



Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention



The nation's only federally supported
resource center devoted to advancing the
National Strategy for Suicide Prevention.

SPRC ED Project: RAND ExpertLens Results

Consensus Panel Review and Discussion Welcome!

Tuesday December 10, 2013

For audio please call **1-866-343-8793**

Be sure to mute the volume on your computer to avoid feedback.

The meeting will begin at 2:00pm Eastern

Technical Orientation Slide

- ✓ Technical problems joining the webinar? Please call 617-618-2984 or Adobe Connect 1-800-422-3623.
- ✓ Questions or comments? Type into the chat box on the left hand side of your screen and we will attempt to assist you.
- ✓ You can also make the presentation screen larger at any time by clicking on the “Full Screen” button in the upper right hand corner of the slide presentation. If you click on “Full Screen” again it will return to normal view.
- ✓ This webinar will be recorded.

SPRC ED Project: Consensus Panel Webinar #2

Tuesday December 10, 2013

Welcome



Speakers



Cara Anna
*Journalist, Editor AAS
Attempt Survivor Blog, and
Founder,
TalkingAboutSuicide.com*

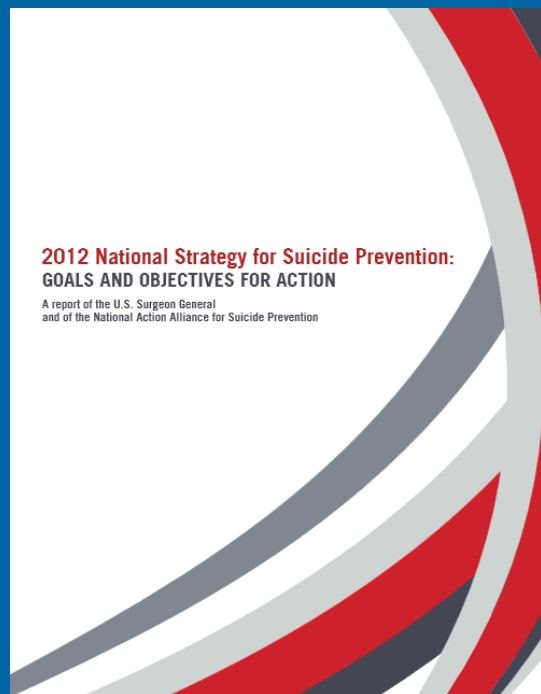


Susan Stefan, JD
*Consultant and
Author*



Barbara Stanley, PhD
*Director, Suicide Intervention
Center, Columbia University
School of Medicine*

2012 NSSP



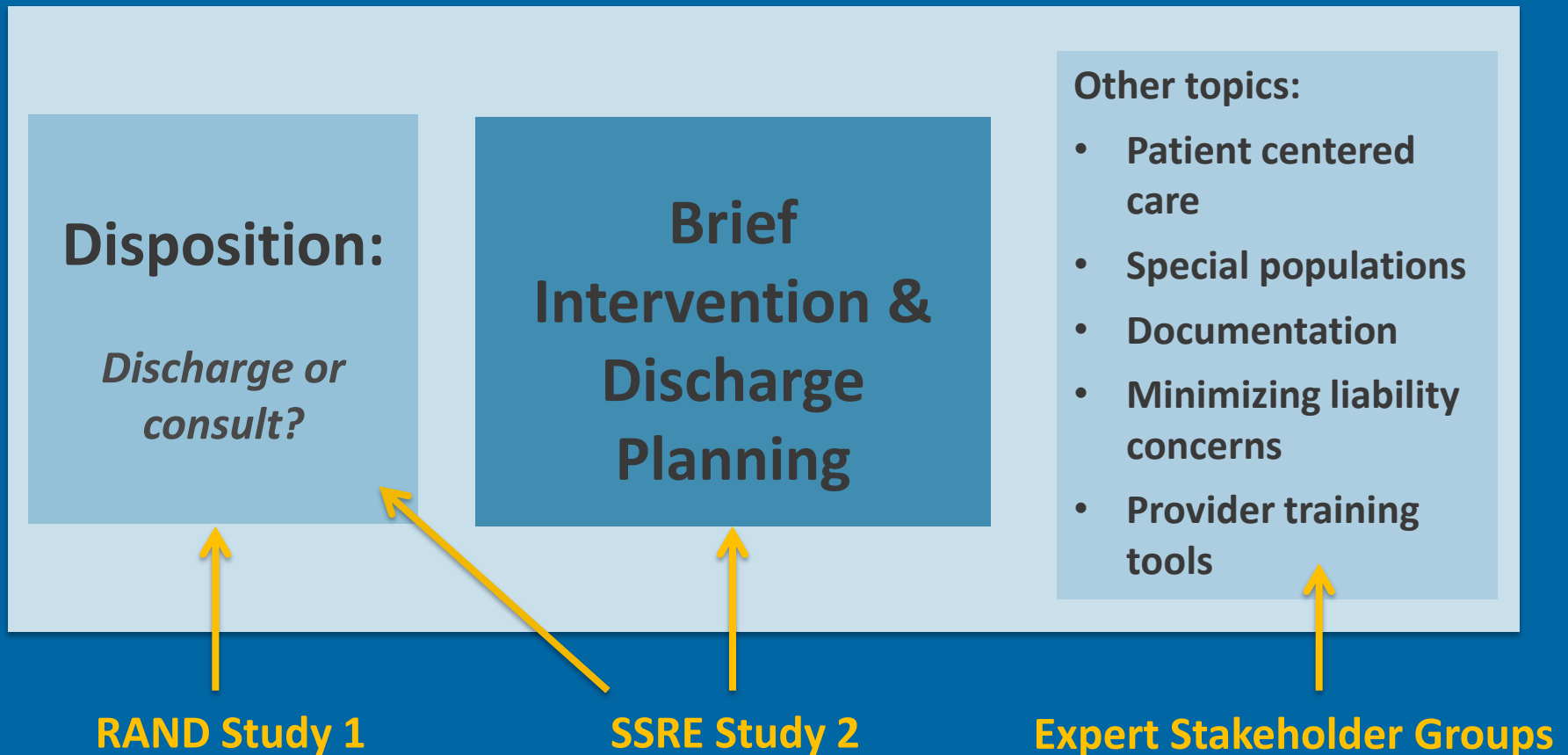
Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

EDs are key settings for providing services to persons with high suicide risk, particularly those who have attempted suicide. In 2009, 374,486 people were treated in EDs for self-inflicted injuries.¹

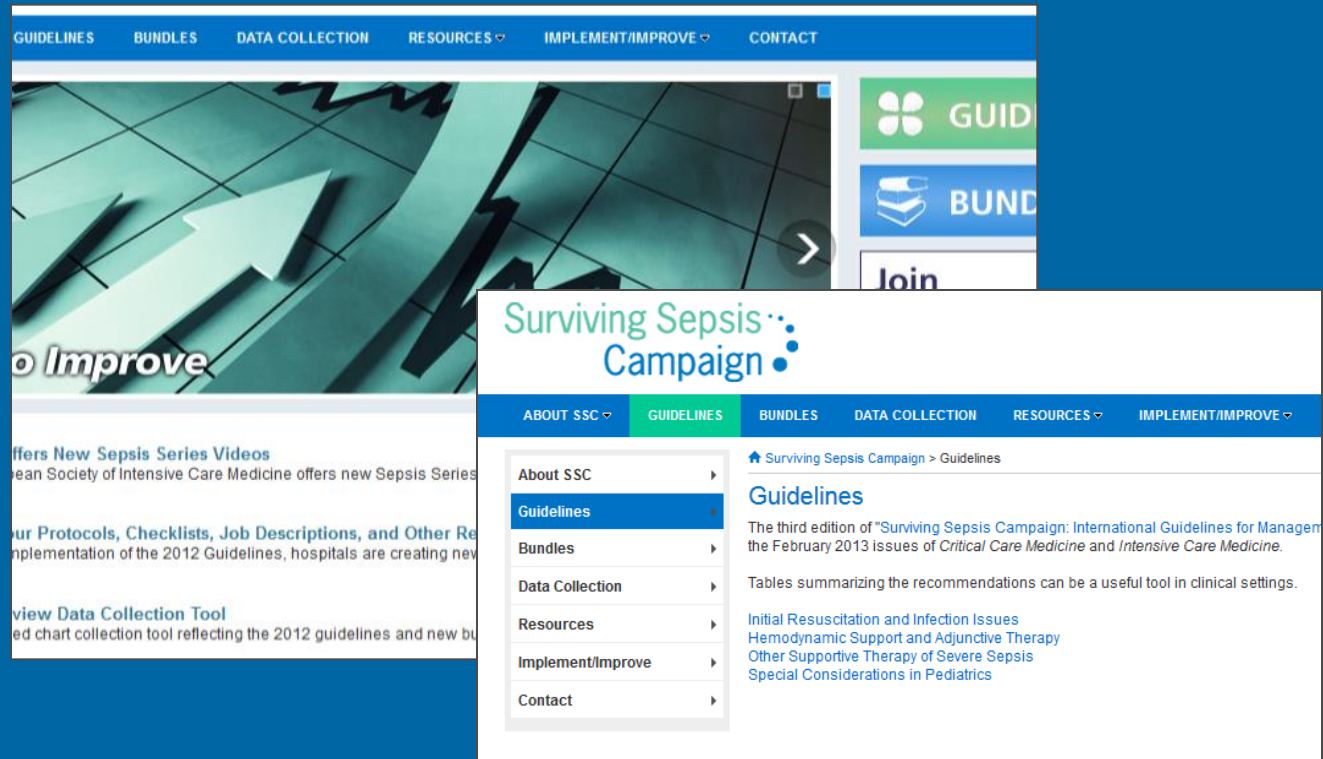
Standardized protocols should be developed for use within EDs that allow for differentiated responses based on risk profiles and assessed clinical needs (e.g., intoxicated and suicidal, chronically suicidal,

http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

End product: key elements



Final product example



<http://www.survivingsepsis.org/Pages/default.aspx>

Decision support tool example:

PERC Rule for Pulmonary Embolism

Rules out PE if all criteria are present and pre-test probability is $\leq 15\%$.

Age > 50	<input type="checkbox"/> NO	<p>No need for further workup, as $< 2\%$ chance of PE.</p> <p>If no criteria are positive and clinician's pre-test probability is $< 15\%$, PERC Rule criteria are satisfied.</p>
HR ≥ 100	<input type="checkbox"/> NO	
O2 Sat on Room Air < 95%	<input type="checkbox"/> NO	
Prior History of DVT/PE	<input type="checkbox"/> NO	
Recent Trauma or Surgery	<input type="checkbox"/> NO	
Hemoptysis	<input type="checkbox"/> NO	
Exogenous Estrogen	<input type="checkbox"/> NO	
Unilateral Leg Swelling	<input type="checkbox"/> NO	

<http://beta.mdcalc.com/perc-rule-for-pulmonary-embolism/>

Consensus Panel Composition

PROVIDER SECTORS	OTHER SECTORS
<ul style="list-style-type: none">• Emergency medicine• Emergency nursing• Emergency psychiatry• Social work• Psychology• Crisis center services• Tele-psychiatry	<ul style="list-style-type: none">• Consumer/patient/family• Research• Legal• Suicide prevention• Special population experts (e.g., substance abuse, pediatric, military)• Federal agencies (SAMHSA, CMS, NIMH)• Intervention/tool developers

Timeline

Month	Actions
JAN – FEB	Study 2: Survey Monkey & online discussion Expert Stakeholder Groups
MAR	Product development (draft)
APR – MAY	External review & pilot test
JUN	Finalize draft
JUL – AUG	Web development
SEPT	Disseminate

Recorded past events

Consensus Panel Orientation Webinar #1 – June 20, 2013

SPRC: *Project Introduction and Study 1 Orientation*

Edwin Boudreaux, PhD: *ED-SAFE Study*

Sandra Schneider, MD, FACEP: *ED Perspective*

Link: <http://edc.adobeconnect.com/p9gc9rpja79/>

RAND ExpertLens Study Results Webinars – November 12 & 13, 2013

SPRC & SSRE: *Results of the RAND ExpertLens Study*

Consensus Panel Small Groups: *Questions & Discussion*

Link November 12 Session: <http://edc.adobeconnect.com/p43v6b9mskv/>

Link November 13 Session: <http://edc.adobeconnect.com/p5o85x3tcep/>

The patients: Some voices

Cara Anna, TalkingAboutSuicide.com
and AttemptSurvivors.com













Emerging voices

- LiveThroughThis.org
- TalkingAboutSuicide.com
- AttemptSurvivors.com
- Next: A national campaign?

Voices from the ED

- “It’s probably the only disease _ and it is a disease _ where the more someone is suffering from it, the less likely they are to seek help.”

Voices from the ED

- “When someone tells me ‘I want to kill myself,’ my first impulse is, ‘Oh, crap.’ I think it’s human nature to automatically panic. But take a deep breath.”

Voices from the ED

- “The professionals who treated me after my attempt were very, very, very helpful.”
- “When I came to, I crawled to an area where I was found. That led to the hospital, where I started to get real help.”

Voices from the ED

- “When you talk about mental illness, a shadow goes up.”
- “It is an illness, that it’s not something you can snap out of.”
- “I don’t know about you, but I don’t see being suicidal a choice.”

Voices from the ED

- “I remember being in the hospital, the staff treating me like a mental case: ‘How stupid could you be, so selfish.’ People were adding insult to injury.”
- “Society is very quick to place judgment. It can make seeking help an embarrassing experience.”

Voices from the ED

- “When you live in a society where you can’t mention the word ‘suicide,’ or live in fear of saying the word ‘suicide’ and there being some negative consequences _ as long as you live in that kind of world, you’re not going to be able to prevent it.”

Voices from the ED

- “There was a psych eval. I lied and told them I wasn’t suicidal. I manipulated the system.”
- “When people started seeing warning signs, I would lie: ‘Everything’s fine. Nothing’s going on.’ People wanted to believe that.”

Voices from the ED

- “You may be hospitalized against your will. You may be medicated against your will.”
- “People who otherwise have progressive views about human rights issues still can think we should be locked up for our own good.”
- “What would have helped is if the psychiatrist had taken my word and let me go, rather than putting me under armed guard.”

Voices from the ED

- “I actually ended telling someone I was suicidal just so they could take me to the hospital. I lied because I wanted them to figure out what was wrong with my meds. But they wouldn’t listen to me, run any tests. This is how it is. If you have the psych history I have, the likelihood of anyone taking anything medical seriously with you is nil.”

Voices from the ED

- “Access to care is huge. Unfortunately, most people who experience suicidal thoughts get turned away if they don’t have coverage. Unless you go in actively threatening, you are told, ‘Nope, we can’t take you.’ I tell people all the time to straight-up lie, tell the ER you have a plan.”

Voices from the ED

- “It’s just a litigious society that we have, there’s such risk aversion.”
- “We’re soooooo litigious here. We’ve hit the point in this country where people are so afraid of doing the wrong thing for someone who’s suicidal that they say, ‘You’re going to the hospital,’ and that’s it.”

Voices from the ED

- So ... what helps?

Voices from the ED

- “I’ve found, the more someone is willing to share truly who they are, I feel safe enough to share my struggles ... And it’s hard for me to do that with someone who’s quote-unquote professional, that is, like, cold and textbook.”
- “I find the hardest to deal with is health care professionals who are not involved with mental illness.”

Voices from the ED

- “I wish medical professionals had more of that component to it, the lived experience.”
- “I want a world where people feel OK saying, ‘I went through that, too.’”

Voices from the ED

- “Honestly, I would just say that 99 percent of doing suicide prevention or crisis intervention or promoting recovery is really just about listening to people and letting people tell their story and letting people have space for that. And we don’t do that enough. And it’s an unfortunate thing.”

Voices from the ED

- “They need to be heard, not fixed.”
- “I think we should stop and be present. I think people don’t know how to do that.”
- “What was so helpful was, she took it out of judging me or fixing me and just was very real with me.”

Voices from the ED

- Yes: “Once you ask somebody, ‘Are you having suicidal thoughts? Are you thinking about killing yourself?’ you’re kind of in the driver’s seat. To talk to them.”
- Not so much: “When I saw my doctor, the question was, ‘Are you suicidal?’ ‘I have been.’ She said, ‘You don’t have a plan, do you? Because if you do, I have to hospitalize you.’”

Voices from the ED

- “There are so many ways that unhappiness, that depression, get communicated. And take the time to observe, to ask, to feel.”
- “All you’re doing is having a conversation. And honest, heartfelt conversations don’t kill. Ignorance and stereotypes and silence, those things do kill.”

Thank you

- Be clear. Especially about consequences.
- Be honest. Especially about your limitations.
- Be human. Especially since people you know, including colleagues, have been through this, too. You just don't know it.

Legal Issues in ED Discharge of Psychiatric Patients

Susan Stefan, Esq.

Suicide Prevention Resource Center

Decemeber 10, 2013

Purpose

- Practice good clinical medicine around ED discharges of psychiatric patients not influenced by erroneous liability concerns
 - Examine and dispel current myths about liability for ED discharge decisions involving psychiatric patients
-

Traditional Views of Psychiatric Emergency Practice

- The primary focus of assessment is to prevent suicide and minimize liability
 - Doctor/Specialist knows best
 - Hospitalization is the gold standard
 - Psychiatric crisis inherently threatens patient's and family's capacity to make informed decisions
 - Risk focused care is the best clinical care and the least risky
-

An Alternative PES Paradigm

- Hospitalization can be regressive, traumatizing, and cost inefficient
- Hospitalization is more often treatment of last resort
- Good clinical care may involve taking risk and it is the thoroughness and communication of awareness of risk that protects patients and treaters alike
- Responsibility for care of self and avoidance of risk is shared by patient provided he or she is not grossly psychotic nor cognitively impaired

An Alternative PES Paradigm cont.

- Crisis evaluation focuses on engaging patient and family in treatment
 - Crisis evaluation is not solely triage but rather treatment
 - The best crisis work reveals and utilizes patient's strengths, inspires hope, and meets patient where he or she is
-

Liability Myths & False Frameworks

- Discharge decision rather than assessment process drives liability
 - Liability can be avoided by admitting psychiatric patients
 - Discharging psychiatric patients is the only risk/liability concern
 - Bad outcomes inevitably lead to liability
 - ED has absolute responsibility for psychiatric patient safety
-

Realities of Legal Liability

- It's not the outcome that drives liability, it's the quality of the assessment process
 - Liability is generally found only for gross errors or violations of federal, state or hospital regulations and policies
 - Underestimated Liability Risks
-

Cerbelli v. City of New York,

600 F.Supp.2d 405, 414 (E.D.N.Y. 2008)

- “If liability were imposed on the physician or the State each time the prediction of future course of mental disease was wrong, few releases would ever be made and the hope of recovery and rehabilitations of a vast number of patients would be impeded and frustrated. This is one of the medical and public risks which must be taken on balance, even though it may sometimes result in injury to the patient and others.”
-

Sheron v. Lutheran Medical Center,

18 P.3d 796, 799 (Colo.App. 2001)

- “Defendants argue that...plaintiff’s case was premised on alleged negligence in discharging Sheron...This argument mischaracterizes plaintiff’s claim. Rather than focusing on the discharge itself, plaintiffs more specifically argue defendants breached their duty to perform an adequate mental status exam and risk assessment.”
-

Examples of findings of liability

- Woman w/bipolar disorder recently d/c from psych hospital, went off meds, asks for admission for severe depression; when ED staff find she has no health insurance, they don't seek recent hosp. records; instead offer her cab fare to state hospital (13 million dollar verdict reduced by 50% for decedent's comparative fault) (Illinois)
-

More....

- ED psychiatrist signs blank discharge papers; man kills himself w/in 24 hours of d/c which no one present at the hospital had authority to grant; no liability for ED psychiatrist (330,000 liability for doctors who were present) (Mass.)
-

Underestimated Liability Risks

- Changing/reducing/eliminating patient's regular psychiatric medication
 - Use of force/restraints
 - Failure to diagnose medical problems
 - Lack of communication = Bad Outcomes
 - Involuntary detention or medication based on inadequate evaluation
 - Seeking consultation and then proceeding without regard to it
 - Ignoring **salient** facts presented by accompanying family/friends
-

Reduce the Risk of Being Sued

- Treat people with respect
 - Provide information and explanations
 - Apologize
 - Teach principles of good documentation
 - Ensure good communication
 - Sit down. Slow down.
 - Attend to the environment: is patient too hot? Too cold? Thirsty? Lights too bright?
-

Reduce Liability Risk When Sued

For Hospitals:

- Formulate policies to respond to predictable high-risk situations
- Perform routine chart audits to ensure proper documentation and care

For Staff:

- Complete documentation
 - “If it’s not written down, it didn’t happen.”
 - Consultation with colleagues
 - Ensure orders are documented and followed
-

Principles of Documentation

The single most important factor that attorneys consider in making litigation decisions is documentation in the chart

- Document observations, not just conclusions
 - Document the basis for decisions, including the potential risk factors associated with the decision
 - Obtain information from collateral sources whenever possible, and identify sources of information
 - Quote when possible rather than summarizing or paraphrasing
-

Principles of Documentation (cont.)

- Document as contemporaneously as possible. Be sure and get the times right.
 - Document protective factors as well as risk factors
 - Assess risk and protective factors over time, not just on the spot
 - Document what you said and did, especially issues of shared responsibility (Are there guns in the house? Who will be present during the day? Is there transportation to appointments?)
-

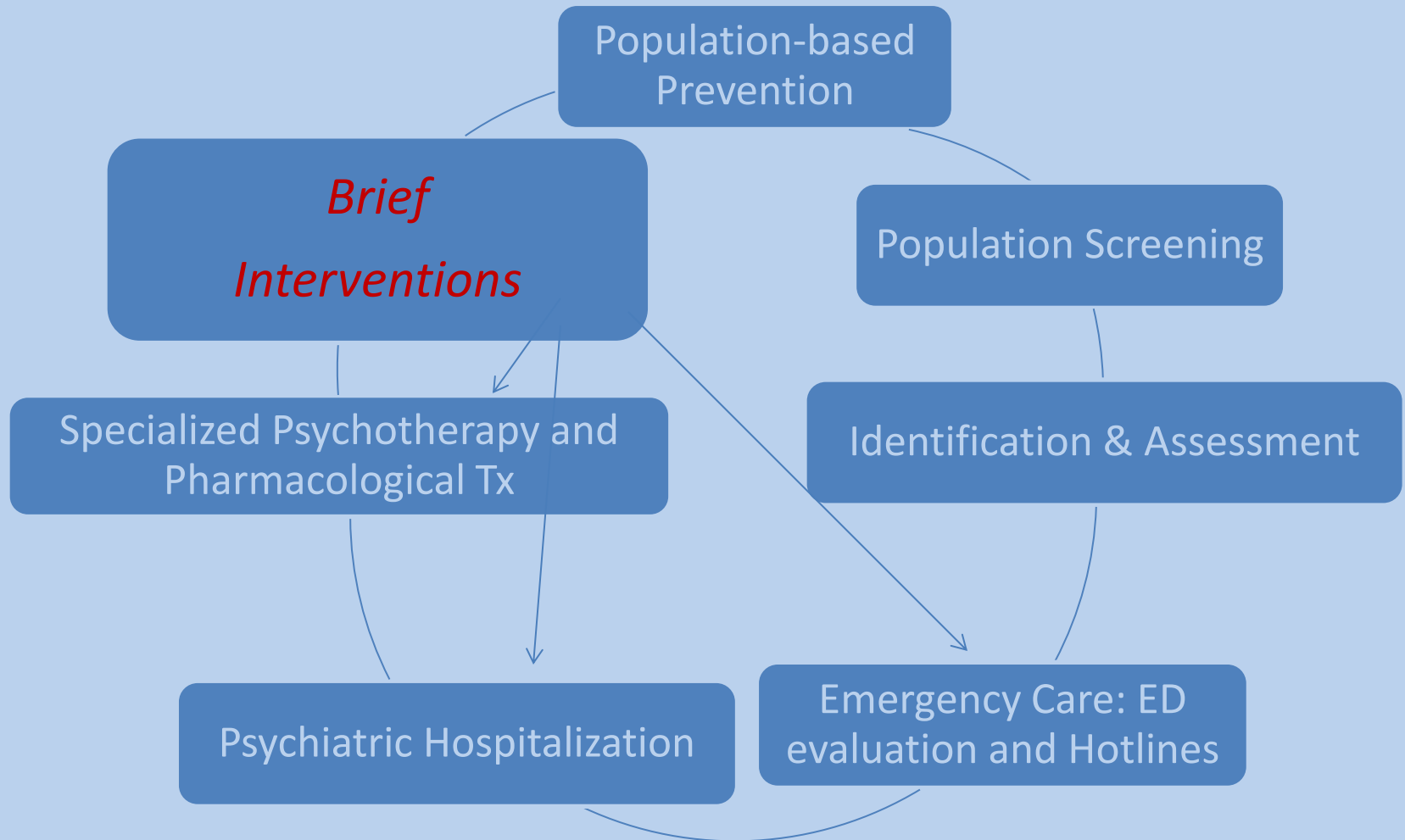
Safety Planning with Suicidal Individuals in Emergency Settings

Barbara Stanley, Ph.D.
New York State Psychiatric Institute
&
Columbia University
College of Physicians and Surgeons
Department of Psychiatry

Disclosures & Support Acknowledgements

- Funding sources: NIH, VA, DoD, AFSP
- SPI Co-Developer: Gregory K. Brown

Suicide Prevention Components



Goals of Brief Suicide Interventions

- to prevent future suicidal behavior
- to increase suicide-related coping
- to decrease suicide ideation
- to enhance treatment engagement
- to defuse the current suicide crisis

Different goals = Different Approaches

- Variety of intervention approaches:

- Psychoeducation

- Crisis response planning

- Single session cognitive behavior therapy

- Motivational interviewing/treatment engagement

- Outreach follow-up: Letters, postcards, phone calls

- Combination of these approaches

Rationale for Brief Interventions:

1. Problem with Treatment Refusal

- Ongoing outpatient treatment is not for everyone--- “Been there, done that.”
“Stigma.” “Not my cup of tea.” “Inaccessible.”
- Males less likely to seek/accept help; more likely to commit suicide

Rationale for Brief Interventions:

2. Problem with Treatment Engagement

- At risk patients are difficult to engage in outpatient psychotherapy (Lizardi & Stanley, 2010; Trusz, et al., 2011)
- 11-50% of attempters refuse or drop out of outpatient therapy quickly (Kurz & Moller, 1984)
- Adolescents and young adults tend to have attitudes that are inconsistent with long term therapy:
 - “The past is the past. It won’t reoccur.”
 - When mood improves, it’s hard for them to imagine that it could worsen again

Rationale for Brief Interventions:

3. Problem with Treatment Retention

- Up to 60% of suicide attempters \leq 1 week of treatment post ED discharge (Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995; Trautman et al., 1993; Taylor & Stansfield, 1984)
- Of those who do attend treatment, 3 months after hospitalization for an attempt, 38% have stopped outpatient treatment
(Monti et al., 2003)
- After a year, 73% of attempters will no longer be in any treatment (Kruee & Hales 1988)

Rationale for Brief Interventions:

4. Current Treatments Have Not Decreased Suicide Rates; In fact, the Numbers Have Risen

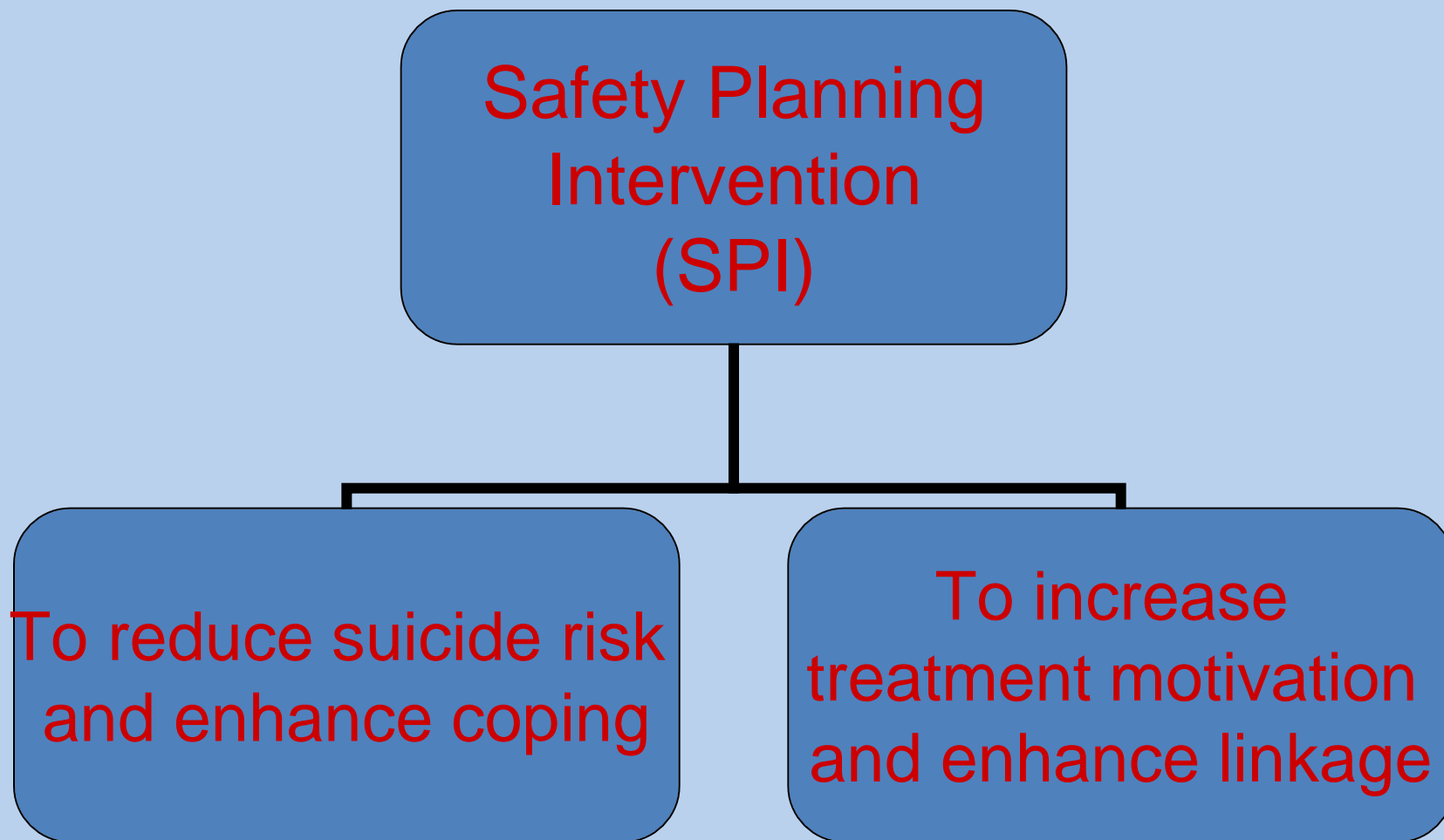
- We have empirically supported psychotherapies but the rate of suicide has not decreased (WISQARS, 2012)
- Limited availability; Limited efficacy

Rationale for Brief Interventions:

5. 'Accessibility' and Low Cost

- Sentinel event/teachable moment opportunity (Boudreaux, 2012)--- teachable moment is often best demonstrated with a significant emotional or traumatic event, emphasis on the 'moment'
- Strike while the iron is hot
- LOW cost, LOW (but not no) burden, easy to implement; easy to train
- Take home point: It's important to intervene whenever suicidal individuals are accessible and most in danger; there may not be another or better opportunity

Safety Planning Intervention Components (Stanley & Brown, 2008; 2012)



Origin of Safety Planning Intervention

(Stanley & Brown, 2008; 2012)

- To maintain safety of high risk patients in outpatient treatment trials (Penn CT study for adults; TASA study for suicidal adolescents)
- Compilation and ordering of evidenced-based suicide interventions
- Expanded and modified as a stand alone intervention for the VA and in civilian Eds
- This one type of SP—others in ASIST and Jobes CAMS

Safety Planning Evidence Base

- Incorporates elements of four evidence-based suicide risk reduction strategies:
 - means restriction
 - teaching brief problem solving and coping skills (including distraction)
 - enhancing social support and identifying emergency contacts, and
 - motivational enhancement for further treatment.

Target Population for Safety Planning Intervention

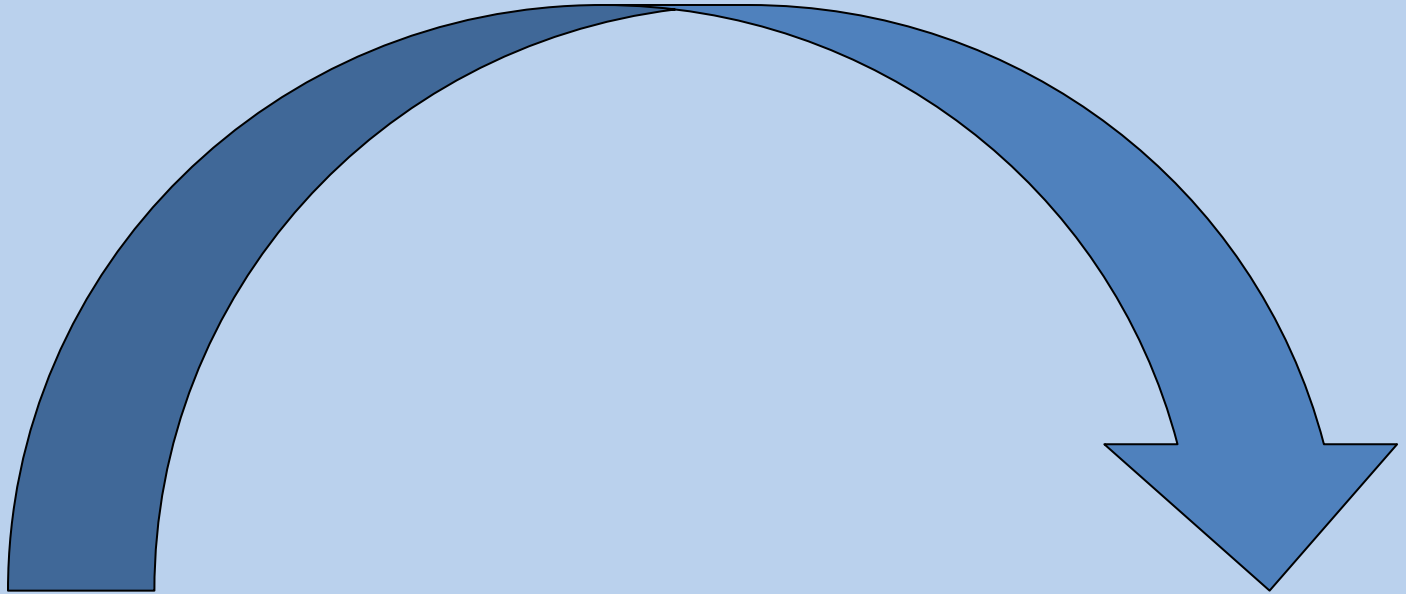
- Individuals at increased risk but not requiring immediate rescue (e.g. on phone can't report that they won't act on SI)
- Patients who have...
 - made a suicide attempt
 - suicide ideation particularly those in the moderate to high risk range
 - psychiatric disorders that increase suicide risk
 - otherwise been determined to be at risk for suicide

'Theoretical' Approaches Underlying SPI

Three theoretical perspectives:

1. Suicide risk fluctuates over time (e.g., Diathesis-Stress Model of Suicidal Behavior, Mann et al., 1999)
2. Problem solving capacity diminishes during crises--over-practicing and a specific template enhances coping (e.g. Stop-Drop-Roll)
3. Cognitive behavioral approaches to behavior change (Emphasize on behavioral)
 - Behavioral strategies to identify individual stressors that have precipitated suicidal behavior in the past.
 - Therapist and patient collaborate to determine cognitive-behavioral strategies patient can use to manage suicidal crises.

Suicide Risk Curve: SPI used to prevent risk from rising too high



Safety Planning Intervention

Overview

- Prioritized written list of coping strategies and resources for use during a suicidal crisis.
- Helps provide a sense of control.
- Uses a brief, easy-to-read format that uses the patient's own words.
- Can serve to motivate people to engage in treatment if the plan is found to be useful.
- Can be used as a single session intervention or incorporated into ongoing treatment

SPI Rationale

- Development and implementation of a safety plan is considered treatment
- Helps to immediately enhance patients' sense of self-control over suicidal urges and thoughts
- Conveys a feeling that they can “survive” suicidal feelings
- Similar to rationale for a fire drill or emergency directions (e.g. plane emergency instructions)

Safety Plan: Overview of Process

- Safety plan includes a hierarchical, step-wise increase in level of intervention from “within self” strategies up to going to ED
- Although the plan is stepwise, patients need to know that if one step is unavailable that they don't stop and wait till it is available

Overview of Safety Planning: 6 Hierarchical Steps

- 1. Recognizing warning signs**
- 2. Employing internal coping strategies without needing to contact another person**
- 3. Socializing with others who may offer support as well as distraction from the crisis**
- 4. Contacting family members or friends who may help to resolve a crisis**
- 5. Contacting mental health professionals or agencies**
- 6. Reducing the potential for use of lethal means**

Recognizing Warning Signs

57%	Low mood/crying
36%	Irritability/anger
43%	Social Isolation
29%	Increased sleep
29%	Anhedonia/loss of interest in activities
29%	Feeling overwhelmed
14%	Feeling numb
14%	Loss of energy
14%	Changes in appetite
7%	Physical pain
7%	Anxiety
7%	Poor concentration

Internal Coping Strategies

58%	Watching TV
43%	Reading
29%	Music
21%	Browsing the Internet
21%	Video games
21%	Exercising/Walking
14%	Cleaning
14%	Playing with Pets
7%	Cooking

Social Settings Providing Distraction

23%	Bookstore/library/coffee shop
23%	Gym
23%	Shopping
23%	Park
23%	Church
15%	Friend's Home

Means Restriction

50%	Give pills to a friend or family member
20%	Seek company/Don't be alone
10%	Place knife in a location that is difficult to access
10%	Discard razor blades
10%	Store pills at workplace
10%	Avoid areas with bridges and trains when warning signs are present

SAFETY PLAN

Step 1: Warning signs:

1. Becoming numb
2. Not being able to think rationally/ Not being able to concentrate
3. Excessive Crying
4. A lot of Anxiety

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. Watch TV-funny shows and movies
2. Reading Magazines (US, Hollywood, Fashion)
3. Play with my dog

Step 3: People and social settings that provide distraction:

1. Name: Joe Smith Phone: 888-888-8888
2. Name: Sally Brown Phone: 777-777-7777
3. Place: Dunkin Donuts 4. Place: Walk around the city/Central Park

Step 4: People whom I can ask for help:

1. Name: Nancy King Phone: 666-666-6666
2. Name: Bob Wang Phone: 555-555-5555
3. Name: _____ Phone: _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name: Dr. Shell Phone: 444-444-4444
Clinician Pager or Emergency Contact: 333-333-3333
2. Clinician Name: Dr. Moran Phone: 222-222-2222
Clinician Pager or Emergency Contact: 111-111-1111
3. Local Urgent Care Services: Columbia Presbyterian Hospital
Urgent Care Services Address: 622 W. 168th Street
Urgent Care Services Phone: 212-305-8075
4. Suicide Prevention Hotline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. Give sleeping pills to husband to store

Example: SPI in Urgent Care/ED Settings

- Most suicidal individuals who go to the ED for help attend very few outpatient treatment sessions
- ED visit is a teachable moment
- Therefore, it's important to intervene whenever individuals are accessible

Typical Strategy for Crisis Intervention

- Assess imminent danger
- Refer for treatment
- But, given the limited success of ED referrals, alternative strategies that include immediate intervention ought to be considered
- Crisis contact may be the ONLY contact the suicidal individual has with the mental health system
- May be able to increase its “therapeutic” capacity

Contrast the Urgent Care Patient with a Suicide Attempt and the ED Patient with a Fracture



Patient with apparent fracture

- Diagnose----exam and x ray
- Treat---apply a cast
- Refer for follow-up

SPI as an equivalent intervention for the suicidal patient



SPI as a 'Cast' for the Suicidal

- Safety Planning Intervention is the equivalent of putting a cast on a broken limb
- Provides immediate intervention to those who do not need require inpatient hospitalization
- Fills the gap between emergency room discharge and follow up treatment

Initial SPI Findings

Comparison of Suicide Ideation for High SI ED Patients: 3 Month Follow- up: SPI < no SPI

	Those Receiving Safety Planning			Comparison Group			Analysis		
	N	Mean/Median	SD	N	Mean/Median	SD	t	df	p
SSI Baseline	15	19.4	5.3	27	19.1	6.1	-		-
SSI Follow-up	15	1.6	2.9	27	6.3	7.8	-		-
SSI Change	15	-17.8	4.8	27	-12.8	8.9	2.4	40	0.02

Effectiveness of SPI

- Interviewed 100 'moderate' risk Veterans who were given the SPI in a VA ED
- Interviewed 3 mo-2 years after ED visit
- All remembered the SPI was done in ED
- All could say where their plan was currently
- 91% felt the safety plan was very helpful in making them feel connected to and cared for
- Most Veterans (93%) indicated they would recommend the interventions to a friend
- High satisfaction with SPI (1-5 Likert-type scale) Satisfaction rating = $1.34 \pm .54$.

Evaluation by Veteran Users

When asked which aspects of the safety plan were most useful,

- 33.3% internal coping strategies
- 25% sources of social support
- 8.3% recognizing warning signs
- 12% reported that simply having a crisis plan was helpful
- 12% reported that having the safety plan enhanced their sense of self efficacy. For example, one Veteran noted that *“You don't realize what to do when you are in that (suicidal) situation, having planned activities like going to a coffee shop and remembering to breathe are effective.”*

Suicidal Individuals' Reactions

- “It helped me not to be such a tough guy and actually go for the help that I needed.”
- “I would tell them (others at risk) it saved my life.”
- “I never thought I could do anything about my suicidal feelings, now I know that I am not at their mercy.”
- “How has the safety plan helped me? It has saved my life more than once.”

Current Uses

- VA --- High suicide risk Veterans
ED demonstration project for moderate risk Veterans not requiring hospitalization
- NY State OMH Outpatient Clinics---Standard of Care
http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- Crisis Hotlines (NSPL) particularly follow-up calls
- EDs, Inpatient Units, Outpatient Clinics (as initial part of treatment with suicidal patients)
- Identified as a Best Practice on the SPRC-AFSP
Registry of Best Practices for Suicide Prevention

Resources

- Stanley B, Brown GK (2012). Safety planning intervention: brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2): 256-264.
- Safety Planning in the VA (*Stanley & Brown VA Safety Planning Manual, 2008*)
- SPI designated as a *Best Practice* by the SPRC/AFSP Registry of Best for Suicide Prevention
- www.suicidesafetyplan.com
- bhs2@columbia.edu; Phone: 646 774-7582

Questions?



Cara Anna
*Journalist, Editor AAS
Attempt Survivor Blog, and
Founder,
TalkingAboutSuicide.com*



Susan Stefan, JD
*Consultant and
Author*



Barbara Stanley, PhD
*Director, Suicide Intervention
Center, Columbia University
School of Medicine*