or herself. The possibility of losing a patient to suicide can provoke anxiety over the possibility of making a clinical error that leads to the patient's death. Both clinicians and organizations often fear that losing a person to suicide may result in costly litigation. For example, physicians in primary care practice may be concerned about how to respond should a person disclose suicidal thoughts, and, therefore, not ask about suicide. Skill development, practice using those skills, and a culture of shared responsibility demonstrated by team care will build the essential clinical confidence to engage and care for patients at risk of suicide.

While there is still a relative dearth of research to guide practitioners in care, some important research to guide practice does exist. Tools and methods to help detect risk, conduct assessments, intervene for safety, and deliver quality treatment and support are available. Again, they are not widely employed, and, many practitioners are unaware of these tools.

Especially in emergency departments and primary care, arguments are raised that time limitations prohibit infusing simple screening procedures. It is important to remember that, at one time, it was not routine to take blood pressures, conduct urinalysis, test for cholesterol, or conduct mammograms and prostate exams. These protocols now are employed because they provide early warning of disease and save lives. Simple suicide screens are also early warning signs of danger, and their use saves lives.

To overcome inconsistent and inadequate care, practice methods should employ evidence-based care, or where that is not a possibility, best practices. The national Suicide Prevention Resource Center (SPRC) maintains an ever-expanding list of programs that meet either the standards of evidence-based care through the National Registry of Evidence-Based Programs and Practices (NREPP) or the principles of best practice. Suicide prevention care should utilize those standards or principles. As new methods and innovations arise, practitioners should evaluate them rigorously and ensure that those methods are reviewed and included in the SPRC registry. Accrediting and credentialing organizations should promote evidence-based and best practice suicide prevention care for organizations and practitioners they accredit or credential.

Care for persons at risk of suicide should be person-centered, where their personal needs, wishes, values, and resources should be the foundation for a continuing care and safety plan. Where appropriate and practical, families and significant others should be engaged and empowered as well. People experiencing suicidal ideations feel embarrassed, guilty and fearful of disclosing their thoughts and feelings. Health and behavioral caregivers can defuse

those feelings and make it more comfortable for persons to disclose. Disclosure is one of the first steps in help-seeking, which is a very potent protective factor against suicide. Clinicians must have the skills to guard against exacerbating the patient's fear to disclose. The inadvertently judgmental or condemning clinician, or the clinician who exhibits fear of the patient's suicidal thoughts, may cause the patient to resist help-seeking in the future, thereby elevating suicide risk.

Direct and open communication patterns, engagement of persons important to the person at risk, and empowering the person to partner in designing his or her care plan are important aspects of engaging and empowering persons at risk. One example was developed by Task Force member, Dr. David Jobes, in the Collaborative Assessment and Management of Suicidality (CAMS). One simple strategy he espouses is not to sit behind a desk while assessing and developing treatment plans with patients. Rather, he advises sitting side-by-side with the patient at certain points during clinical engagement to work through an assessment/treatment planning tool, thereby creating a greater sense of equality and partnership in the helping relationship. Engaging, empowering and motivating patients and their families help promote productive interactions with clinicians and should be an integral aspect of treating suicide risk.

In the Core Values section, the Task Force identified continuity of care and shared service responsibility as critical building blocks to effective care. Four elements of care are offered below, which should be incorporated in designing a continuing care service structure. Using evidence-based or best practice principles, care should be patient-centered and planned.

The following four elements of a care continuum must be included in any community's suicide prevention design: (1) screening and assessment for suicide risk, (2) intervention (safety planning, means restriction), (3) treatment responses (including direct treatment or referral depending on the setting and degree of risk), and (4) follow-up processes.

Figure 1 briefly summarizes how each should be addressed in the four care environments included in this report (i.e., primary and general health care, emergency departments and medical-surgical care, behavioral health care, and crisis services). More thorough descriptions of each element follow Figure 1.



Figure 1  
Care Summary for Suicide Prevention

SETTINGS	CONCERNS ABOUT CURRENT PRACTICE	SCREENING & ASSESSMENT	INTERVENTION & TREATMENT	FOLLOW-UP
<p><b>Primary Care</b></p>	<p>There is a National recommendation to screen for depression; however, practice is rare.</p> <p>Resources are available, such as PHQ-9, PHQ-9 modified teen version, TeenScreen Program and HHS-SAMHSA SAFE-T cards, but implementation of existing recommendations is variable.</p> <p>PCP’s time is limited to focusing on the presenting problem, so a suicide risk screen is not a priority.</p>	<p>Screen every patient for suicide risk by asking 1+ questions related to suicide risk during their intake questionnaire and when otherwise indicated. PHQ-9 is one such tool.</p> <p>Positive screens result in a referral to a trained behavioral health expert for a comprehensive assessment. This may involve establishing relationships with local behavioral health providers, including crisis centers.</p> <p>The “Is your patient suicidal” poster is placed in all PCP settings.</p> <p>Personnel in each PCP setting should determine the most practical method of implementing these recommendations in their practice.</p> <p>National Guidelines should be developed to promote best practices and provide specific tools to assist PCP’s in suicide prevention.</p>	<p>PCPs collaborate with behavioral health to determine the most appropriate level of intervention.</p> <p>Develop a collaboratively designed safety plan.</p> <p>Inquire about means and restrict access to means.</p> <p>Pharmacologic care.</p> <p>Address suicide risk directly.</p> <p>Make appropriate referrals to behavioral health &amp; maintain communication.</p> <p>Encourage patients to follow through with therapy visits.</p>	<p>Make follow-up contact with all suicidal patients, e.g., “caring letters” or follow-up calls.</p>

Care Summary for Suicide Prevention

SETTINGS	CONCERNS ABOUT CURRENT PRACTICE	SCREENING & ASSESSMENT	INTERVENTION & TREATMENT	FOLLOW-UP
<p><b>ED-Medical/Surgical</b></p>	<p>The ‘Is your patient suicidal?’ poster (publication of the Suicide Prevention Resource Center) is recommended but not commonly placed in EDs.</p> <p>There is wide variance between and within EDs surrounding suicide risk screening and assessment.</p> <p>EDs may utilize in-house psychiatric staff or social workers, outside crisis agencies, or other behavioral health professionals to provide suicide risk assessments.</p>	<p>All patients, when feasible, are assessed for suicide risk with one or more questions addressing suicidality on the intake questionnaire.</p> <p>Positive screens lead to comprehensive assessment by a behavioral health professional, whether onsite or by other methods.</p> <p>The “Is your patient suicidal” poster is placed in all EDs.</p> <p>Personnel in each ED setting should determine the most practical method of implementing these recommendations in their practice.</p> <p>National Guidelines should be developed to promote best practices and provide specific tools to assist ED personnel in suicide prevention.</p>	<p>Collaborate with behavioral health to determine the most appropriate level of intervention and safety plan.</p> <p>Inquire about means and restrict access to means.</p> <p>Pharmacologic care.</p> <p>Inpatient psychiatric care for high risk patients.</p> <p>Develop plan with patient to reduce emotional distress &amp; suicidal feelings.</p> <p>Make informed referrals for treatment on release from hospital based on assessment &amp; needs of the patient.</p> <p>Referrals should be made to providers that can see the patient within 24-72 hours of discharge.</p>	<p>Develop some method of follow-up contact with persons leaving care.</p>

## Care Summary for Suicide Prevention

SETTINGS	CONCERNS ABOUT CURRENT PRACTICE	SCREENING & ASSESSMENT	INTERVENTION & TREATMENT	FOLLOW-UP
<b>Behavioral Health</b>	<p>There is a lack of National consensus standards and agency consistency. As a result, individual and agency variability is great.</p> <p>A suicide risk screen is completed at intake.</p> <p>The type, depth, and frequency of screening and assessment vary among clinicians.</p> <p>Tools, such as the HHS-SAHMSA SAFE-T card are available but may not be used regularly.</p>	<p>Each individual is screened for suicide risk at every point of contact with a behavioral health professional.</p> <p>If the screen is positive, a comprehensive suicide risk assessment is completed, using at a minimum, the factors of desire, intent, capability &amp; buffers.</p> <p>Level of acuity of risk is determined based on the outcome of the assessment.</p> <p>National suicide risk screening &amp; assessment standards, including training requirements, are developed, implemented &amp; evaluated for behavioral health settings.</p>	<p>Collaborate with other providers to determine the most appropriate level of intervention and safety plan.</p> <p>Evidenced-based interventions aimed at reducing risk of suicide are identified &amp; implemented.</p> <p>Inquire about means and restrict access to means.</p> <p>Pharmacologic care.</p> <p>Develop plan with patient to reduce emotional distress &amp; suicidal feelings.</p> <p>Build therapeutic alliances with patients and use research guided techniques to treat suicidality.</p>	<p>Develop some method of follow-up contact with persons leaving care.</p>

**Care Summary for Suicide Prevention**

SETTINGS	CONCERNS ABOUT CURRENT PRACTICE	SCREENING & ASSESSMENT	INTERVENTION & TREATMENT	FOLLOW-UP
<p><b>Crisis</b></p>	<p>Suicide risk assessment is usually completed at all crisis contacts.</p> <p>There is wide variance in this group with regard to training, reporting requirements, and the risk assessment tool utilized.</p>	<p>Each individual is screened for suicide risk at every point of contact with a Crisis professional.</p> <p>If the screen is positive, a comprehensive suicide risk assessment is completed, using at a minimum the factors of desire, intent, capability &amp; buffers.</p> <p>Level of acuity of risk is determined based on the outcome of the assessment.</p> <p>National suicide risk screening and assessment standards, including training requirement, are developed, implemented &amp; evaluated.</p>	<p>Collaborate with other providers to determine the most appropriate level of intervention.</p> <p>Evidenced-based interventions aimed at reducing risk of suicide are identified &amp; implemented.</p> <p>Develop a collaboratively designed safety plan.</p> <p>Inquire about means and restrict access to means.</p> <p>Referral to appropriate treatment provider, mobile crisis team, EDs' or outpatient clinics.</p>	<p>Use of caring letters, follow-up calls or online communication.</p>

The following describes the four critical clinical care elements that must be addressed in treating suicidal persons.

1. **Screening and Suicide Risk Assessment – *Screening for suicide risk should be a universal part of Primary Care, Hospital Care (especially emergency department care), Behavioral Health Care, and Crisis Response intervention. Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, means availability, presence of acute risk factors (including history of suicide attempts), and level of risk.*** Other than during the treatment for a medical emergency, every person contacting medical and behavioral health care should be screened for suicide using a standardized, simple tool. There has been growing recognition and use of tools to screen for depression and alcohol abuse. Because of the potential lethality of a suicide attempt, a screening should be done for thoughts of killing oneself and self-harm. Appendix B offers some examples of potential screening instruments.

Recently, Medicare added procedure codes to screen for depression for Medicare patients. There are two simple questions that Medicare will reimburse physicians for asking. These questions ask patients to report whether, over the past two weeks, they have been bothered by little interest or pleasure in doing things and whether they have been bothered by feeling down, depressed or hopeless. A simple question relating to suicide and self-harm should be added to these questions. The question could simply ask how much the patient has been bothered by feeling better off dead or wanting to hurt him- or herself. The Task Force calls on other insurance carriers to follow Medicare’s example and reimburse for this type of simple screening process

As occurred at Henry Ford Health Service, the Task Force recognizes that physicians may be concerned about asking this type of question without resources to help them respond to identified risk. It is essential that physicians and hospitals have access to behavioral health support for patients that have positive responses to suicide screens. Such support can be forged from local mental health providers or could be provided remotely (e.g., telephone, on-line) by crisis service organizations. State and local government health and mental health organizations can help provide the impetus for forging critical local relationships.

A useful tool for hospital emergency departments is a poster, *“Is Your Patient Suicidal: Emergency Department Poster,”* developed by a Task Force operating under the auspices of the American Association of Suicidology,<sup>\*</sup> which was contracted for it by SPRC. The poster lists warning signs, simple steps to follow, and provides the Lifeline telephone number. *“Suicide Risk: A Guide for ED Evaluation and Triage,”* supplements the poster with additional clinical guidance. Additional information on the poster, including how to obtain can be found on the SPRC Web Site ([www.sprc.org](http://www.sprc.org)). Evaluations of this poster have demonstrated success at

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<sup>\*</sup> Other members include the Emergency Nurses Association, the American Foundation for Suicide Prevention, the American College of Emergency Physicians, and the American Association for Emergency Psychiatry.

raising awareness and response by emergency departments to responding to suicide risk. The Task Force recommends that similar posters be developed and distributed for primary care, ambulatory care, long-term care and other health care situations, and that posters focus on screening, assessment, and risk factors appropriate for each setting.

Regardless of the setting, if the screen yields a positive result for potential suicide risk, then a full assessment should be completed. The assessment should be completed by a professional with appropriate and specific training in assessing for and evaluating suicide risk. This professional must have the skills to engage patients in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment.

The assessment should include the following critical factors related to suicide risk:\*

- **Suicidal desire**, including suicidal ideation, psychological pain, hopelessness, helplessness, perceived burden on others, feeling trapped, and feeling intolerably alone;
- **Suicidal capability**, including history of suicide attempts, exposure to someone else's death by suicide, available means of killing self/others, currently intoxicated, substance abuse, acute symptoms of mental illness, and extreme agitation/rage;
- **Suicidal intent**, including attempt in progress, plan to kill self/others, preparatory behaviors, and expressed intent to die; and
- **Buffers/connectedness**, including immediate supports, social supports, planning for the future, engagement with helper, ambivalence for living/dying, core values/beliefs, and sense of purpose.

A person identified at risk of suicide should also be assessed for level of risk and the most appropriate care environment in his or her community to address risk and care needs. The first priority in the ensuing care plan is safety. Patients assessed as having a clear intention to taking their lives will require higher levels of safety protection than those with less of a commitment toward dying. Some imminent-risk persons (e.g., persons with command hallucinations and ready access to lethal means) may require inpatient care because of the need for increased level of supervision and higher intensity of care. Many high-risk persons with appropriate supports and safety plans, however, may be better served in a community care setting with adequate support.

For behavioral health and crisis services organizations, it is expected that staff will conduct the risk assessment either on site or remotely. For primary and hospital

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\* The four factors were taken from: Joiner, Thomas, PhD et.al. *Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline*. *Suicide and Life-Threatening Behavior*: 37 (3). June 2007.

care, there are different methods for conducting suicide risk assessments. Health services can designate trained clinical personnel to conduct them. However, the Task Force acknowledges that many primary and emergency service providers will have neither the staff resources nor the expertise to conduct adequate assessments and to complete referrals fully. As such, these public health service providers can also work under agreement with behavioral health organizations or with behavioral health professionals in private practices to conduct assessments.

While face-to-face assessments are preferable, in some cases they may not be practicable. Therefore, assessments could be conducted by trained professionals from remote sites with nurses or other health services personnel sitting with the patient. In some rural areas where behavioral health services and trained staff are less available to conduct risk assessments in emergency or primary care settings, another option may be for these settings to conference in (via video or telephonically) mental health professionals trained in conducting risk assessments. Some telepsychiatry services and Lifeline member crisis centers are currently performing such functions effectively in some of these settings.

Appendix B also provides examples of risk assessment instruments.

2. **Intervening to increase coping to ensure safety – *All persons identified as at-risk of suicide by primary care practices and clinics, hospitals (esp. emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care, which includes inquiring about means access and planning to restrict access to means.*** The safety plan should give the patient techniques and resources to relieve recurring suicidal thoughts at home. These could include strategies for mitigating intolerable distress and pain, with specific steps for seeking support and help if thoughts of death and suicide become intrusive. Further, the safety plan would include lethal means restriction strategies (balanced with respect to other obligations, including legal and ethical requirements under federal and state laws). Limiting access to medications, chemicals, and removing or locking firearms and other weapons are important actions to keep patients safe. If the patient is living with his or her family, safety and referral plans should be discussed and coordinated with the family (with patient consent). The roles of family members in safety plans and implementing referrals should be developed collaboratively with them as full partners in the process.

Behavioral health and crisis services organizations should routinely incorporate safety planning and means restrictions strategies in their care. For persons who continue treatment with a behavioral health organization, compliance with safety planning should be an ongoing facet of the treatment contract. Where hospitals, primary care clinics and physician offices have resources to carry out assessments, safety planning should become routine parts of the assessment, referral and discharge process. For those primary care settings and hospitals without the resources to assess for care, safety planning and means restrictions strategies can be carried out by a designated behavioral health entity, including crisis service organizations (e.g., staff at local Lifeline crisis centers, mobile crisis teams).

**3. Treating suicide risk – *Treatment of persons with suicide risk should be carried out in the least restrictive setting using research-guided practice techniques.*** While

the Task Force recommends the use of evidence-based practice (i.e., research-driven practice based on randomized clinical trial designs), it recognizes the relative paucity of such research to guide practice. In a best practices overview report written for Veterans Affairs’ providers (authored by Drs. David Jobes, Mark De Santis and Donald Myrick), the authors found only 49 randomized clinical trials in the world’s literature. (The report is found in Appendix C.) In this review, the authors make the following observations:

- There is limited evidence of the overall efficaciousness of **pharmacotherapy-only** treatment for suicidal risk;
- Similarly, there is limited evidence to support the widespread use of **inpatient psychiatric hospitalization** for suicidal patients;
- **Follow-up interventions and case management treatment** have demonstrated a significant impact on reducing suicide behaviors including deaths;
- **Thus far, certain coping oriented psychotherapies have** the most research support for effectively treating suicidal risk. In particular, the research supports highly-structured, problem solving approaches. The following evidence-based approaches are highlighted in the overview report:
  - ***Dialectical Behavior Therapy*** – the most thoroughly studied and efficacious psychotherapy for suicidal behavior
  - ***Cognitive Therapy*** – the next most studied and supported suicide-relevant psychotherapy
  - ***Other Promising Interventions*** – The authors cited two other interventions that exhibit strong correlational support and are now being studied in randomized clinical trials – ***Safety Planning Intervention*** and ***Collaborative Assessment and Management of Suicidality***

The Task Force acknowledges that hospitals may provide inpatient psychiatric care for some patients at extremely high risk of suicide (e.g., those with command hallucinations, weapon availability and recent prior attempts). However, hospitals generally should make informed referrals for treatment on the patient’s release from hospital care, including emergency departments. The referral would be based on the assessment and needs of the patient. For patients in severe emotional distress, referrals should be to providers or practitioners that can see the patient within 24 – 72 hours. These providers should have the capability of providing intensive community care, including outpatient care.

Primary care physicians can play important roles in treating suicide risk. Where pharmacologic care is part of the treatment plan, primary care physicians can monitor this aspect of care, especially for lower and mid-risk patients. Primary care physicians may be the practitioner with whom persons feel most comfortable confiding. As such, physicians can be pivotal in making the connection to



therapeutic care for patients, and in convincing patients to follow through with therapy visits.

Crisis lines, online crisis chat services and other emerging technology-based care (e.g., text help) may be the only contact some at-risk persons have with individuals and organizations that can deliver help. Some people may prefer the potential anonymity of a telephone or a computer to a face-to-face encounter. Or, they may live in rural areas where the nearest services are at such a distance that traveling to them poses a substantial barrier. They may have no or inadequate health insurance and be unable to afford traditional in-person care. Seeking help remotely is a growing phenomenon with demonstrated effectiveness.

SAMHSA-funded evaluations of crisis call centers have demonstrated that they can be effective at significantly reducing emotional distress and suicidality. Such services should become a critical element of the network of suicide prevention organizations, not only as stand-alone care service organizations, but also as partners in care for primary and emergency care health organizations.

It was noted earlier that persons must be assessed for suicide. Similarly, treatment must be directly focused on reducing suicidality. Focusing on treating depression, chemical dependence or other issues without directly treating suicidality is insufficient and inadequate care. Behavioral health organizations must build therapeutic alliances around the patient's suicidality and use research-guided techniques to treat suicide risk. This clearly means that clinicians must have the knowledge and skills to treat suicidality. Concurrent treatment can address other problems including underlying mental disorders, but there must be a treatment plan directed specifically at treating suicide risk. As with the assessment and safety plan, the treatment plan should be developed collaboratively with the patient empowering him or her to take actions necessary to reduce emotional distress and pain, to better regulate their emotions, and develop more effective interpersonal skills. In many, if not most cases, treating suicidality can be short-term, and the clinician should strive toward the total elimination of suicidal feelings.

4. **Follow Up – Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.** While contacting persons with suicide risk who have left care may appear to be a nice frill to formal service delivery, there is promising research that demonstrates its efficacy in reducing emotional distress and suicide deaths. From the “caring letters” intervention studies of suicidal inpatients by Dr. Jerome Motto and colleagues,<sup>\*</sup> it was found that a simple follow-up letter expressing concern for the patient's welfare caused significantly fewer deaths. Similarly, Dr. Madelyn Gould<sup>\*\*</sup> and a SAMHSA-funded evaluation team have conducted research on follow-up calls made to persons who contacted the National Lifelines number. In this study, 90 percent of respondents indicated that the calls helped somewhat or a great deal in keeping

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<sup>\*</sup> Motto JA, Bostrom AG: A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services* 52:828–833, 2001.

<sup>\*\*</sup> Gould, Madelyn: Presentation to Clinical Care and Intervention Task Force. July 15, 2011.

them safe and 54 percent indicated that the calls helped significantly with keeping them from killing themselves. The research on suicide risk has demonstrated that isolation and lack of connectedness elevate suicidality considerably. Knowing that someone cares as shown by follow-up contact helps persons feel less isolated and connected building buffers against suicide.

Given the evidence, the Task Force recommends that regardless of setting, some method of follow-up contact should be made with persons at risk leaving care, particularly those leaving acute care settings such as emergency departments and inpatient units. These interventions should be seen as integral to care, not merely a nice option. Many crisis services have already instituted follow-up calls, and, the Task Force recommends that this become a universal practice. Online crisis chat services can follow up with online messages. Primary care and hospital based services should develop methods that work best for them in following up on patients with suicide risk. Again, behavioral health partners may be able to carry out that function for the provider or practitioner. For example, pilot projects with Lifeline crisis centers that have followed up with at-risk individuals discharged from inpatient and emergency department settings have shown promise in reducing risk, subsequent suicide attempts and hospital readmissions.

The Task Force believes that making suicide a never event must be the nation's vision. Public and behavioral health organizations save countless lives every day. By creating an organizational culture where suicide attempts and deaths are unacceptable events, and managing a care environment around that cultural shift, even more lives can be saved.

Figure 2 captures the critical elements leading to suicide prevention through systems change.

Figure 2



## RECOMMENDATIONS FOR ACTION

Project Connect of NAMI New Hampshire promotes, “It takes a community to prevent suicide.” The National Action Alliance for Suicide Prevention’s vision of a nation free from the tragedy of suicide means that the American community must mobilize for action, embracing a shared-responsibility philosophy, and accepting the challenge of change. The Task Force has outlined a vision of care; attaining that vision will require organizational change, and systematic and ongoing upgrading of clinical knowledge and skills. Recognizing the challenge may be great for some organizations, it will be important to offer strategies to motivate, support and sustain systemic improvements. The following recommendations are offered to facilitate that process.

**Recommendation 1: *The U.S. Department of Health and Human Services (DHHS) should spearhead two public-private task forces to catalyze change strategies recommended in this report.*** To effectuate change requires that health and behavioral health organizations and practitioners embrace a zero suicide goal, and manage operations to achieve it. Change also requires that clinicians and caregivers working with suicidal persons have the knowledge and skill sets to engage persons in care successfully and to deliver effective services.

***Recommendation 1A: DHHS should convene a task force charged with identifying and implementing strategies to mobilize and facilitate public and behavioral health organizational change, including collaborations among organizations to promote continuity of care for persons at risk of suicide.*** Taking on suicide remains a daunting challenge. Yet, the U.S. Air Force, Henry Ford Health Services, Magellan Health Services, and the National Suicide Prevention Lifeline have demonstrated that dramatic successes in reducing suicide deaths can be realized. Determined leaders in these organizations opened the door to cultural transformation. These models are replicable and adaptable for other providers and practitioners. National leadership can facilitate more success stories, which should begin to build on each other. The proposed task force would promote suicide as a never event in bounded health/behavioral health organizations. The Task Force’s membership should include HRSA, SAMHSA and other relevant agencies; professional organizations (e.g., American Hospital Association, American Medical Association, American Nursing Association, National Association of Social Workers, American Psychological Association, American Psychiatric Association); accrediting bodies, including the Joint Commission and CARF; suicide prevention experts; state health, mental health and chemical abuse prevention, treatment and recovery leaders; and health, behavioral health and crisis service leaders from across the country, and SPRC. This Task Force would become an emissary for system transformation, marketing successes, and challenging system change.

***Recommendation 1B: DHHS should convene a task force charged with incorporating suicide detection, risk formulation and prevention in the preparatory training of clinicians across the country.*** In talking to national experts, the Task Force heard that many, if not most, clinicians are insufficiently prepared to address suicide risk across the country. Professionals lacking the education and skill to address suicide will likely be fearful to engage persons seeking help in a care relationship. Screening and assessment processes will often not be delivered or provided inadequately. As new physicians,

psychiatrists, psychologists, social workers, nurses, mental health counselors, etc., are trained, it is vital that some level of suicide training be incorporated within their curricula. DHHS should engage a consortium minimally consisting of HRSA, SAMHSA and other relevant federal agencies; professional organizations (e.g., American Psychological Association, American Medical Association, NASW, American Association of Colleges of Nursing); key colleges and universities; representative leaders from the professions; licensing boards; experts in suicide prevention practice; and SPRC. Making suicide a never event requires elevation of clinical preparedness. The federally-convened task force should serve as the engine for appropriately embedding suicide prevention education into clinical training, beginning at college and graduate school levels. While the curricula will differ across disciplines, certain core principles of detection and care should be incorporated. The effort should focus on how to incorporate curricula within existing preparatory training programs.

**Recommendation 2: *State suicide prevention lead agencies, other relevant state agencies, and key stakeholders (e.g., health, mental health, addiction services, child serving, aging or social services agencies) should consider incorporating strategies to promote suicide as a never event within state health and behavioral health organizations as one critical element for updating or advancing their state plans.*** In the first recommendation, the Task Force calls for national leadership employing public-private consortia to promote suicide prevention in health care/behavioral health care organizations and to incorporate suicide prevention training in clinical preparation programs. The National Strategy for Suicide Prevention Task Force is reviewing the current National Strategy for Suicide Prevention with an eye toward updating it and proposing revisions. The Clinical Care and Intervention Task Force recognizes that the states have responded to the current National Strategy with suicide prevention plans and have taken impressive measures to promote and implement suicide prevention strategies within their jurisdictions. The Task Force recommends that state leadership be exercised to enrich existing suicide prevention plans by creating and articulating the goal of suicide as a never event in health and behavioral health organizations.

States should build on existing suicide prevention partnerships to include a broader spectrum of public health and behavioral health stakeholders to update state plans and implement wider strategies. Under the leadership of the state suicide prevention lead agencies, task forces could be formed similar to those proposed nationally to catalyze systems change in health and behavioral health organizations within each state. Partnerships among state agencies and other key organizations representing public health, mental health, substance abuse, child welfare, aging and others can adopt suicide prevention goals that bolster their capacity to identify, assess, intervene, treat, and follow-up with persons at risk. For home-bound, high-risk individuals, it may be that care managers, visiting nurses, home health aides, etc. are the care professionals that provide life-saving services, and should be reflected in state efforts.

Additionally, states could create local task forces to work with colleges and universities to incorporate suicide prevention education and training within curricula for persons preparing to become clinicians. Education agencies, public and private university leaders and associations, should partner with suicide prevention leads, and suicide prevention experts to adapt curricula to include effective suicide prevention education.

**Recommendation 3: *All health and behavioral health care accrediting organizations should create guidance to organizations on elevating suicide prevention practice in accredited organizations from clinical settings to health plans. Accredited organizations should set goals of reducing suicide and self harm, and take progressive steps to implement and measure progress, with an ultimate goal of zero deaths among members/patients.*** Accrediting organizations hold considerable sway with organizations they accredit. As such, standards of care they create, and/or guidance they issue can provide a powerful stimulus for organizations to improve clinical practice. For example, the Joint Commission demonstrated the power of accrediting and licensing organizations to motivate enhanced suicide practice in 24-hour care with the release of revised National Patient Safety Goals. The Task Force calls on all health and behavioral health accrediting organizations to review their standards with respect to suicide prevention and care. They should issue clinical guidance to organizations that they accredit to elevate suicide prevention practice. In response, accredited organizations should adopt and implement steps to reduce suicide and self-harm with the goal of eliminating suicides among persons who receive care from them.

As members of the Action Alliance, the Joint Commission and CARF have discussed the potential of issuing joint guidance on suicide prevention to their respective constituencies. The Task Force applauds the two organizations' intentions. The Task Force recommends that guidance be focused on elevating practice in emergency and ambulatory care, and in behavioral health settings. Further, the Task Force suggests that the two organizations involve other critical stakeholders in their deliberations, including (but not limited to) the Lifeline, the AMA, the American Association of Family Physicians (AAFP), and other appropriate accrediting organizations. The Lifeline can assist with structuring guidance on community resources available to public health settings, and with how to share responsibilities for assessment, safety planning and ongoing treatment referrals with local crisis centers. By incorporating the medical associations into the process, it can provide a platform for these associations to issue guidance on improving suicide prevention practice to their constituencies, including physicians in private or group practices, which may further increase the potential for saving lives.

**Recommendation 4: *All health and behavioral health plans and providers should develop plans to reduce suicide and self harm. They should select evidence-based and best practices that are relevant to their mission that can reduce suicide and self harm, and implement and monitor the impact of these efforts.*** Health plans should commit to reducing suicide and self harm among their members, using the strategies outlined in this report. Suicide among health plan members and populations under care in clinical settings should be defined as a never event and subjected to quality improvement efforts such as root cause analysis. The Task Force has recommended that primary and general health care providers, emergency care departments and behavioral health organizations adopt and implement suicide prevention as a critical organizational goal, with the ultimate aim of eliminating suicides. Augmenting this recommendation is the call for state and national leadership to cultivate this transformational shift, and accrediting organizations to issue guidance for setting and implementing this goal. Health and behavioral plans can also influence suicide prevention practice. For example, Medicare has instituted a new procedure code that reimburses physicians for simple depression screening. Adding one suicide prevention screening question would allow physicians to address suicide concomitantly. The Task Force calls on other health and behavioral health plans to reimburse for depression and suicide risk screening.

**Recommendation 5: *National guidance should be created for providing suicide prevention care through technology-based services (e.g., telephone crisis hotlines, on-line crisis chat services).*** Too many people experiencing thoughts of suicide do not seek necessary care. The reasons are numerous and well-known – shame, fear, lack of access to services, and cost, for example. A rapidly growing help technology exists through care that can be accessed by telephone or on line. While telephone hotlines have existed for decades, the National Suicide Prevention Lifeline and its network of crisis centers have given the field a robust resource for remote care to people who cannot or will not seek help in person. One state has developed a psychiatrist-staffed hotline for primary care physicians. A growing technology exists with on-line care in the form of crisis chat services and e-therapy, which are also piloted at a number of crisis centers around the nation. Social media sites offer the potential to be a further resource for providing outreach to those in need, offering information and linkages to online chat, telephonic or other vehicles where intervention and prevention assistance can be delivered. In addition, there are emerging technologies for providing assistance through texting. As technological advances continue to expand, the potential of offering timely care rises dramatically. While many of the services being delivered are being provided by persons with expert training, there are few standards governing care delivery via technology. To address this concern, in 2011, the Lifeline; Trevor Project; and the Rape, Abuse and Incest National Network have formed the Online Crisis Support Consortium, consisting of a number of national leaders in online crisis intervention, to ascertain and promote promising practices and successful approaches in web-based and mobile communications. Appendix D describes the National Suicide Prevention Lifeline’s values, policies and guidelines for care.

The Task Force has recommended that public health providers consider collaborating with nearby Lifeline crisis centers as one resource for conducting assessment, intervention and referral of persons at risk of suicide. Clearly, similar collaborative strategies could be applied to online care as it grows over time. The Task Force recommends that DHHS convene a national advisory group with the specific purpose of issuing guidance to the field regarding care delivered via technology. This should cover engaging persons at risk, screening, risk assessment, safety planning, effective referral strategies, follow-up, and how to intervene in an emergency situation. It is also important to increase evaluation and research studies on technology-based services.

**Recommendation 6: *The Suicide Prevention Resource Center (SPRC) should build on its current record of success by increasing its capacity to assist local suicide prevention services in two major areas.*** For almost a decade, the Suicide Prevention Resource Center has served as a valuable national technical assistance, resource and infrastructure-building center. The Task calls for two specific efforts to augment SPRC's current infrastructure and function.

***Recommendation 6a: Regional Centers of Excellence on Suicide Prevention should be established under the auspices of the national Suicide Prevention Resource Center to deliver training, technical assistance and consultation to communities, providers and practitioners.*** In the first recommendation, the Task Force called for a National Task Force to identify strategies for infusing suicide prevention education into clinical preparation programs. Incorporating suicide prevention education into clinical preparation training will better prepare the future workforce but will not address knowledge and skills deficits in the current workforce. Therefore, the Task Force recommends establishing Regional Centers of Excellence located strategically throughout the country to elevate skills in the existing workforce. In establishing Regional Centers, SPRC should strategically include critical stakeholders and partners in their design, implementation and governance. This could include SAMHSA, the National Suicide Prevention Lifeline, Surgeon General, and other critical experts. The Regional Centers of Excellence could be based in university settings, crisis centers, training and clinical organizations, or other suitable venues. Regional Centers could locate all the assistance under one organization, or the functions could be distributed among a number of organizations. The Regional Centers would function as local branches of the Suicide Prevention Resource Center.

The Centers should serve as local resources for assisting the field with suicide prevention. A similar network exists in the addiction field, the Addiction Technology Transfer Centers (ATTC), which are located regionally around the country. The ATTC's provide technology transfer, workforce development, training, distance education, research translation, product dissemination, technical assistance, and systems change support. The proposed Regional Centers would provide most, if not all, of these same functions, and be linked to SAMHSA, the Lifeline and other national suicide prevention efforts. Additionally, the Regional Centers of Excellence should be equipped to provide consultation to clinical staff on difficult issues such as local suicide clusters or contagions.

***Recommendation 6b: The Suicide Prevention Resource Center should establish and facilitate a clinical and research advisory group to translate research into clinical practice guidance, providing an expert forum for advising the work of the Regional Centers of Excellence.*** While there is a relative dearth of randomized control trial studies on suicide prevention effectiveness, there are many clinical researchers pursuing important clinical studies. The Task Force recommends that SPRC create a Clinical and Research Advisory Panel made up of national suicide prevention clinical and research experts. The Clinical and Research Advisory Panel would help translate the growing body of research into practice. It would serve as an expert forum to guide the operations of the Regional Centers of Excellence. It would also assist SPRC in its ongoing technical assistance and training functions, and help inform state efforts on updating state plans and advancing suicide prevention.



**Recommendation 7: *Suicide prevention should be incorporated in national health care reform implementation. State health and behavioral health agencies should incorporate the recommendations contained in this report in guidance to and expectations for health plans and specialty and mainstream health providers (e.g., hospitals, clinics, group practices, treatment facilities).*** A critical principle of health care reform and quality health care is to deliver care in a more integrated fashion. While this principle affects many layers of health care, integration of general and emergency health services with mental health and addiction care offer opportunities to embed effective suicide prevention care in emerging health care environments.

Collaborative care should be established as the standard of care for detection, treatment and management of behavioral health problems in primary care. Emerging models of care such as Patient Centered Medical Homes (PCMH), Health Homes (HH) and Accountable Care Organizations (ACO) should incorporate collaborative suicide prevention strategies in their design and implementation. These models of care are patient-centered and coordinated across all elements of the complex health care system (e.g., specialty care, hospitals, home health agencies, nursing homes) and the patient's community (family, and public and private community-based services). Care is facilitated by health information exchange and other means to ensure patients have access to the care they need. Incorporating suicide as a never event should mark the design and implementation of new and changing models of health and behavioral health care. The National Action Alliance for Suicide Prevention and its federal partners should monitor the implementation of health care reform to promote quality suicide prevention services as new models of health care delivery evolve.

# APPENDICES

**APPENDIX A**  
**BRIEF SUMMARIES OF FOUR PRESENTATIONS TO TASK FORCE**

**AIR FORCE SUICIDE PREVENTION INITIATIVE (1996 – 2002)**

“When the Air Force launched its first suicide-prevention program, there was a lot of debate about whether or not it was even possible to reduce suicide through this type of an effort,” according to David Litts. “A lot of people, including mental health practitioners, were skeptical. But over a six-year period, the suicide rate dropped by one-third.”

The Air Force Suicide Prevention Initiative was not based on a series of clinical interventions. Instead, it effected a significant culture change of attention, caring and belief through the following core elements:

- Strong commitment from top leadership demonstrated through consistent and effective communication;
- Skills and information training on suicide intervention for all Air Force members, varying in intensity based upon rank and level of responsibility;
- Creating the first privileged communication for suicidal personnel who are under investigation; and
- Encouraging the responsibility of all Air Force members to care for one another — “buddy care.”

**HENRY FORD HEALTH SYSTEM (2001 – PRESENT)**

As a model, in 1996, the Henry Ford Health Service (HFHS) had developed a very strong quality improvement system that consistently made incremental improvements in target areas (e.g., inpatient falls, medication errors). They were committed to improving care for depression using these tools, and applied for Robert Wood Johnson Foundation’s Pursuing Perfect Care initiative, which aimed to realize the Institute of Medicine’s principles for a “21st-century health system.” Don Berwick was the President and CEO of the Institute of Health Improvement at the time and the primary author of the Chasm Report. He challenged the HFHS leadership that their goals for this effort (e.g., measuring improved clinical status) were insufficient. They should instead pursue perfection. In this context, a staff member suggested that perfect depression care should result in zero suicide deaths. Over the next six months, staff wrestled with this radical concept and, in the end, this commitment became the cornerstone of their future approach and success.

Within four years, the suicide rate at HFHS Behavioral Health Services HMO had decreased by 75 percent. More recently, the program has generated considerable excitement and attention as it has not reported a suicide death for those enrolled in its care for ten consecutive quarters.

According to HFHS Vice-President Ed Coffey, MD, the keys to the program success included the following elements:

- Partnership with patients through advisory council for design of the program and increased partnership throughout treatment planning and care process;
- Planned care model, including stratification of risk into three levels with accompanying interventions, including emphasis on means restriction;
- Established and maintained all clinician competency and training in Cognitive Behavioral Therapy (CBT);
- Robust performance improvement techniques; and
- Improved access to immediate care for patients, including drop-in group medication appointments, advanced same day access to care and e-mail “visits.”

#### NATIONAL SUICIDE PREVENTION LIFELINE (2005 – PRESENT)

Prior to 2000, many in the suicide prevention field doubted the effectiveness of crisis call centers. There was little research or data to evidence positive outcomes and few national standards of practice. In 2004, SAMHSA awarded the Mental Health Association of New York City (through a subsidiary Link2Health) the contract to manage the National Suicide Prevention Lifeline, a network of over 150 crisis agencies across the country. In 2005, SAMHSA released a series of findings from independent evaluators of Lifeline member crisis centers, demonstrating that these crisis centers were effective in reducing emotional distress among crisis callers and significantly reducing suicidality among suicidal callers.

In the past six years, these centers have dramatically increased the capacity and calls to 1-800-273-TALK, implemented a Veteran’s hotline through a partnership with the VA, and added chat technology to augment the telephonic interface. More importantly, they have introduced best practice standards which are utilized across the network. According to Link2Health Executive Director Dr. John Draper, the most important advances include the following:

- 2007 publication of the SAMHSA Suicide Risk Assessment Standards; and
- 2011 publication of the SAMHSA Policies and Guidelines for Helping Callers at Imminent Risk of Suicide

#### MARICOPA SUICIDE DETERRENT SYSTEM PROJECT (2009 – PRESENT)

The experience of the Central Arizona Programmatic Suicide Deterrent System Project shows that dramatic progress can be made by specialty health plans and systems that focus on the population *at highest risk for suicide*: individuals with serious mental illness (SMI) and severe emotional disturbance (SED). In 2009, Richard Clarke, CEO of Magellan Health Services of

Arizona, challenged a community collaborative of the ten largest behavioral health providers to eliminate suicide for those enrolled in the Regional Behavioral Health Authority (RBHA). The May/June 2011 Behavioral Healthcare talked about some of the encouraging early feedback that correlates with this project, including a 38 percent reduction in suicide deaths, decreased hospitalization rates for those enrolled in ACT and dramatic increases in staff confidence following two day ASIST training (Applied Suicide Intervention Skills Training). According to Chief of Adult Services, David Covington, the essential elements of this project include:

- Comprehensive CMHC staff training to move suicide care from specialty referral to core mission;
- Suicide attempt survivor leadership and support, through participation in design and implementation of peer support groups;
- Active engagement of family in the treatment process, “the new normal,” and community integration and support; and
- Development of race and ethnicity best practices for suicide care

## **APPENDIX B SUICIDE RISK SCREENING AND ASSESSMENT RECOMMENDATIONS**

This document outlines specific recommendations for suicide risk screening and assessment in four major settings in which individuals come into contact with medical and/or mental health personnel. The recommendations are intended to improve upon the current level of practice and move toward the ultimate vision of care; a zero defect system. Some recommendations reflect minimal expectations and can be easily implemented, while others may require agencies and personnel to stretch far above their current practice. Outside agencies, such as accrediting bodies, should also influence the practice of suicide risk screening and assessment in these settings.

### **Primary Care and Other Outpatient Medical/Surgical Settings:**

1. Follow national recommendations to screen for depression by implementing a simple screening tool, such as the PH-Q 9 or PHQ-9 modified (teen version), which includes 3 questions related to suicide risk.
2. Every patient is screened for suicide risk, using a screening instrument that asks at least one question about suicide risk. Examples follow in this appendix, as well as websites to access some of them.
3. The screen should be completed at the initial visit, for example, when the patient completes the intake questionnaire, at annual visits, and when otherwise appropriate e.g., (when the patient verbalizes mental health concerns or when the provider suspects mental health issues are present).
4. Each practice and/or provider would consider the most practical approach to administration, scoring, and interpretation of results, based on their resources. Policies and Procedures should be developed to operationalize the process.
5. A positive screen, indicating potential risk for suicide, would lead medical staff to consider a variety of potential action steps and interventions that have clear pathways for accessing them. Examples include: a psychiatric or psychological consult, calling the Lifeline or local Crisis provider, hospitalization, starting a medication regimen, referring to an outpatient provider, involving family, removal of firearms, etc.
6. A positive screen should additionally result in a more comprehensive assessment, completed by a trained behavioral health professional. Factors of desire, intent, capability, and buffers should be included in this assessment. The behavioral health professional should be able to determine level of risk based on the outcome of this assessment.
7. The behavioral health professional should collaborate with the medical provider to determine the most appropriate level of interventional, based on the outcome of the assessment and professional judgment, and may assist in its implementation.
8. PCP's should be provided with a Toolkit to assist the practice of suicide risk screening and to identify follow-up steps. Addressing access to a behavioral health professional that can provide a suicide risk assessment and how to collaborate with other behavioral health entities in the community is needed as well. The SAMHSA toolkit and TeenScreen are examples of existing tools.
9. National Policies and Procedures should be developed to promote use of best practices and consistency among providers in this setting.
10. Trainings identified as best practices for PCP personnel should occur regularly.

**Emergency Departments and Other Inpatient Medical/Surgical Settings:**

1. The 'Is your patient suicidal' poster should be placed in all EDs, easily viewed by staff.
  2. Each ED should develop and implement Policies and Procedures for suicide risk screening and assessment.
  3. A brief, evidence-based suicide risk screen or question(s) addressing suicidality should be added to the initial intake questionnaire for all patients.
  4. Every patient is screened for suicide risk; if the screen indicates potential suicide risk, then a comprehensive assessment is done by a behavioral health professional. The assessment should include the risk and protective factors: desire, intent, capability, and buffers.
  5. The behavioral health professional will work with the medical provider to determine the most appropriate level of interventional and may assist in its implementation.
  6. Training identified as best practices in suicide screening, assessment, and intervention is provided to ED personnel with ongoing frequency.
1. National Policies and Procedures should be developed to promote use of best practices and consistency among staff in ED's.

**Specialty Behavioral Health Settings (Inpatient and Outpatient):**

1. Each person is screened for suicide risk at every contact; if the screen indicates possible suicide risk, a more comprehensive assessment of risk is completed.
2. The assessment includes, at a minimum, the factors of desire, intent, capability, and buffers.
3. The result of the suicide risk screening and/or assessment should guide whether and what evidence-based interventions are to be implemented.
4. Agency policies and procedures surrounding suicide risk screening and assessment are implemented, and use of evidence-based instruments is highlighted.
5. National suicide risk screening and assessment standards for behavioral health settings are developed, implemented, and evaluated for their effectiveness. Robust performance improvement measures are performed.
6. Industry standard training for behavioral health professions regarding suicide risk screening and assessment is provided with ongoing frequency.

**Crisis Settings:**

1. Each person is screened for suicide risk during each contact with a Crisis provider.
2. If the screen is positive, a more comprehensive assessment of risk is completed, and level of acuity is determined.
3. The assessment includes, at a minimum, the factors of desire, intent, capability, and buffers.
4. Standardized suicide risk screening and assessment tools, using evidence-based practices, should be developed by each Crisis agency and used consistently by Crisis staff.
5. Level of acuity gleaned from the suicide assessment should be taken into account when considering the type of intervention to utilize.
6. Implement agency policies and procedures surrounding suicide risk and assessment.
7. Industry standard training for Crisis staff regarding suicide risk screening and assessment is provided with ongoing frequency.
8. National suicide risk and assessment standards for Crisis settings should be developed, implemented, and evaluated for their effectiveness.

The following pages contain examples of Screening and Assessment Tools.



Name
MRN

**PATIENT BEHAVIORAL HEALTH SCREENING QUESTIONNAIRE**

Today's Date \_\_\_\_\_ Room Number \_\_\_\_\_ Age \_\_\_\_\_  Female  Male

Referring Clinician \_\_\_\_\_ RN/SW/MD/other

Referral Date \_\_\_\_\_ Date of RN Admission Assessment \_\_\_\_\_

Clinician Completing Questionnaire \_\_\_\_\_ RN/SW/MD/other

1. When was the last time you had 4 or more drinks in 1 day?	Never	More than 12 months ago	3-12 months ago	Within the last 3 months
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(0)	(1)	(2)	(3)

2. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	Never	Once	Twice	More than twice
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(0)	(1)	(2)	(3)

3. Over the last 2 weeks, how often have you been bothered by any of these problems?	Not at all	Several days	More days than not	Nearly every day
a. Feeling nervous, anxious, or on edge .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Not being able to stop or control your worrying .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Feeling down, depressed, or hopeless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Having little interest or pleasure in doing things .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Having thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(0)	(1)	(2)	(3)

\*\*\* The screening tool is **positive** when any of the following criteria are met:  
 - The response to Item 1 (SASQ) is "within the last 3 months."  
 - The response to item 2 (SQST) is  $\geq 1$ .  
 - The total score of Items 3a-d (PHQ-4) is  $\geq 6$ .  
 - The score of Item 3e is  $\geq 1$ .





**PHQ- 9**  
**PATIENT HEALTH QUESTIONNAIRE- SHORT FORM**

<b>1. Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>				
	Not at all (0)	Several days (1)	More than half the time (2)	Nearly every day (3)
a. Little interest or pleasure in doing usual activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating; e.g., difficulty with reading the newspaper or watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you has been moving around more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</b>				
Not difficult at all (0) Somewhat difficult (1) Very difficult (2) Extremely difficult (3)				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Patient Health Questionnaire Modified for Teens (PHQ-9 Modified)

### Overview

The PHQ-9 Modified for Teens is a 13-item self-completion screening questionnaire designed to detect symptoms of depression and suicide risk in adolescents. In addition to the 9 core items that ask about symptoms of depression, there are two items that inquire about the severity of symptoms (or impairment) and two additional items that ask about suicide risk. The questionnaire takes less than five minutes to complete and score, and it can be scored by the doctor, nurse, medical technician or other office staff prior to the patient's exam with the PCP. The PHQ-9 Modified is derived from the PHQ-9 that is used for adults. Both the American Academy of Pediatrics and the U.S. Preventive Services Task Force recommends that depression screening be conducted annually.

### Administration

It is recommended that parents are informed that depression screening will be administered as part of the exam. In order to obtain honest answers, patients should be left alone to complete the PHQ-9 Modified in a private environment and should be informed of their rights regarding confidentiality before the questionnaire is administered.

A Survey From Your Healthcare Provider — **TeenScreen<sup>®</sup> Primary Care**  
**PHQ-9 Modified for Teens**

Name \_\_\_\_\_ Clinician \_\_\_\_\_  
 Medical Record or ID Number \_\_\_\_\_ Date \_\_\_\_\_

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?  
 For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?  Yes  No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?  
 Not difficult at all  Somewhat difficult  Very difficult  Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life?  Yes  No

13. Have you ever, in your **whole life**, tried to kill yourself or made a suicide attempt?  Yes  No

FOR OFFICE USE ONLY Score \_\_\_\_\_

Q, T2 and Q, T3 = Y or TS = 11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Lawrence C. Wittchen, Kurt Kroenke, and Andrew Z. Black) PHQ-9 Modified 10/2002

The PHQ-9 Modified comes in the form of a tear-off pad and is available in both English and Spanish. You may choose to distribute a copy of the questionnaire to patients in the waiting or exam room as the patient comes in for their appointment.

### Patient Safety Screener<sup>1</sup>

To be administered by primary nurse during primary nursing assessment.

Introductory script: Because some topics are hard to bring up, we ask the same questions of everyone.

	Interpretation
<b>1. Over the past 2 weeks, have you felt down, depressed, or hopeless?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Patient unable to complete	Depressed mood
<b>2. Over the past 2 weeks, have you had thoughts of killing yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Patient unable to complete	At least active ideation, general thoughts without thoughts of ways, intent, or plan
<b>3. Have you ever attempted to kill yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Patient unable to complete	Lifetime attempt
<b>4. . . . If Yes to item 3, ask: when did this last happen?</b> <input type="checkbox"/> Within the past 24 hours (including today) <input type="checkbox"/> Within the last month (but not today) <input type="checkbox"/> Between 1 and 6 months ago <input type="checkbox"/> More than a six months ago <input type="checkbox"/> Refused <input type="checkbox"/> Patient unable to complete	If within the last 6 months, considered recent attempt

Apply protocols for further suicide evaluation and management as appropriate to the clinical practice guidelines in place at the individual site.

**Note:** The research to validate this Patient Screener against the Beck Suicide Scale is still in progress.

<sup>1</sup> Boudreaux, Miller, Camargo, NIMH, U01MH088278

## Examples of Assessment Tools

### National Suicide Prevention Lifeline Suicide Risk Assessment Standards

*It is policy that each Lifeline caller be asked about suicidality. An affirmative answer will require that the telephone worker conduct a full suicide risk assessment with the caller consistent with the core principles and subcomponents below. These standards are guidelines for Lifeline Centers as to the minimum requirements for the core principles and subcomponents of each Center's suicide risk assessment instrument. The Center can use its own suicide risk assessment instrument as long as all of the core principles and subcomponents are incorporated.*

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#### CORE PRINCIPLES & SUBCOMPONENTS

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SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal Ideation • Hurting self and/or others	History of suicide attempts	Attempt in progress	Immediate supports
	Exposure to someone else's death by suicide		Social supports
Psychological pain	History of/current violence to others	Plan to hurt self/other • Method known	Planning for the future
	Available means of hurting self/other		Engagement with helper • Telephone worker
Hopelessness	Currently intoxicated	Preparatory behaviors	Ambivalence for living
	Substance abuse		Core values/beliefs
Helplessness	Acute symptoms of mental illness, for example: • Recent dramatic mood change • Out of touch with reality	Expressed intent to die	Sense of purpose
Perceived burden on others	Extreme agitation/rage, for example: • Increased anxiety • Decreased sleep • Recent acts and/or threats of aggression		
Feeling trapped			
Feeling alone			

Revised as of 2/2/07

1



**DANGER TO SELF/ DANGER TO OTHERS ASSESSMENT**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

<b>1. REASON FOR ASSESSMENT:</b>	
<b>DTS Assessment N/A</b> <input type="checkbox"/>	<b>DTO Assessment N/A</b> <input type="checkbox"/>
<b>2. IDEATIONS:</b> (thoughts of dying or killing oneself): <input type="checkbox"/> None (No thoughts) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (Obsessive thoughts)	<b>(Thoughts of harming others):</b> <input type="checkbox"/> None (No thoughts) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (Obsessive thoughts)
<b>3. PLAN:</b> (How would client carry out ideations?): <input type="checkbox"/> None (Unclear) <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High <input type="checkbox"/> Severe (detailed & specific)	<b>(How would ct carry out ideations?):</b> <input type="checkbox"/> None (Unclear) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (detailed & specific)
<b>4. MEANS:</b> (Access to weapons/instruments): <input type="checkbox"/> None (No access to means) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (to continuous access to means)	<b>(Access to weapons/instruments; Access to identified victim)</b> <input type="checkbox"/> None (No access to means) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (to continuous access to means)
<b>5. LETHALITY OF PLAN:</b> (Dangerousness of plan): <input type="checkbox"/> N/A (Minimal risk of loss of life) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (to certainty of death)	<b>(Dangerousness of plan):</b> <input type="checkbox"/> None (Minimal risk of loss of life) <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Severe (to certainty of death)

**NATIONAL SUICIDE PREVENTION LIFELINE RISK ASSESSMENT DOCUMENTATION AND LOG SHEET**

Date of call \_\_\_\_\_ Time of Call (24) \_\_\_\_\_ Age of Caller \_\_\_\_\_ Zip Code of Caller \_\_\_\_\_ Number of Caller ID \_\_\_\_\_  
 Gender of Caller  Female  Male  Unable to determine # of Referrals Given  0  1  2 - 4  5 + Staff Initials \_\_\_\_\_

**How did you hear about 273-TALK?**

- Internet (web/email)  Brochure  Wallet Cards  Counselor/Therapist
- Phonebook  Posters  Friend/Family  Pen/Magnet/Giveaways
- Newspaper  Radio  Physician  Bus/Train/Billboards
- Magazine/Newsletter  TV  Faith-based Leader  Other \_\_\_\_\_

**Are you a vet?**  
 Yes  
 No

**What prompted call?**

- AODA/Addiction  Info on Suicide (I & R)  Homelessness Issues  Sexual Orientation Issues
- Loneliness  Mental Health/Illness  Physical Illness  Family Problem (parent/kids)
- Suicidal Crisis  Post-disaster Needs  Abuse/Violence  Death of family member/friend
- Suicidal Thoughts  Economic Problems  Relationship Problems  Other \_\_\_\_\_

**SUICIDE RISK ASSESSMENT STANDARDS/CORE PRINCIPLES AND SUBCOMPONENTS**

Are you thinking of suicide?  Yes  No Comment: \_\_\_\_\_  
 Have you thought about suicide in the last two months?  Yes  No Comment: \_\_\_\_\_  
 Have you ever attempted to end your life?  Yes  No Comment: \_\_\_\_\_

**ONE OR MORE "YES" ANSWERS, PROCEED TO SUICIDAL DESIRE**

SUICIDAL DESIRE Caller to rate level 0 - 10 (0 = none)	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS CONNECTEDNESS
<b>SUICIDAL IDEATION</b> Desire to harm self and/or others 0 1 2 3 4 5 6 7 8 9 10	HISTORY OF SUICIDE ATTEMPTS # _____ When last? _____ How? _____ EXPOSURE TO ANOTHER'S DEATH BY SUICIDE Who/when? _____	<b>ATTEMPT IN PROGRESS</b> <b>ENACT CALL TRACE</b> <b>CALL 911</b>	<b>IMMEDIATE SUPPORTS</b> Who is with you? Can I call someone?
<b>PSYCHOLOGICAL PAIN</b> 0 1 2 3 4 5 6 7 8 9 10	HISTORY OF VIOLENCE How/when? _____	<b>PLAN TO HURT SELF/OTHERS</b> Who? Method known How/when?	<b>SOCIAL SUPPORTS</b> Who/what do you feel supported by?
<b>PERCEIVED BURDEN ON OTHERS</b> 0 1 2 3 4 5 6 7 8 9 10	AVAILABLE MEANS OF HURTING SELF/OTHERS How/what? _____	PREPARATORY BEHAVIORS (List)	<b>PLANNING FOR THE FUTURE</b>
<b>HOPELESSNESS</b> 0 1 2 3 4 5 6 7 8 9 10	DO YOU TAKE MEDS? HAVE YOU BEEN TAKING THEM? CURRENTLY INTOXICATED? YES NO ?? OTHER MEDS/DRUGS INTENDED? YES NO ?? HX OF SUBSTANCE ABUSE? YES NO ??	EXPRESSED INTENT TO DIE	<b>ENGAGEMENT WIT HELPER</b>
<b>HELPLESSNESS</b> 0 1 2 3 4 5 6 7 8 9 10	Recent dramatic mood changes		<b>AMBIVALENCE FOR LIVING</b>
<b>FEELING TRAPPED</b> 0 1 2 3 4 5 6 7 8 9 10	Out of touch with reality Increased anxiety Decreased sleep		<b>CORE VALUES/BELIEFS</b>
<b>FEELING INTOLERABLY ALONE</b> 0 1 2 3 4 5 6 7 8 9 10	Recent acts and/or threats of aggression		<b>SENSE OF PURPOSE</b>

If caller is within Washington County, arrange mobile contact for full safety assessment and safety planning. If caller is in another locale, make contact with law enforcement and/or local crisis resources. Include additional information and documentation on the back of this form.

<u>Identifying and Demographic Information</u>
<u>History of the Present Illness (include <i>current mental status</i> and <i>current suicidal ideation, planning, and intent</i>)</u>
<u>Psychiatric History and Treatment</u>
<u>Social and Developmental History</u>
<u>Family History of Suicide</u>
<u>Current Serious Medical Illnesses</u>
<u>History of Current, Recent, and Past Suicidal Ideation, Planning and Attempts</u>
<u>Clinical Impressions and Formulation of Suicide Risk -</u> High Risk – All three core factors are present ( <b>Desire, Intent, Capability</b> ) Risk is high despite absence or presence of buffers. Moderate to High Risk – <b>Desire</b> paired with <b>Intent</b> or <b>Capability</b> . Absence or presence of buffers may increase or reduce risk. Moderate to Low Risk – Any factor present alone, absence or presence of buffers may increase or reduce risk.

Interviewer's Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinical Supervisor Review/Date \_\_\_\_\_ Program Manager Review/Date \_\_\_\_\_

**APPENDIX C****Best Practices Report on Evidence-Based Suicide Treatments and Interventions****VISN 7 Suicide Risk Reduction Process Improvement Project\***

David A. Jobes, Ph.D., Mark De Santis, Psy.D., and Donald L. Myrick, M.D.

## Overview

This report is designed to give VISN 7 Suicide Risk Reduction Committees a broad overview to the suicide treatment/intervention evidence base to help in their deliberations about the use of evidence-based care in their respective facilities. This report will review the major domains of interventions and focus primarily on those interventions that have been studied with randomized clinical trial (RCT) designs to investigate the efficacy or effectiveness of an approach. To be clear, we believe that there may be valuable non-evidence based clinical “best practices” worth using. We further believe that clinical interventions with correlational support can also be quite valuable. Nevertheless, this report emphasizes RCT-derived data as the scientific “gold standard” of what we know works in *causal* fashion. However, given the general pervasiveness of suicidal risk in general mental health practice, there are still remarkably few randomized clinical trials (n=49) in the *world’s* literature providing empirical support for suicide-specific treatments and interventions.

*Pharmacological Treatment*

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\* **Note:** This overview report on suicide-specific evidence based approaches was written as part of a process improvement project conducted from 2008-2011 in “VISN 7” (8 VA Medical Centers in Georgia, Alabama and South Carolina) and was supported by an IPA contract between VISN 7 and Catholic University. It was written to provide a practical overview to VA Mental Health providers and is not an exhaustive review of the extant literature.



Contrary to contemporary practice, there is remarkably little support for a purely pharmacotherapy-only approach in the treatment of suicidal risk. Problematically, drug manufacturers routinely *exclude* high risk suicidal individuals in their development of new medications. While there are some correlational data about the use of SSRI's in relation to suicide (e.g., Verkes et al., 1988), there is better RCT evidence for the use of clozapine with schizophrenic and schizoaffective patients (Meltzer et al., 2003), and there is growing evidence for the use of lithium carbonate with bipolar patients (Hawton et al., 2005). However, given the pervasive use of pharmacotherapy in contemporary mental health care, there is a pronounced need for more clinical trial research to better study the impact of medications on the treatment of suicidal risk.

#### *Inpatient Psychiatric Care*

At this point in time, the wide spread use of inpatient psychiatric hospitalization as a suicide-specific intervention does not yet enjoy clear empirical support in the handful of RCT's that have been conducted (e.g., Waterhouse & Platt, 1990). This does not mean that inpatient care is not effective; it simply means that this common response to suicidal risk does not yet have clear-cut empirical support within the extant literature. That said, there are some emerging inpatient suicide-specific care models that seem promising (Ellis et al., 2011; Holloway, 2011).

#### *Intensive Follow-up and Case Management*

There is considerably more RCT evidence in support of intensive follow up and case management delivered in different forms for suicidal risk. In a particularly seminal study, Dr. Jerome Motto and colleagues (2001) conducted randomized clinical trial using a "caring letter" intervention with discharged suicidal inpatients that had rejected further treatment. In this RCT, the experimental subjects were sent a simple letter expressing concern and support every four

months over a five year period (in contrast to the control group that received no such letter). The results show that those patients who received the caring letter had significantly fewer deaths by suicide in comparison to the control subjects. This kind of research has been further replicated using similar “non-demand” follow-up interventions and RCT research designs (e.g., Carter et al., 2005). In this vein, the use of follow-up case management and supportive non-demand out-reach has also has been shown to impact suicidal behavior (e.g., Vaiva et al., 2006; Welu, 1977).

### *Psychotherapy for Suicidal Risk*

Generally speaking, there tends to be more robust support for psychotherapy as the optimal clinical treatment for suicidal risk. While a range of theories and psychotherapies have been studied, the research generally supports structured, problem-solving, approaches that specifically target and treat suicidal ideation and behavior (independent of diagnosis). What follows are highlights of this literature.

*Dialectical Behavior Therapy.* The psychotherapy with the best empirical support is “Dialectical Behavior Therapy” (DBT) developed by Dr. Marsha Linehan at the University of Washington. This treatment is most often associated with the treatment of borderline personality disorder but is now being used with other conditions (e.g, eating disorders and bipolar disorder). DBT has been shown in multiple studies to decrease suicide attempt behaviors, self-harm behaviors, and other suicide-relevant markers like suicidal ideation and hopelessness (Linehan, 1993; Linehan et al., 2006). With its emphasis on skills training and mindfulness-based emotion regulation, DBT is the most thoroughly studied and efficacious of the existing psychotherapies for suicidal behavior.

*Cognitive Therapy.* The next most studied and supported suicide-relevant psychotherapy is the Cognitive Therapy (CT) approach developed by Dr. Aaron Beck and

colleagues at the University of Pennsylvania. Their important RCT with emergency department-identified suicide attempters provided convincing evidence that ten sessions of a suicide-specific CT intervention for suicide attempters caused decreases in follow-up suicide attempt behaviors among experimental patients when compared to control group patients (Brown et al., 2005). The CT intervention for suicide is written about in more depth in a recent book by Wenzell, Brown, and Beck (2009). The CT intervention is primarily focused on what Beck refers to as the “suicidal mode” which is activated by certain experiences, memories, thoughts, and situations. By learning about what triggers the suicidal mode, patients in CT treatment can learn to develop and use different non-suicidal coping responses.

This model is now being actively studied in other RCT investigations by Beck’s group and others. For example, Dr. David Rudd (2011) is currently studying a short outpatient CT intervention with active duty suicidal Army Soldiers at Ft. Carson. Similarly, Dr. Marjan Holloway (2011) is conducting a promising RCT of an adaptive version of the CT intervention with suicidal Soldiers within an inpatient treatment model at Walter Reed Army Medical Center.

#### *Other Promising Interventions*

There are two additional promising interventions that enjoy correlational support and are now being more thoroughly studied in randomized clinical trials. These interventions are not traditional psychotherapies but do provide evidence-based guidance for clinicians to work effectively with suicidal patients.

*Safety Planning Intervention.* Dr. Barbara Stanley at Columbia University and Dr. Greg Brown at the University of Pennsylvania have developed a structured 6-step Safety Planning Intervention (SPI) that has been widely adopted within VA mental health care (Stanley & Brown, in press). This intervention is built on similar ideas of previous work (e.g., Rudd’s notion of “Crisis Response Planning”) and provides a simple straightforward approach for developing a

brief outpatient approach that is far superior to the still widespread use of “no harm/no-suicide contracts.” Data from a VISN 2 demonstration project using SPI in a VAMC emergency department were recently presented at the 2011 DOD/VA Suicide Prevention Conference by Drs. Stanley and Brown. The “Safe Vet” SPI intervention was both feasible and effectively used with non-hospitalized suicidal veterans seen in the ED. The Safe Vet intervention also included the use of non-demand follow-up phone calls linking suicidal veterans to outpatient mental health care. Incredibly, 80% of suicidal vets engaged in the Safe Vet demonstration project ultimately sought outpatient mental health care in the weeks following their ED discharge.

*The Collaborative Assessment and Management of Suicidality.* Jobes (2006) and colleagues have developed an evidence-based intervention called the “Collaborative Assessment and Management of Suicidality” (CAMS) that has been used in various VA settings (Jobes, 2011). CAMS is a therapeutic framework that emphasizes collaborative assessment, crisis response planning, and problem-focused interventions that designed to identify and treat the “drivers” of suicidal risk. There is correlational support for the use of CAMS in a non-randomized trial of CAMS in the US Air Force (Jobes et al., 2005). Recently, CAMS has been shown to effectively treat suicidal ideation, overall symptom distress, hopelessness, and reasons for living at 12 month follow-up in comparison to enhanced usual care in a small randomized clinical trial (Comtois et al., in press). CAMS is now being studied in a well-powered randomized clinical trial at Ft. Stewart GA with n=150 suicidal Soldiers in a Department of Behavioral Medicine outpatient mental health clinic. VA Central Office is licensing CAMS for use throughout the VA system through CPRS; the license between VA and Guilford Press is pending within VA Central Office contracting.

#### *Summary and Conclusion*

This report provides a general overview of the extant literature about empirically supported treatments and interventions for suicidal risk. It is neither meant to be exhaustive nor definitive; this report should nevertheless walk VISN 7 Suicide Risk Reduction Committees through various considerations relevant to current empirically based best practices for potential use in treating suicidal risk in each VISN 7 facility.

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**Appendix D****NATIONAL SUICIDE PREVENTION LIFELINE  
HELPING CALLERS AT IMMINENT RISK OF SUICIDE:  
VALUES, POLICIES AND GUIDELINES****Values Underlying NSPL Policies and Guidelines for Helping Callers at Imminent Risk of Suicide**

The National Suicide Prevention Lifeline (NSPL) seeks to instill hope, sustain living, and promote the health, safety and well-being of callers and community members it serves. Whereas the primary mission of the National Suicide Prevention Lifeline is to prevent the suicide of callers to its service, all crisis center staff must undertake necessary actions intended to secure the safety of callers determined to be attempting suicide or at Imminent Risk of suicide.

The National Suicide Prevention Lifeline promotes the most collaborative, least invasive course(s) of action to secure the health, safety and well-being of the individuals it serves. Obtaining the at-risk individual's cooperation is the most certain approach to ensure his/her continuing care and safety.

The National Suicide Prevention Lifeline recognizes that ensuring the health, safety and well-being of individuals it serves is a shared responsibility between NSPL's network of member crisis centers and their local crisis and emergency response systems. In order to enhance the continuous, safe and effective care of individuals it serves who are attempting suicide or at Imminent Risk of suicide, NSPL promotes collaboration between its member Centers and the essential local crisis and/or emergency services in their communities.

*The Values noted here serve as founding principles of the NSPL network that underlie NSPL's Policies and Guidelines for Helping Callers at Imminent Risk of Suicide. NSPL network Centers are not required to state that they share these Values to retain their membership to the network. However, Centers are required to adhere to NSPL Policies and Guidelines to retain their network membership.*

*The NSPL Policies and Guidelines set forth in this document are based on available evidence and clinical consensus to help center staff in securing the safety of the callers, and are therefore required of all network member Centers. However, these Policies and Guidelines are not intended to be construed or to serve as "standards of care." Standards of care are determined on the basis of individual fact patterns and all information reasonably available for an individual Caller and are subject to change as scientific knowledge and technology advance and caller assistance patterns evolve.*

## Helping Callers at Imminent Risk of Suicide: Policy and Guidelines for Telephonic Practices

Center Policies and/or Protocols shall direct Center staff to actively engage Callers and initiate any and all measures necessary—including active rescue—to secure the safety of Callers determined to be attempting suicide or at Imminent Risk of suicide. *[For a definition of the term “Imminent Risk,” see **Attachment A.**]*

Specifically, Center Policies and/or Protocols shall adhere with the following **Guidelines for Helping Callers at Imminent Risk of Suicide:**

**1. Active Engagement:** Center Policies and/or Protocols shall direct Center Staff to actively engage Callers determined to be attempting suicide or at Imminent Risk of suicide and make efforts to establish sufficient rapport so as to promote the Caller’s collaboration in securing his/her own safety, wherever possible. *[For further definition of “active engagement,” see **Attachment A** of this document.]*

**2. Least Invasive Intervention:** Center Policies and/or Protocols shall direct Center Staff to consider involuntary emergency interventions as a last resort, to seek collaboration with individuals at Imminent Risk, to include the person’s wishes, plans, needs, and capacities towards acting on his/her own behalf to reduce his/her risk of suicide, wherever possible. *[For examples of recommended intervention measures, see **Attachment B.**]*

**3. Initiation of Life-Saving Services for Attempts in Progress:** To the degree it is evident to Center Staff that a suicide attempt is in progress during an NSPL call, whether the information is gathered directly from the person at risk or someone calling on his/her behalf, Center Policies and/or Protocols shall direct Staff to undertake procedures to ensure that the Caller receives emergency medical care as soon as possible. While Center Staff should make reasonable efforts to obtain the endangered individual’s consent to receive such services wherever possible, Center Policies and/or Protocols shall not require that the individual’s willingness or ability to provide consent be necessary for Center Staff to initiate medically necessary rescue services.

**4. Active Rescue:** If, in spite of the Center Staff’s best efforts to engage the at-risk individual’s cooperation, he or she: a) remains unwilling and/or unable to take such actions likely to prevent his/her suicide, and b) remains at Imminent Risk, Center Policies and/or Protocols shall require Center Staff to initiate rescue measures that they believe are reasonable to secure the immediate safety of the Caller, up to and including calling emergency response services (via 911 or other local emergency call number). *[For further definitions of “Imminent Risk” and “Active Rescue,” see **Attachment A.** For recommendations regarding supervisory consultation and/or review related to active rescue, see **Attachment B.** For suggested language regarding the issue of confidentiality, see **Attachment H.**]*

**5. Third Party Callers:** For persons calling on behalf of someone (“Third Party Callers”) they believe to be in the process of an attempt or at Imminent Risk of suicide, and to the degree that Center Staff have a reasonable belief that this Third Party Caller is reliably informed as to the risk status of the person he/she is calling about, Center Policies and/or Protocols shall direct Center Staff to actively engage the Third Party Caller towards determining the least invasive, most collaborative actions to best ensure the safety of the person believed to be in the process of an attempt or at Imminent Risk (up to and including active rescue, as a last resort). *[For examples of such actions, see **Attachment C**. Center Policies and/or Protocols shall also address the issue of anonymity of Third Party Callers in order to promote greater informant reliability and collaboration with Callers. For recommendations regarding how Centers may address the issue of Third Party Caller anonymity, see **Attachment D**.]*

**6. Supervisory Consultation:** Center Policies and/or Protocols shall direct Supervisory Staff to be available to Center Staff during all hours of the Center's operations for timely consultation from Center Staff needing assistance in determining the most appropriate intervention(s), including active rescue, for any individual who could be at Imminent Risk of suicide. *[For a definition of “supervisory staff,” see **Attachment A**. For recommendations regarding supervisory consultation and/or review related to active rescue, see **Attachment G**.]*

**7. Caller I.D.:** In order to enable a Center’s Active Rescue efforts as defined herein, each Center must maintain Caller I.D. or some other method of identifying the Caller’s location that is readily accessible to Center Staff in real time (i.e., during the call; can include NSPL Real Time Call Trace system). *[For suggested language regarding the issue of confidentiality, see **Attachment H**.]*

**8. Confirmation of Emergency Services Contact:** In cases where Centers activate emergency rescue services to secure the safety of individuals determined to be attempting suicide or at Imminent Risk of suicide, and where local first responder entities are willing and able to provide such confirmation, Center Policies and/or Protocols will direct Center Staff to confirm that such emergency services have successfully made contact with the at-risk individual. **In such cases where a center reports that local first responder agency authorities are unwilling or unable to offer confirming information to the Center, the Center must provide documentation to NSPL demonstrating their efforts to collaborate with local first responder agencies.** *[For examples of recommended procedures to confirm emergency contact, and/or documentation of attempts to seek collaboration, see **Attachment E**.]*

**9. Procedures for Follow-Up when Emergency Services Contact is Unsuccessful:** To the degree that Center Staff has confirmed that emergency response services initiated by the Center were unsuccessful in making contact with the individual at Imminent Risk, the Center Policies and/or Protocols shall direct Center Staff to take additional steps to address the safety needs of the at-risk individual. *[For examples of recommended procedures to determine caller safety when emergency services contact did not occur, see **Attachment E**.]*

**Helping Callers at Imminent Risk of Suicide: Policy for Establishing and Maintaining Collaborative Relationships with Local Crisis and Emergency Services.**

In order to enhance the safe, effective and seamless care of at-risk individuals receiving emergency services dispatched by Center Staff, Centers shall establish collaborative relationships (formal and/or informal) with one or more crisis or emergency service providers in their community.

*[For examples of crisis or emergency service providers and a list of examples illustrating “formal” and “informal” collaborative relationships between Centers and emergency/crisis providers, see **Attachment F**.]*

**ATTACHMENTS A through H:**  
**DEFINITIONS, GUIDANCES AND RECOMMENDATIONS**  
*for the*  
**NATIONAL SUICIDE PREVENTION LIFELINE**  
**POLICIES AND GUIDELINES for**  
**HELPING CALLERS AT IMMINENT RISK OF SUICIDE**

*The following items in Attachments A-H are intended to provide clarification of terms and examples of recommended methods that Centers might employ towards ensuring their adherence to NSPL Policy and Guidelines for Helping Callers at Imminent Risk of Suicide.*

## ATTACHMENT A

## DEFINITION OF KEY TERMS IN IMMINENT RISK POLICIES AND GUIDELINES

**Imminent Risk:** A Caller is determined to be at “imminent risk” of suicide if the Center Staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person’s current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on Center Staff to take urgent actions to reduce the Caller’s risk; that is, if no actions were taken, the Center Staff believe that the Caller would be likely to seriously harm or kill him/her self. Imminent Risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent (See National Suicide Prevention Lifeline Suicide Risk Assessment Standards Packet for further clarification).

**Active Engagement:** Intentional behaviors undertaken by Center Staff to effectively build an alliance with the Callers at Imminent Risk towards mutual understanding and agreement on actions necessary to successfully reduce Imminent Risk or accept medical interventions when the person is in the process of a suicide attempt. “Active” refers to intentional behaviors of the Center staff to positively affect the Caller’s mood, thoughts and/or behavior towards reducing Imminent Risk, as opposed to “passive” behaviors designed to let Callers at Imminent Risk lead themselves to their own conclusions about what to do or not do. “Engagement” refers to effectively building an alliance with the Caller at Imminent Risk, often evidenced by: the degree to which a Caller expresses feeling understood by the responder; and/or a mutual agreement towards actions necessary to reduce the individual’s Imminent Risk, such as the Caller accepting help if he/she is in the process of a suicide attempt. According to this definition, active engagement is staff behavior that seeks to collaborate with and empower the Caller towards securing his/her own safety, or the safety of the person he/she is calling about. Active engagement is typically necessary for both a comprehensive, accurate assessment of a Caller’s suicide risk as well as for collaborating on a plan to maintain the Caller’s safety.

**Active Rescue:** Actions undertaken by Center staff that are intended to ensure the safety of individuals at Imminent Risk or in the process of a suicide attempt. “Active” refers to the Center staff’s initiative to act on behalf of individuals who are in the process of an attempt or who are determined to be at Imminent Risk, but who, in spite of the helper’s attempts to actively engage them, are unwilling or unable to initiate actions to secure his/her own safety. “Rescue” refers to the need to provide potentially life-saving services. Center staff should only undertake such initiative without the at-risk individual’s expressed desire to cooperate if he/she believes that—without this intervention—the individual is likely to sustain a life-threatening injury.

**Supervisory Staff:** Center Staff that regularly act in a managerial or training capacity, who have knowledge of the Center’s most current policies and procedures related to helping Callers at Imminent Risk of suicide. Such personnel might include Center Directors, Training Coordinators/Supervisors, Shift Supervisors, or some other title consistent with the spirit of this definition. Peers (colleagues with no other official designation or routine role as staff supervisor or trainer) acting as consultants are not alone sufficient to meet this requirement.

**ATTACHMENT B****EXAMPLES OF RECOMMENDED INTERVENTION MEASURES FOR CALLERS AT IMMINENT RISK**

Examples of recommended approaches for staff in helping callers at imminent risk include, but are not limited to:

- Obtaining agreement from the Caller to take actions on his/her own behalf that immediately reduces Imminent Risk (i.e., intent to die in the immediate sense is diminished and replaced by actions and plans intended to enhance the individual's personal care and safety);
- Obtaining agreement from a significant other as well as from the Caller that said significant other will intervene towards better assuring the safety of the Caller;
- Obtaining agreement from the Caller to a three-way call with a professional currently treating the Caller, thus returning responsibility to the primary professional overseeing the Caller's ongoing care. Such interventions are most effective in ensuring ongoing safety when Center Staff completely explain to the treatment professional why the Caller has been assessed to be at Imminent Risk;
- Obtaining agreement from the Caller to receive an evaluation in the home by a mobile crisis/outreach team trained and licensed to conduct such behavioral health examinations;
- Securing transportation of the person at risk to a hospital emergency room to undergo lifesaving medical procedures, treatments and/or psychiatric evaluation; and
- Contacting public safety officials (e.g., police, sheriff) to facilitate a home visit to assess the safety of the Caller, when no other less invasive method is available to determine the Caller's safety.

See **Attachment G** for recommendations regarding supervisory review of instances of active rescue.

*Note: The above list of examples is not all-inclusive and should not be viewed as examples of "acceptable course of actions" outside the actual context of any specific call. These examples should be understood as common measures often undertaken on hotline calls that are in the general spirit of concordance with National Suicide Prevention Lifeline Guidelines, with the understanding that appropriate interventions can only be determined by the specific safety needs of an individual call or Caller.*

## ATTACHMENT C

### RECOMMENDED PROCEDURES FOR THIRD PARTY CALLERS REPORTING IMMINENT RISK

In circumstances where a Caller is a Third Party reporting that another individual is at Imminent Risk of suicide, it is recommended that Center Staff actively engage the Caller to:

- Gather all relevant information from the Caller related to the other's reported risk status, to the degree the Caller can provide such information (see NSPL Suicide Risk Assessment Standards for ascertaining risk);
- Obtain contact information from the Third Party Caller, as well as information about his/her relationship to the person at risk, towards better ensuring informant reliability and the Caller's collaboration in planning interventions to reduce risk; and
- Obtain contact information for the person at risk from the Third Party Caller, to the degree known.

When working with a Third Party Caller and planning interventions/actions, Center Staff should seek the least invasive, most collaborative approach towards ensuring the safety of the individual at risk. Examples of recommended measures that may be undertaken by Center staff when working with Third Party Callers include, but are not limited to:

- Facilitating a three-way call with the Third Party and the person reported to be at risk so that Center Staff may assess and intervene with the individual directly, with the support of the Third Party's concerns and information;
- Facilitating a three-way conversation with the Caller and the treatment professional to discuss the current situation and potential safety plans, only if the person at risk is in treatment, unwilling or unable to inform his/her caregiver of his risk, and the Third Party Caller has access to the caregiver's contact information and agrees to a three-way call;
- Confirming that the Third Party is willing and able to take reasonable actions to reduce risk to the person, such as:
  - Removing access to lethal means
  - Maintaining close watch on the person at risk during a manageable time interval between the call and the scheduled time when the person is seen by a treatment professional
  - Escorting the person at risk to a treatment professional or to a local urgent care facility (e.g., hospital emergency room)
- Obtaining agreement from the Third Party to collaborate with a mobile crisis/outreach service facilitated by Center staff to evaluate the person at risk within a time frame that—in the best judgment of Center Staff—is reasonable in that it accounts for current level of risk;
- Using information obtained from the Third Party to contact another Third Party or the individual at risk directly, in cases where the Third Party is either unwilling or unable to help directly with the intervention.



**ATTACHMENT D****RECOMMENDATIONS FOR WORKING WITH  
THIRD PARTY CALLERS WISHING TO REMAIN ANONYMOUS**

There are occasions when Third Party Callers wish to remain anonymous. This situation may pose concerns to a Center in that it may undermine assurances of both the callers' reliability as an informant and their willingness to collaborate on behalf of the person at risk. Therefore, Centers should develop Policies and/or Protocols regarding Third Party Caller anonymity that promote greater informant reliability and collaboration with persons reporting others at Imminent Risk.

The National Suicide Prevention Lifeline recommends that Center Policies and/or Protocols only consider making exceptions for preserving Third Party anonymity in those unusual situations where:

- Center Staff have reason to believe that revealing the identity of the Third Party to the person at risk might aggravate risks to either the Third Party or the person he/she is concerned about (e.g., a victim of domestic violence reports her husband is planning to kill her, his children, then himself); or
- The Third Party declines to give his/her name and his/her identity is reasonably believed to be less relevant than their report of a clear and present risk to the safety of the person he/she is calling about (e.g., a stranger near a bridge reports a person climbing over the rail and standing on the ledge).

## ATTACHMENT E

### EXAMPLES OF RECOMMENDED PROCEDURES TO CONFIRM EMERGENCY SERVICE CONTACT WITH CALLERS.

Steps that can be taken to confirm that emergency service contact was made include, but are not limited to:

- Staying on the line with the Caller until the emergency service provider has arrived and their presence is apparent to the Center staff;
- Contacting local Public Service Answering Point (PSAPs, or “911 Call Centers”) to determine pick-up/transport status of the individual at risk (such as using reference or tracking numbers, etc.);
- Contacting the emergency room or mobile crisis/outreach staff to determine status of their contact with the individual at risk (including giving mobile crisis/outreach staff all information collected by Center Staff regarding individual at risk’s status);
- Contacting the professional responsible for the care and treatment of the individual at risk;
- Contacting the individual at risk directly to obtain affirmation that he/she has made contact with the emergency service provider, and/or conducting an assessment of the individual to verify that he/she is no longer at Imminent Risk of suicide;
- Contacting the significant other who took responsibility for the individual at risk’s safety.

### EXAMPLES OF RECOMMENDED PROCEDURES FOR DETERMINING CALLER SAFETY WHEN EMERGENCY SERVICE CONTACT DID NOT OCCUR

Examples of recommended procedures to determine caller safety when emergency service contact did not occur include, but are not limited to:

- Contacting the individual at risk to assess the his/her current risk status and continuing need for service linkages;
- Contacting significant others (friends, family) believed to have potential access to the individual at risk who are willing and able to conduct a safety check;
- Contacting the individual at risk’s treatment professional or case worker to conduct further evaluation and safety check;
- Providing the individual at risk’s contact and address information—to the extent known—to the appropriate mobile crisis/outreach team for follow-up, if one is available in the individual’s area;
- Informing local law enforcement authorities or other appropriate first responders of the situation and requesting continued safety checks until the safety status of the individual at risk can be confirmed (e.g., arrangements or procedures are in place that allow Center staff to be notified of the individual’s safety status).

**EXAMPLES OF DOCUMENTATION SHOWING EFFORTS IN  
GAINING OFFICIAL AGREEMENT FROM FIRST RESPONDERS TO OBTAIN  
CONFIRMATION OF EMERGENCY SERVICE CONTACT**

All NSPL Centers must make efforts to obtain confirmation of emergency service contact for Callers. This may involve making official arrangements with local Public Service Answering Point administrators (PSAPs, or “911 Call Centers”), local ambulance/emergency service providers, and/or law enforcement agencies. It is possible that in spite of reasonable, assertive efforts by the Center, first responder authorities may not respond to Center overtures towards collaboration, or may directly refuse to provide such information to the requesting Center. Nevertheless, the Center, in order to follow this NSPL Guideline, must provide documentation to the NSPL demonstrating their reasonable, assertive efforts towards collaborations with local first responder agencies. Below are examples of acceptable documentation:

- Letters, e-mail or other written correspondence from a local first responder authority (or authorities) declining to collaborate towards providing contact-confirming information. The correspondence must include the name of the declining individual, his/her position with the agency, and the agency’s name.
- In the absence of the above, a minimum of two separate incidences of written correspondence from the Center to a first responder agency in the form of letters or e-mails that indicate:
  - date(s) of correspondence;
  - name and title of official to be contacted;
  - name of agency being contacted;
  - name and title of Center staff initiating correspondence; and
  - name of the Center initiating correspondence.

It should be noted by the Center that evidence of unsuccessful attempts in collaborating with first responder agencies does not suggest that no further efforts should be made to enable this collaboration in the future. When Centers provide the NSPL with this documentation, the NSPL will, in turn, provide technical assistance to the Center towards establishing a successful collaboration with a local first responder agency. When the NSPL provides such technical assistance, it is expected that the Center will continue to pursue such collaborations in the spirit of these guidelines. 12

## ATTACHMENT F

### EXAMPLES OF EMERGENCY SERVICE PROVIDERS FOR CRISIS CENTER COLLABORATION

Examples of emergency service providers for collaboration include, but are not limited to:

- Police departments,
- Fire departments,
- County sheriff offices,
- Mobile crisis/psychiatric outreach teams,
- Hospital emergency departments,
- 911, and
- Emergency Medical Services (e.g. ambulance/transport services)

### EXAMPLES OF FORMAL AND INFORMAL RELATIONSHIPS BETWEEN CENTERS AND LOCAL EMERGENCY SERVICE PROVIDERS

Centers are required to establish and maintain formal and/or informal relationships with local crisis and/or emergency service providers.

Examples of formal relationships with crisis or emergency providers include, but are not limited to:

- Cooperative agreements,
- Memoranda of Understanding (MOU),
- Relationships officially authorized by a local government entity (e.g., city health department, or a county mental health department), and
- Intra-agency policies for collaboration between a Center and an emergency service provider housed within the same parent agency

Examples of informal relationships include, but are not limited to:

- Regular communications with local emergency or crisis service providers to coordinate rescue and care efforts;
- Exchange of outreach and education materials that promotes awareness and use of call center services; and
- Training of local emergency service provider staff regarding Center's services.

**ATTACHMENT G****RECOMMENDATIONS REGARDING SUPERVISORY REVIEW  
RELATED TO ACTIVE RESCUES**

The National Suicide Prevention Lifeline recommends that supervisory consultation and/or review occur before, during and/or after instances where active rescue has been initiated for Callers by Center Staff. In reviewing active rescue events, supervisors should evaluate both the process (how was the decision made) and documentation related to the call. Documentation should minimally include risk assessment information (noting the presence of imminent risk) and indicate that less invasive courses of action were either inappropriate for the situation or declined by the caller.

In order to better ensure optimal care of future Callers at Imminent Risk, it is further recommended that Supervisory Staff review instances of active rescues and use lessons learned to:

1. Inform subsequent Center Staff training and supervisory practices; as well as
2. Inform cooperative communications with relevant crisis or emergency response service providers.

**ATTACHMENT H****NSPL WEBSITE CONFIDENTIALITY STATEMENT**

The following is the language regarding confidentiality that has been posted on the NSPL website. It is recommended that NSPL centers use similar language on their own web sites. Centers should feel free to borrow in its entirety if needed.

- The Lifeline is committed to maintaining the confidentiality of callers to the network.
- The confidentiality of any information disclosed during a call to one of the Lifeline centers will be upheld at all times. The only potential exceptions to preserving confidentiality are during circumstances in which an individual provides consent to share information relevant to maintaining their own health and safety and/or the individual is perceived to be at imminent risk of injury or death.
  - In cases in which an individual is assessed to be at imminent risk of injury or death, Lifeline center protocols will direct staff to actively collaborate with all callers to obtain consent to disclose information, as appropriate. Such actions are consistent with the Lifeline value of using the least invasive means to ensure the health, safety, and well being of individuals at risk of suicide.
  - In the uncommon circumstance in which a caller is unable or unwilling to provide consent, Lifeline centers may allow the sharing of confidential information to essential individuals/agencies for the purpose of securing an individual's safety. Such actions are consistent with the Lifeline value of taking all action necessary to ensure the health, safety, and well being of individuals at risk of suicide.
- The National Suicide Prevention Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. The Lifeline network is made up of over 140 independently operated crisis centers nationwide that are connected to the toll free number 1-800-273-TALK which is administered and maintained by the Lifeline. In connection with participation in the Lifeline network, all centers are required to comply with all federal, state and local statutes, rules, regulations and ordinances applicable to the center. This includes all relevant laws and regulations related to privacy of personal protected health information.
- The Lifeline reserves the right to change its privacy practices. If privacy practices change, a revised statement will be posted on the Lifeline website.

If you have any questions about the Lifeline Confidentiality Statement, please feel free to contact us at: <http://www.suicidepreventionlifeline.org/About/Contact.aspx>

**Value Statement**

*The National Suicide Prevention Lifeline (NSPL) seeks to instill hope, sustain living, and promote the health, safety and well-being of callers and community members it serves. Whereas the primary mission of the National Suicide Prevention Lifeline is to prevent the suicide of callers to its service, all crisis center staff must undertake necessary actions intended to secure the safety of callers determined to be attempting suicide or at Imminent Risk of suicide.*

*The National Suicide Prevention Lifeline promotes the most collaborative, least invasive course(s) of action to secure the health, safety and well-being of the individuals it serves. Obtaining the at-risk individual's cooperation is the most certain approach to ensure his/her continuing care and safety.*

*The National Suicide Prevention Lifeline recognizes that ensuring the health, safety and well-being of individuals it serves is a shared responsibility between the NSPL's network of member crisis centers and their local crisis and emergency response systems. In order to enhance the continuous, safe and effective care of individuals it serves who are attempting suicide or at Imminent Risk of suicide, the NSPL promotes collaboration between its member Centers and the essential local crisis and/or emergency services in their communities.*

**SUGGESTED LANGUAGE REGARDING CONFIDENTIALITY  
FOR CALLERS TO THE LIFELINE**

The following is a suggested response when a caller asks the question: Is this call confidential?

*Keeping your information confidential is very important to us. The only thing that will be more important to us than your privacy is your safety. If you or someone you care about is in danger, we will do whatever we can to assure your safety or theirs. For example, this may include sharing the information we have with medical and emergency services personnel.*