Patient Management Tools

Many concrete and easy-to-use tools are available to assist you and your staff in preventing suicide. This section includes pocket-sized tools to facilitate assessment and intervention with at-risk patients in the office, as well as templates for helping to ensure the patients' safety outside of your office.

In This Section

Primary Care Pocket Guide

The Pocket Guide for Primary Care Professionals provides a summary of important risk and protective factors for suicide, questions you can use in a suicide assessment, and a decision tree for managing the patient at risk for a suicide attempt. The card is designed to be printed on both sides and folded in quarters to fit easily in the pocket. Hard copies are available for purchase through the WICHE Mental Health Program at mentalhealthemail@wiche.edu or by calling 303-541-0311.

SAFE-T Pocket Card

http://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card

This pocket card, designed by mental health experts for mental health professionals, provides a brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The website above will direct you to the SAMHSA Publications Ordering website where the card can be downloaded or ordered free of charge. https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/SMA09-4432 . SAMHSA's free suicide prevention app, Suicide Safe, is based on the SAFE-T card and can be downloaded for iOS and Android devices. More information about Suicide Safe is available at: https://store.samhsa.gov/apps/suicidesafe/index.html.

Safety Planning Guide

http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians

The pocket-sized safety planning guide reminds clinicians of the most important points to cover in collaboratively developing a safety plan with a patient. The guide was adapted from content developed by the Department of Veterans Affairs.

Patient Safety Plan Template

http://www.sprc.org/resources-programs/patient-safety-plan-template

The Patient Safety Plan Template is filled out collaboratively by the clinician and the patient and then used independently by the patient to help ensure their safety in their day-to-day lives. The Safety Planning Guide (listed above) can be used as a source of questions to ask to facilitate development of the Safety Plan.

Crisis Support Plan

The Crisis Support Plan is used by the patient and the clinician to enlist social support from a trusted friend or relative should a suicide crisis recur. It explains roles that supportive individuals can take to help protect the person at risk for suicide and serves as an informal contract that the designated support person will fulfill these roles. Active support of a friend or loved one is among the strongest protective factors against suicide.

Screening: uncovering suicidality[2]

Transition Question: Confirm Suicidal Ideation
Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? **(Note: the transitional question is not part of scoring.)**

1. **Thoughts of carrying out a plan.** Recently, have you been thinking about how you might kill yourself? **If yes, consider the immediate safety needs of the patient.**
2. **Suicide intent.** Do you have any intention of killing yourself?
3. **Past suicide attempt.** Have you ever tried to kill yourself?
4. **Significant mental health condition.** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?
5. **Substance use disorder.** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?
6. **Irritability/agitation/aggression.** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression.

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the the answer to the transition question and any of the other six items is "Yes", further intervention, including assessment by a mental health professional, is needed.

Assess suicide ideation and plans[3]

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

Assess suicide intent

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

Endnotes:

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

[2] *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.* Suicide Prevention Resource Center. Newton, MA. http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf.

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

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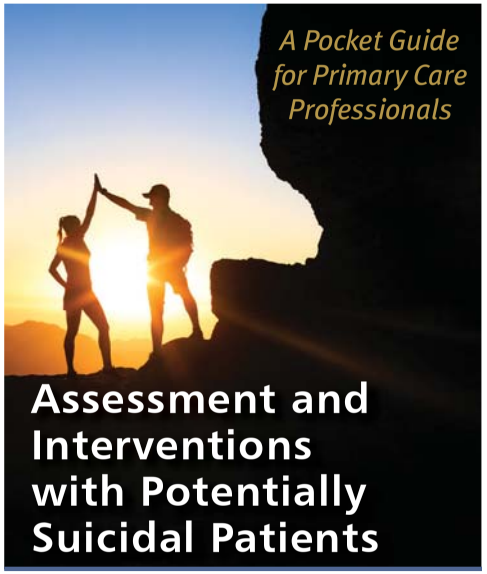
WICHE

Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/



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Assessment and Interventions with Potentially Suicidal Patients

Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

High Risk

Patient has a suicide plan with preparatory or rehearsal behavior

- Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement
  - Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits
- Patient has good social support, intact judgment; psychiatric symptoms, if present, have been addressed
  - Take action to prevent the plan
  - Safety planning
  - Consider (locally or via telemedicine):
    1) psychopharmacological treatment with psychiatric consultation
    2) alcohol/drug assessment and referral, and/or
    3) individual or family therapy referral to evidence based treatment

Moderate Risk

Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt

- Evaluate for psychiatric disorders, stressors, and additional risk factors
- Safety planning
- Consider (locally or via telemedicine):
  1) psychopharmacological treatment with psychiatric consultation
  2) alcohol/drug assessment and referral, and/or
  3) individual or family therapy referral to evidence based treatment

Low Risk

Patient has thoughts of death only; no plan or behavior

- Evaluate for psychiatric disorders, stressors, and additional risk factors
- Consider (locally or via telemedicine):
  1) psychopharmacological treatment with psychiatric consultation
  2) alcohol/drug assessment and referral, and/or
  3) individual or family therapy referral to evidence based treatment

Encourage social support, involving family members, close friends and community resources. If patient has therapist, call him/her in presence of patient.

Record risk assessment, rationale, and treatment plan in patient record. Continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers.

Suicide Risk and Protective Factors[1]

RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- Current/past psychiatric disorders: especially mood disorders (e.g., depression, Bipolar disorder), psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (e.g., Borderline PD).
  Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication.
  For children and adolescents: oppositionality and conduct problems.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- Chronic medical illness (esp. CNS disorders, pain).
- History of or current abuse or neglect.

PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk.

- Internal: ability to cope with stress, religious beliefs, frustration tolerance.
- External: responsibility to children or pets, positive therapeutic relationships, social supports.

RESOURCES

- Download this card and additional resources at **http://www.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

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

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

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

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

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

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

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

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WICHE

Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/

Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

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

WHO SHOULD HAVE A SAFETY PLAN?

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

HOW SHOULD A SAFETY PLAN BE DONE?

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

IMPLEMENTING THE SAFETY PLAN

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

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Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

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

Step 2: Internal Coping Strategies

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

Step 3: Social Contacts Who May Distract from the Crisis

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

Step 4: Family Members or Friends Who May Offer Help

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

Step 5: Professionals and Agencies to Contact for Help

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

Step 6: Making the Environment Safe

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

Patient Safety Plan Template

Step 1. Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2. Internal coping strategies – things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3. People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4. People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

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

1. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
2. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
3. Local Urgent Care services _____
   Urgent Care services address _____
   Urgent Care services phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6. Making the environment safe:

1. _____
2. _____

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

_____

Crisis Support Plan

For: _____ Date: _____

I understand that suicideal risk is to be taken very seriously. I want to help _____ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases, inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - _____
  - _____
- Help _____ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms and ammunition
  2. Remove or lock up:
     - knives, razors, and other sharp objects
     - prescriptions and over-the-counter drugs (including vitamins and aspirin)
     - alcohol, illegal drugs, and related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict access to vehicle, ropes, inflammables, etc. as appropriate.
  5. Limit or restrict access to vehicle/car keys as appropriate.
  6. Identify people who might escalate risk for the client and minimize their contact with the client.
  7. Provide access to things client identifies as helpful and encourage healthful behaviors such as good nutrition and adequate rest.
- Other _____

If I am unable to continue to provide these supports, or if I believe that the Crisis Action Plan is not helpful or sufficient, I will contact [name of therapist or therapy practice] immediately and express my concerns.

If I believe _____ is a danger to self or others, I agree to:

- Call [name of therapist or therapy practice and phone number]
- *or* call 911
- *or* help _____ get to a hospital.

I agree to follow by this plan until _____. Support signature: _____

Client signature: _____ Therapist signature: _____

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