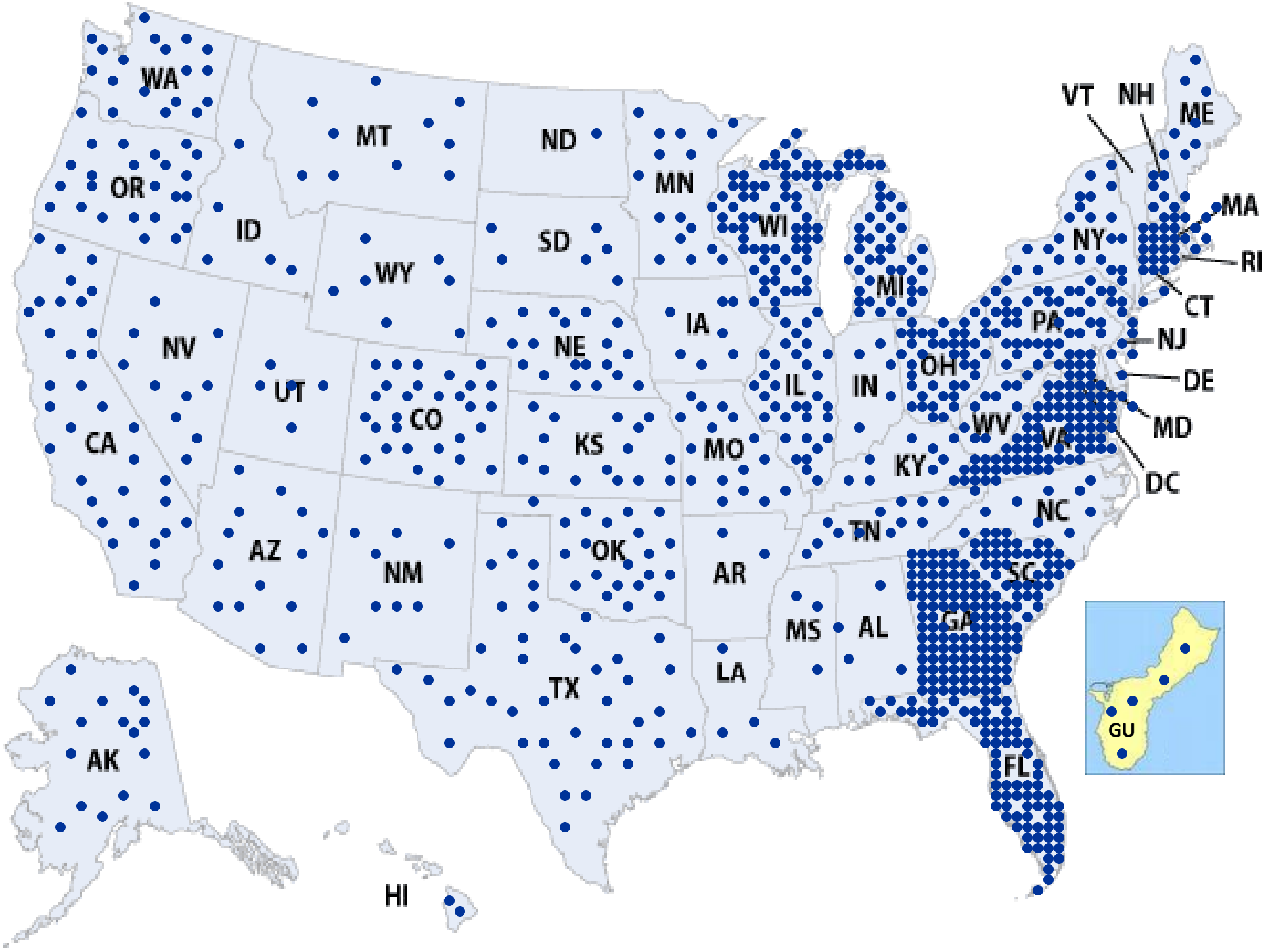
SUICIDE PREVENTION RESOURCE CENTER

Welcome to SPRC's Research to Practice Webinar on

Linking Together a Chain of Care: How Clinicians Can Prevent Suicide

EDC

SAMHSA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Linking Together a Chain of Care: How Clinicians Can Prevent Suicide

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Suicide Prevention Resource Center

March 30, 2010

Overview

- Epidemiology
- Detecting suicide risk
- Clinical interventions and tools
- Training Implications

Epidemiology

Incidence

- ~ 1 Million suicides/year worldwide*
- >33,000 suicides/year in the U.S.**
- Suicide attempts, U.S.(adults)***
  - 1.1 M attempts
  - 678,000 attempts requiring medical care
  - 500,000 attempts resulting in an overnight hospital stay
- Suicide ideation, U.S. (adults)***
  - 8.3 M (3.7%) seriously considered suicide during past year

Source: * World Health Organization. *Suicide Prevention.* Retrieved from http://www.who.int/mental_health/prevention/en.
** National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html.
***Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.

Demographics

- **Suicides:**
  - **Male:female = 4:1**
  - **Elderly white males -- highest rate**
  - **Working aged males – 60% of all suicides**
  - **American Indian/Alaskan Natives, youth and middle age**
- **Attempts:**
  - **Female>>male**
  - **Rates peak in adolescence and decline with age**
  - **Young Latinas and LGBT**

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html.

Epidemiology among Patients

Prevalence of suicidal behaviors

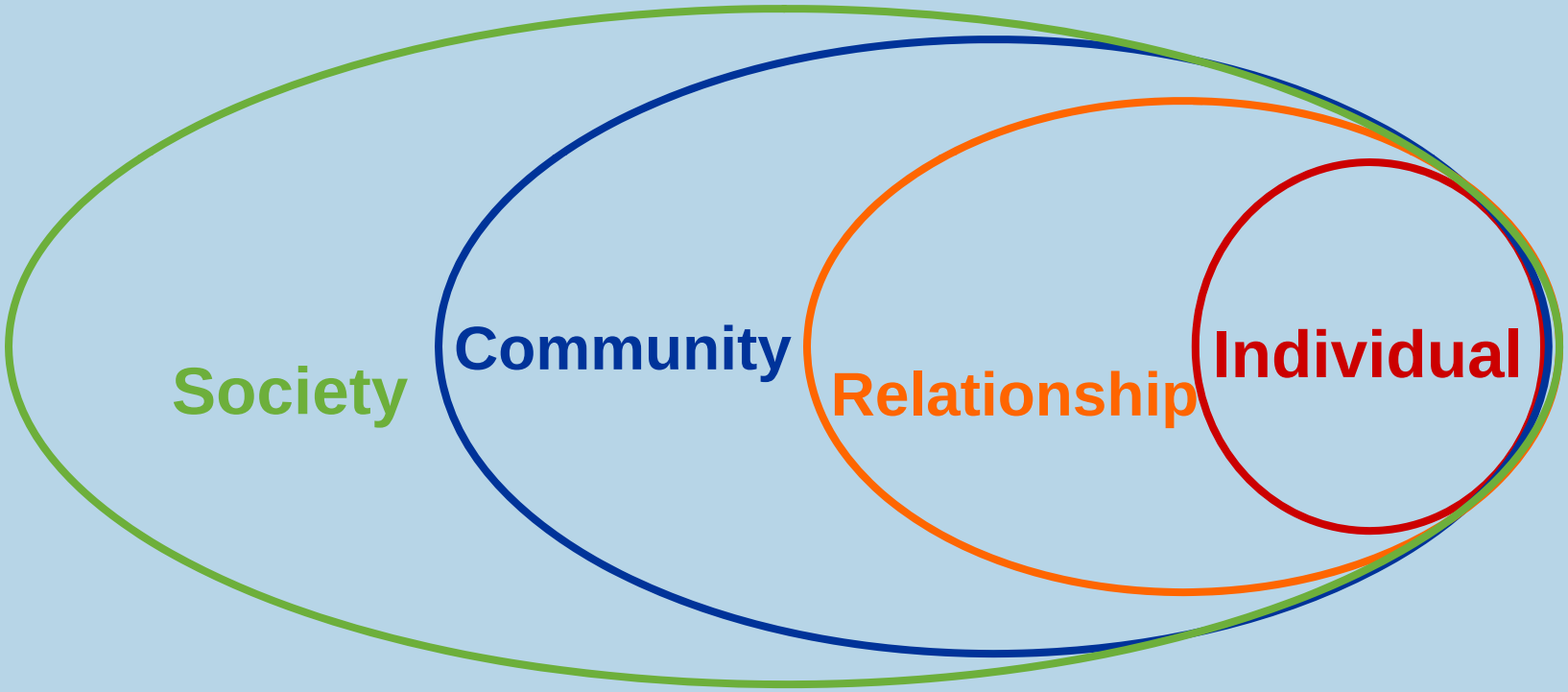
- Suicidal ideation at time of visit
  - Primary care: 2- 4 percent (Olfson (1996, 2003))
  - Emergency departments: 8-12 percent*
- Suicide attempts
  - Pts with major depression: 10% attempted during a past major depressive episode**
- Suicide
  - Pts with serious mental illness: lifetime suicide risk 4-8% (1% lifetime suicide risk for general population)***

* Claassen, C.A. & Larkin, G.L. (2005). Occult suicidality in an emergency department population. *The British Journal of Psychiatry*, *186*, 352-353.

** Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.

*** Litts, D. A., Radke, A. Q., & Silverman, M. M. (Eds.). (2008). Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority. Washington, D.C.: NASMHPD/SPRC.

Understanding Risk Factors



Clinically Salient Suicide Risk Factors

- Previous suicide attempt
  - Majority die on first attempt
- Suicidal ideation, plan, intent

Suicidality

- Major mood or anxiety disorder
- Substance abuse disorder
- Other mental illnesses
- Co morbidity (psych/SA)
- Physical illness, chronic pain
- CNS disorders/traumatic brain injury
- Insomnia

Generally:
Risk ↑'d with
1) severity of symptoms,
2) # of conditions
3) recent onset

Additional Salient Risk Factors for MHPs

- **Impulsivity**

  Source: U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville, MD: U.S. Department of Health and Human Services.

- **Failed belongingness**
- **Perceived burdensomeness**
- **Loss of fear of death and pain**

  Source: Joiner, T. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.

Protective Factors

- Family and community connections/support
- Clinical care (availability and accessibility)
- Resilience
- Coping skills
- Frustration tolerance and emotion regulation
- Cultural and religious beliefs; spirituality

Source:

U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville, MD: U.S. Department of Health and Human Services.

Cha, C., Nock, M. (2009). Emotional intelligence is a protective factor for suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(4), 422-430.

Warning Signs (For the Public)

Tier 1: Call 911 or seek immediate help

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36(3), 255-262.*

Warning Signs (For the Public)

Tier 2: Seek help by contacting a mental health professional or calling 1-800-273-TALK

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36(3), 255-262.*

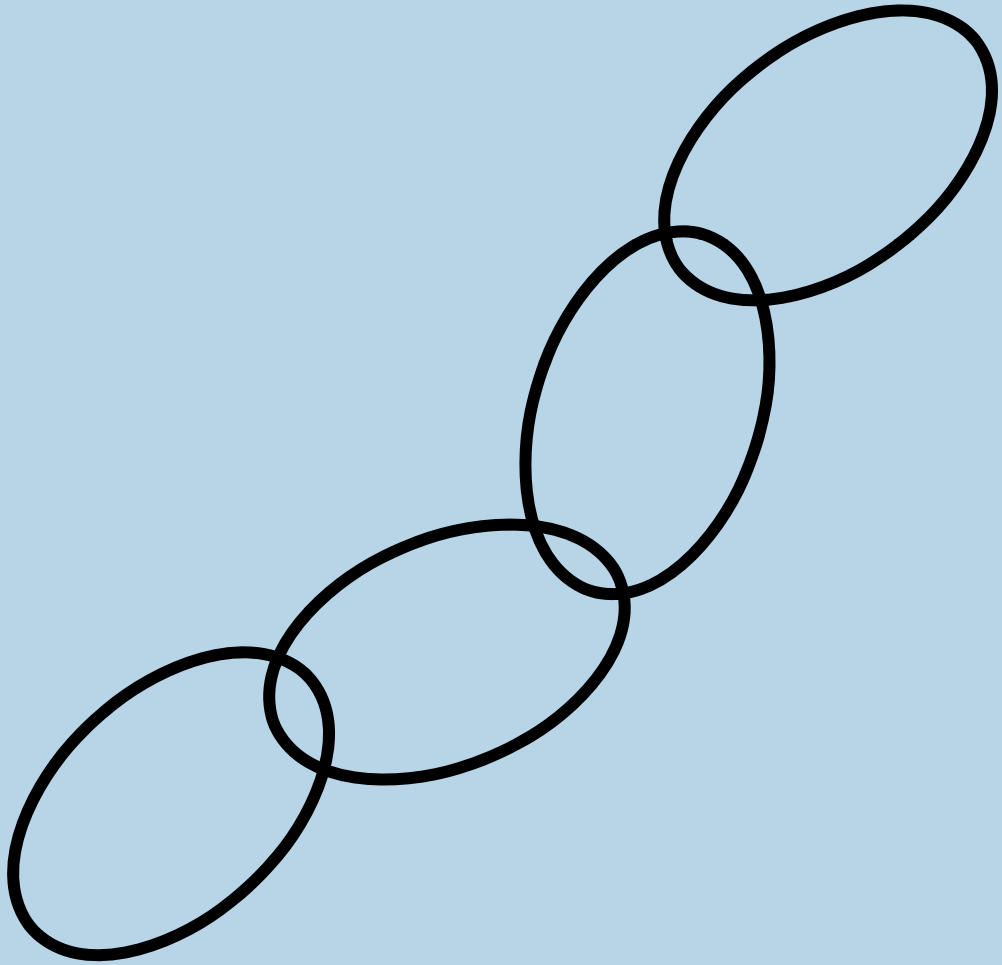
Triggering Events

- **Acute events leading to:**
  - **Humiliation,**
  - **Shame, or**
  - **Despair**
- **Includes real or anticipated loss of:**
  - **Relationship**
  - **Status: financial or health**

Source: Education Development Center, Inc. (2008). Suicide risk: A guide for ED evaluation and triage. Available online at: http://www.sprc.org/library/ER_SuicideRiskGuide8.pdf.

Clinical Chain in Suicide Prevention

- Detecting potential risk
- Assessing risk
- Managing suicidality
  - Safety planning
  - Crisis support planning
  - Patient tracking
- MH Treatment
- F/U Contact



Poll

PRIMARY CARE

A Suicide Prevention Toolkit for (Rural) Primary Care

http://www.sprc.org/pctoolkit/index.asp

Why Primary Care?

- Suicide decedents twice as likely to have seen a PC provider than a MH provider prior to suicide*
- Reach working-aged men
- Many key risk factors for suicide are easily observed in primary care settings
- Fits chronic disease mgmt model in pt centered medical home
- Patient education

* Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909-916.

Contact with Primary Care and Mental Health Prior to Suicide

All Ages	Month Prior	Year Prior
Mental Health	19%	32%
Primary Care	45%	77%

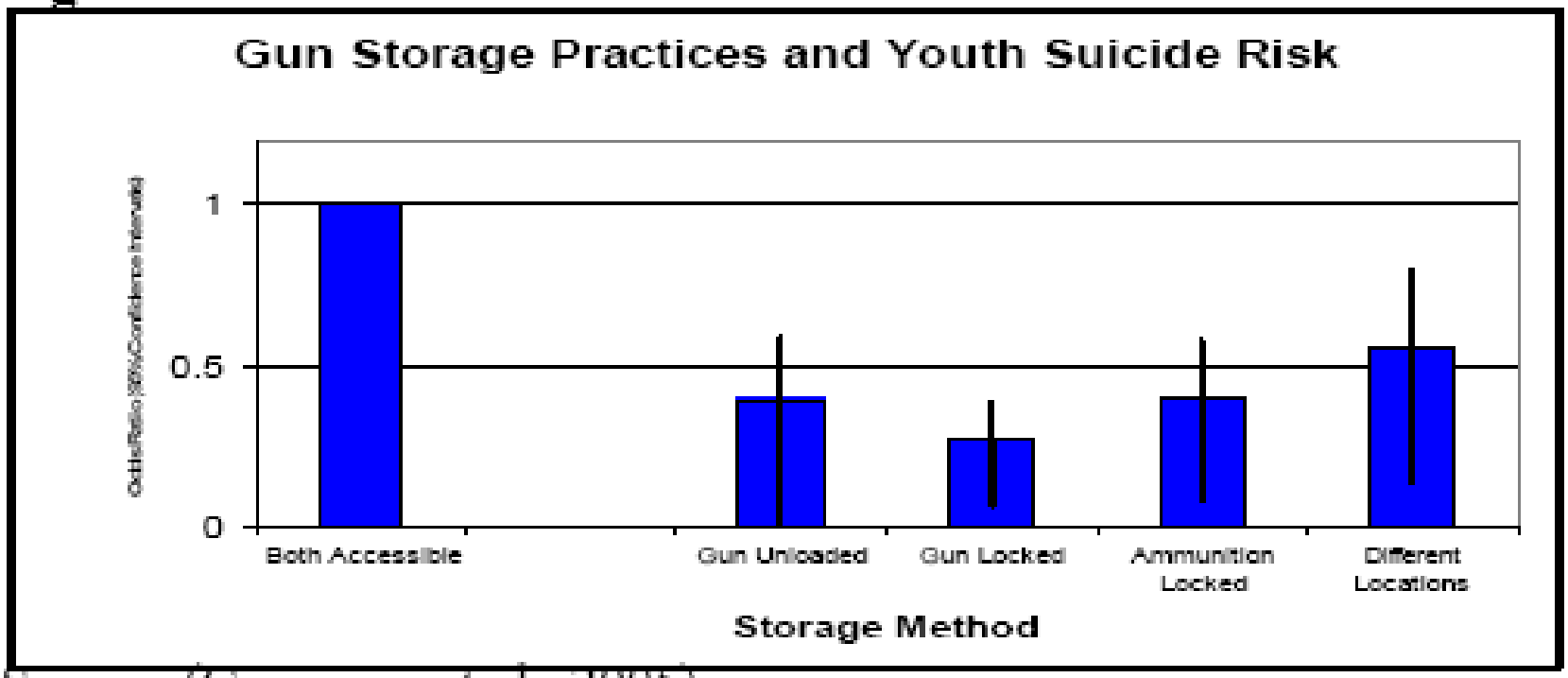
Contact w/ PC by Age	Month Prior
Age <36	23%
Age >54	58%

Contact w/ MH by Gender	Month Prior	Year Prior
Men	18%	35%
Women	36%	58%

Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909-916.

Safe Firearm/Ammunition Storage

Figure 3.



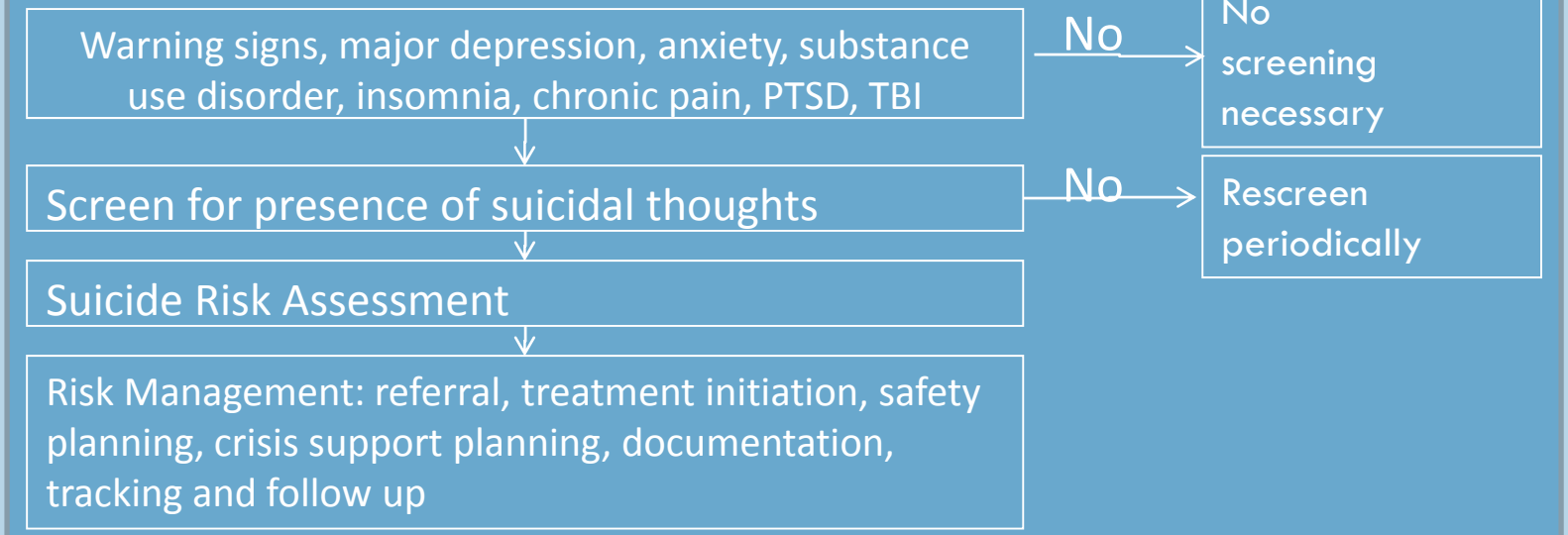
Source: (Grossman et al., 2005)

Toolkit: Primary Care Suicide Prevention Model

Prevention Practices

1. Staff vigilance for warning signs & key risk factors
2. Universal depression screening for adults and adolescents
3. Patient education:
   Safe firearm storage
   Suicide warning signs & 1-800-273-TALK (8255)

Intervention



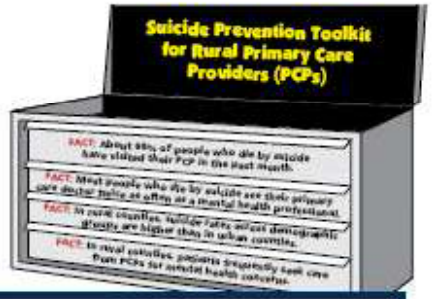
Toolkit: Overall Layout

- **Six sections**
  - Getting started
  - Educating clinicians and office staff
  - Developing mental health partnerships
  - Patient management tools
  - Patient education tools
  - Resources
- **The Toolkit is available in 2 forms**
  - Hard copy, spiral bound ordered through WICHE
  - Electronic copy (www.sprc.org)

1. Getting Started

QUICK START GUIDE

How to use the Suicide Prevention Toolkit



STEP 1 Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.

STEP 2 Meet to develop the "Office Protocol" for potentially suicidal patients. See the "Office Protocol Development Guide" instruction sheet in the Toolkit.

STEP 3 Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

STEP Develop a referral network to facilitate the collaborative care of suicidal

Office Protocol Development Guide

To be used with instruction sheet to create an office protocol that may be referred to when a potentially suicidal patient presents

Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected…

✓ _____ should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).

✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization…

✓ Our nearest Emergency Department or psychiatric emergency center is _____. Phone #_____.

✓ _____ will call _____to arrange transport.
(Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)

Backup transportation plan: Call_____.

✓ _____will wait with patient for transport.

Documentation and Follow-Up…

_____will call ED to provide patient information.

✓ _____will document incident in_____.
(Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)

✓ Necessary forms are located _____.

✓ _____will follow-up with ED to determine disposition of patient.
(Name of individual or job title)

✓ _____ will follow up with patient within_____.
(Name of individual or job title) (Time frame)

2. Educating Clinicians and Office Staff

- Primer with 5 brief learning modules
  - Module 1- Prevalence & Comorbidity
  - Module 2- Epidemiology
  - Module 3- Effective Prevention Strategies
  - Module 4- Suicide Risk Assessment
    - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
  - Module 5- Intervention
    - Referral, PCP Intervention, Documentation & Follow-up

3. Developing Mental Health Partners

- **Letter of introduction to potential referral resources--template**
  - Increasing vigilance for patients at risk for suicide
  - Referring more patients
  - SAFE-T card for Mental Health Providers
  - Invitation to meet to discuss collaborative management of patients
  - NSSP recommends training for health care professionals
  - Nationally disseminated trainings for MHPs

3. MH Partners

SAFE-T

Suicide **A**ssessment **F**ive-step **E**valuation and **T**riage

for Mental Health Professionals

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

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

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, 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 (i.e., 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 disorders 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 (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

3. MH Partners – Telemental Health

- Web-based guide for developing a telemental health capacity (created by the U CO Denver as part of SAMHSA's Eliminating Health Disparities Initiative) www.tmhguide.org
- Resources for
  - Clinicians/Administrators
  - Consumers
  - Policymakers
  - Community Members
  - Media

3. MH Partners

- SAMHSA mental health and substance abuse treatment locator guides (www.samhsa.gov)
- Veterans resource locator (http://www.suicidepreventionlifeline.org/Veterans/ResourceLocator.aspx)

4. PC Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

SPRC

RHRC Rural Health Research & Policy Centers

WICHE Western Interstate Commission for Higher Education

Suicide Risk and Protective Factors[1]

RISK FACTORS

- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive 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: also oppositionality and conduct problems.
- **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.
- **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 beloved pets, positive therapeutic relationships, social supports.

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4. PC Patient Management—Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Screening: uncovering suicidality[2]

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

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

Assess suicide intent

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

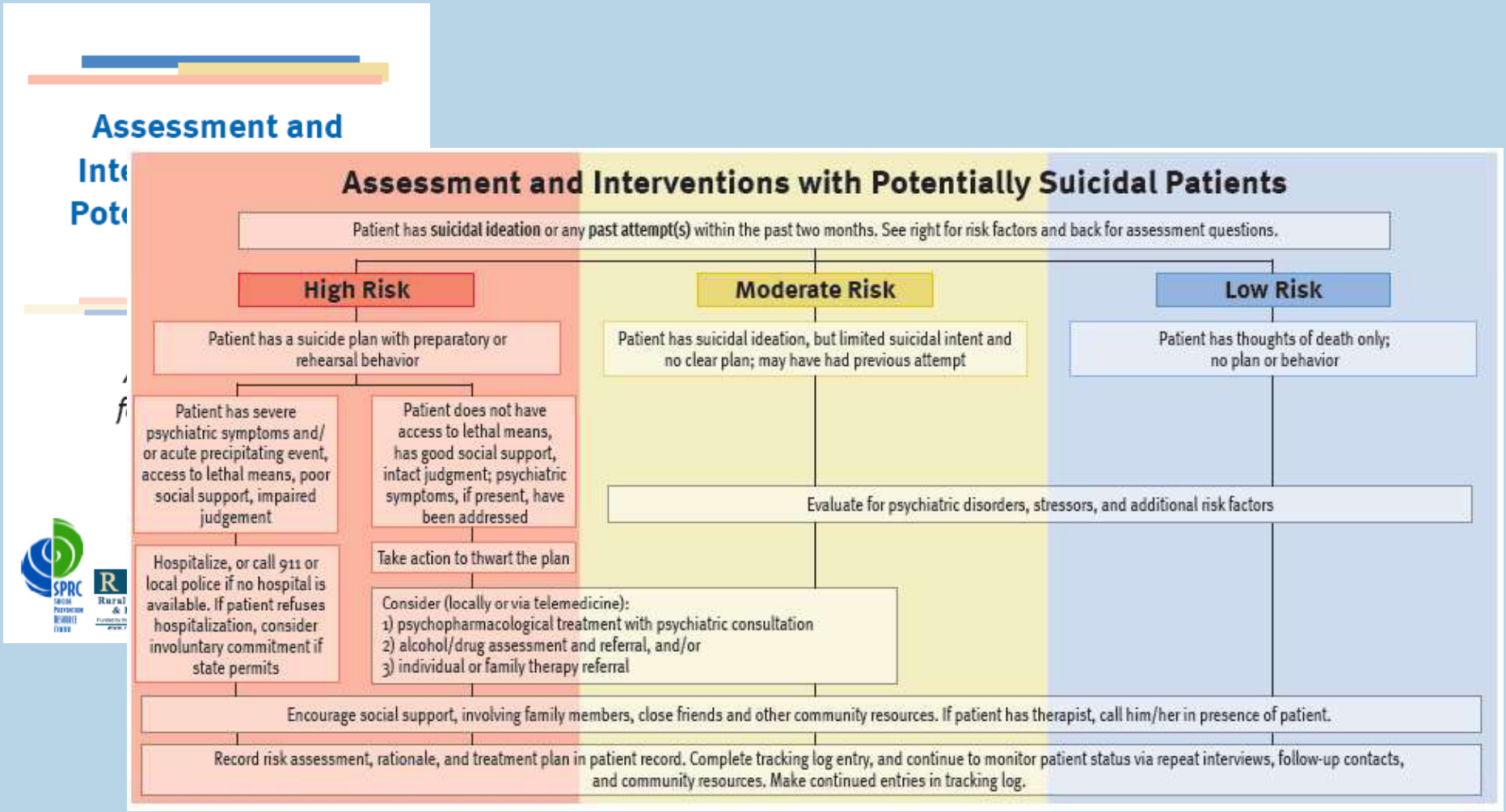
Endnotes:

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

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

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

4. PC Patient Management—Pocket Card



EMERGENCY DEPARTMENT

ED Treatment of Mental Disorders

- 100 million ED visits in 2002.
- 20% increase in number of visits over prior decade.
- 15% decrease in number of EDs over prior decade.
- 6.3% of presentations were for mental health.
- 7% of these were for suicide attempts = 441,000 visits.

Larkin, G.L., Claassen, C.A., Emond, J.A., Pelletier, A.J., & Camargo, C.A. (2005). Trends in U.S. emergency department visits for mental health conditions, 1992-2001. *Psychiatric Services, 56*(6), 671-677.

ED Treatment of Mental Disorders

- Suicidal ideation (SI) common in ED patients who present for medical disorders.
- Study of 1,590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans.
- 4 of those 31 attempted suicide within 45 days of ED presentation.

Source: Claassen CA, Larkin GL. Occult suicidality in an emergency department population. British J Psychiatry. V186, 352-353, 2005.

- 1 in 10 suicides are by people seen in an ED within 2 months of dying

Source: Weis, M. A., Bradberry, C., Carter, L. P., Ferguson, J., & Kozareva, D. (2006). An exploration of human services system contacts prior to suicide in South Carolina: An expansion of the South Carolina Violent Death Reporting System. *Injury Prevention, 12(Suppl. 2), ii17-ii21.*
C. Bradberry, personal communication with D. Litts regarding South Carolina NVDRS-linked data. December 19, 2007.

ED Treatment of Mental Disorders

Kemball et al (2008)

- 165 ED patients with suicidal ideation self-identified on a computer screening
- Physician and nurse were informed
- Six month f/u
  - 10% were transferred to psychiatric services
  - Only 25% had any notation in the chart re suicide risk
  - 4 were seen again in the ED with suicide attempts—none were there for mental health problems on the index visit

Kemball, R.S., Gasgarth, R., Johnson, B., Patil, M., & Houry, D. (2008). Unrecognized suicidal ideation in ED patients: Are we missing an opportunity. *American Journal of Emergency Medicine, 26*(6), 701-705.

Emergency Department

- Look for signs of acute suicide risk

Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of Acute Suicide Risk

- Talking about suicide
- Seeking lethal means
- Purposeless
- Anxiety or agitation
- Insomnia
- Substance abuse
- Hopelessness
- Social withdrawal
- Anger
- Recklessness
- Mood changes

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

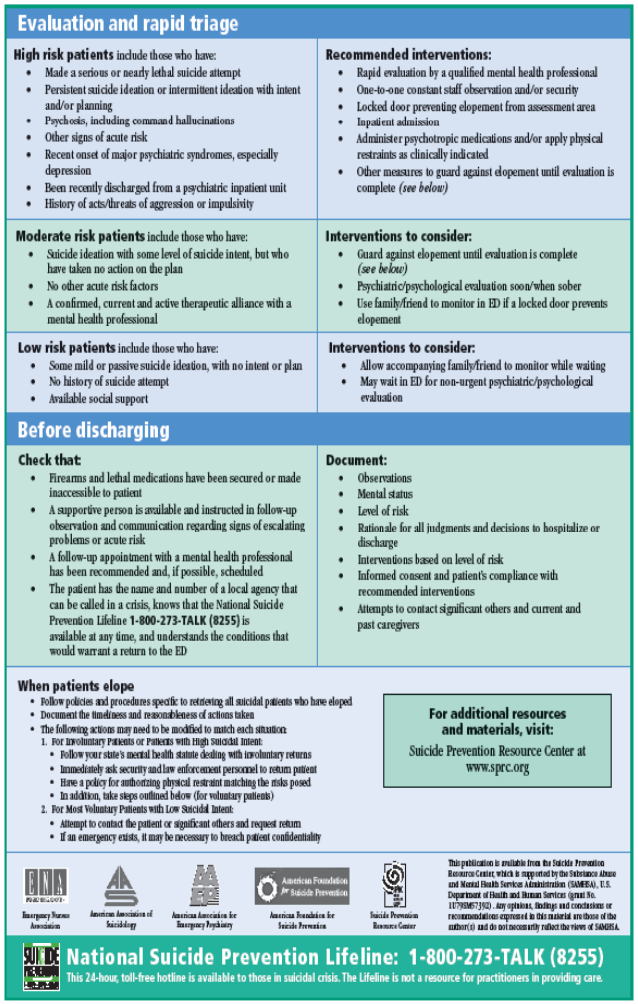
This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57392). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.

Emergency Department

- **Screen:**
  - **Universally or selectively**
  - **Paper/pencil, computer, or by clinician**



Evaluation and rapid triage

High risk patients include those who have:
- Made a serious or nearly lethal suicide attempt
- Persistent suicide ideation or intermittent ideation with intent and/or planning
- Psychosis, including command hallucinations
- Other signs of acute risk
- Recent onset of major psychiatric syndromes, especially depression
- Been recently discharged from a psychiatric inpatient unit
- History of acts/threats of aggression or impulsivity

Recommended interventions:
- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete *(see below)*

Moderate risk patients include those who have:
- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current and active therapeutic alliance with a mental health professional

Interventions to consider:
- Guard against elopement until evaluation is complete *(see below)*
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend to monitor in ED if a locked door prevents elopement

Low risk patients include those who have:
- Some mild or passive suicide ideation, with no intent or plan
- No history of suicide attempt
- Available social support

Interventions to consider:
- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation

Before discharging

Check that:
- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED

Document:
- Observations
- Mental status
- Level of risk
- Rationale for all judgments and decisions to hospitalize or discharge
- Interventions based on level of risk
- Informed consent and patient's compliance with recommended interventions
- Attempts to contact significant others and current and past caregivers

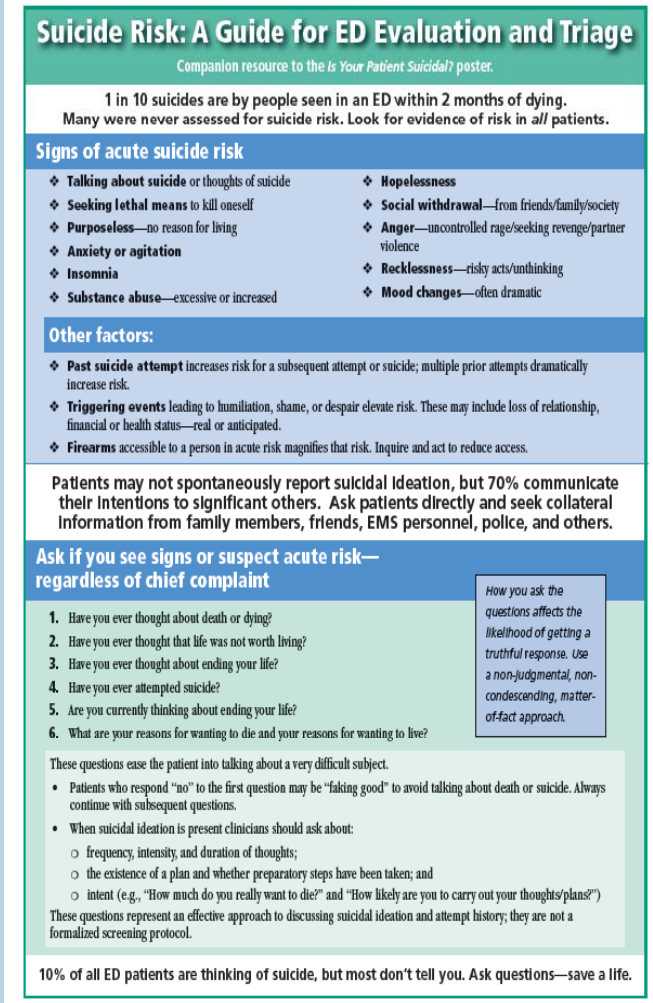
When patients elope
- Follow policies and procedures specific to retrieving all suicidal patients who have eloped
- Document the timeliness and reasonableness of actions taken
- The following actions may need to be modified to match each situation:
  1. For Involuntary Patients or Patients with High Suicidal Intent:
     - Follow your state's mental health statute dealing with involuntary returns
     - Immediately ask security and law enforcement personnel to return patient
     - Have a policy for authorizing physical restraint matching the risks posed
     - In addition, take steps outlined below (for voluntary patients)
  2. For Most Voluntary Patients with Low Suicidal Intent:
     - Attempt to contact the patient or significant others and request return
     - If an emergency exists, it may be necessary to breach patient confidentiality

For additional resources and materials, visit:
Suicide Prevention Resource Center at www.sprc.org

Emergency Nurses Association · American Association of Suicidology · American Association for Emergency Psychiatry · American Foundation for Suicide Prevention · Suicide Prevention Resource Center

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57392). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.



Suicide Risk: A Guide for ED Evaluation and Triage

Companion resource to the *Is Your Patient Suicidal?* poster.

1 in 10 suicides are by people seen in an ED within 2 months of dying.
Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of acute suicide risk

- **Talking about suicide** or thoughts of suicide
- **Seeking lethal means** to kill oneself
- **Purposeless**—no reason for living
- **Anxiety or agitation**
- **Insomnia**
- **Substance abuse**—excessive or increased
- **Hopelessness**
- **Social withdrawal**—from friends/family/society
- **Anger**—uncontrolled rage/seeking revenge/partner violence
- **Recklessness**—risky acts/unthinking
- **Mood changes**—often dramatic

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if you see signs or suspect acute risk—regardless of chief complaint

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions ease the patient into talking about a very difficult subject.

- Patients who respond "no" to the first question may be "faking good" to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
  - frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans?")

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

Emergency Department

Evaluation and rapid triage

High risk patients include those who have: • Made a serious or nearly lethal suicide attempt • Persistent suicide ideation or intermittent ideation with intent and/or planning • Psychosis, including command hallucinations • Other signs of acute risk • Recent onset of major psychiatric syndromes, especially depression • Been recently discharged from a psychiatric inpatient unit • History of acts/threats of aggression or impulsivity	**Recommended interventions:** • Rapid evaluation by a qualified mental health professional • One-to-one constant staff observation and/or security • Locked door preventing elopement from assessment area • Inpatient admission • Administer psychotropic medications and/or apply physical restraints as clinically indicated • Other measures to guard against elopement until evaluation is complete *(see below)*
Moderate risk patients include those who have: • Suicide ideation with some level of suicide intent, but who have taken no action on the plan • No other acute risk factors • A confirmed, current and active therapeutic alliance with a mental health professional	**Interventions to consider:** • Guard against elopement until evaluation is complete *(see below)* • Psychiatric/psychological evaluation soon/when sober • Use family/friend to monitor in ED if a locked door prevents elopement
Low risk patients include those who have: • Some mild or passive suicide ideation, with no intent or plan • No history of suicide attempt • Available social support	**Interventions to consider:** • Allow accompanying family/friend to monitor while waiting • May wait in ED for non-urgent psychiatric/psychological evaluation

Poll

Skill Building:
Risk Detection Using Normalizing Technique

- Scenario A: 74 y/o male being treated with marginal success for severe chronic back pain associated with degenerative changes in the lumbar spine. He was recently widowed. His affect is consistent with someone who has lost hope.
- Scenario B: 24 y/o veteran of two Iraq War deployments with traumatic brain injury. After two years of rehabilitation, he is coming to terms with the magnitude of his long-term disability.
- Scenario C: 38 y/o female with debilitating panic attacks that interfere with work performance and her ability to meet her responsibilities to her family. She mentioned drinking more and more to try to "get through".

MENTAL HEALTH

Mental Health Services

- ~19% of suicides had contact with MH within the past month; ~32% within the past year (Luoma, 2002)
- 41% of suicide decedents who had received inpatient psychiatric care died within one year of their discharge; 9% within one day. (Pirkis, 1998)
- Of patients admitted for attempt (Owens et al., 2002)
  - 16% repeat attempts within one year
  - 7% die by suicide within 10 years
  - Risk of suicide "hundreds of times higher" than general population

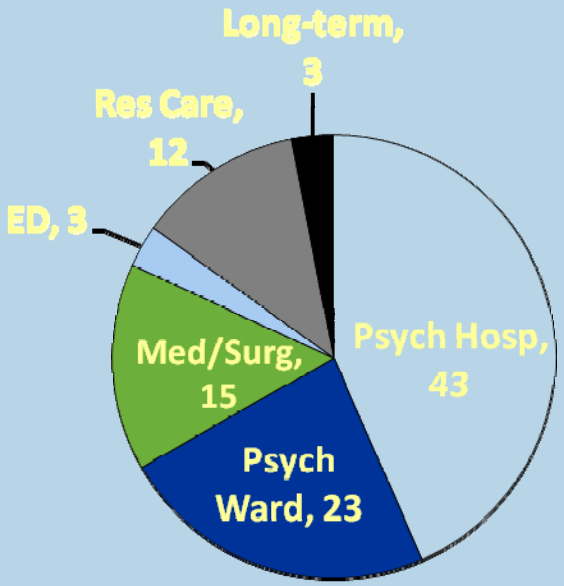
Inpatient Suicide

- Second most common sentinel event reported to The Joint Commission (First is wrong-side surgery)
- Since 1996*: 416(14%)
- Method:
  - 71% Hanging
  - 14% Jumping

Factors in Suicide

- 87% Deficiencies in physical environment
- 83% Inadequate assessment
- 60% Insufficient staff orientation or training

Clinical Setting



* Sentinel event reporting began in 1996.

Source: Joint Commission on Accreditation of Healthcare Organizations. (2005). *Reducing the Risk of Suicide*. Oak Brook, IL: JCAHO.

Trends in Suicidal Behavior 1990-1992 vs 2001-2003 National Comorbidity Survey and Replication*

Suicide	1990-1992 14.8/100k	2001-2003 13.9/100k
Ideation	2.8%	3.3%
Plan	.7%	1.0%
Gesture	.3%	.2%
Attempt	.4%	.6%

- 9708 respondents, face-to-face survey, aged 18-54
- Queried about past 12 months
- No significant changes

* Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA, 293*(20), 2487-2495.

Trends in Suicidal Behavior 1990-1992 vs 2001-2003 National Comorbidity Survey and Replication

	1990-1992	2001-2002	*P*
Ideators with plans	19.6%	28.6%	*p=.04*
Planners with gestures	21.4%	6.4%	*p=.003*
Tx among ideators with gestures	40.3%	92.8%	
Tx among ideators with attempts	49.6%	79.0%	

* Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA, 293*(20), 2487-2495.

Insufficient Treatment

"A recognition is needed that effective prevention of suicide attempts might require substantially more intensive treatment than is currently provided to the majority of people in outpatient treatment for mental disorders."[1]

[1] Kessler, R.C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA, 293*(20), 2487-2495.

CLINICAL INTERVENTIONS

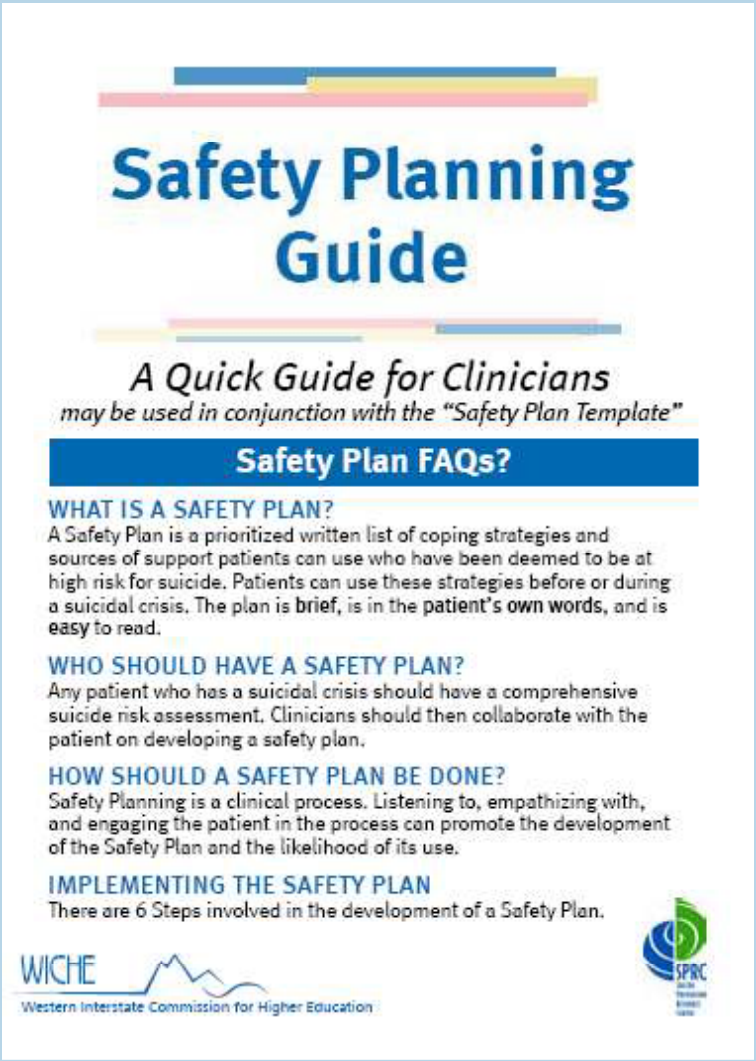
Patient Management Tools

- **Safety Plan/Crisis Response Plan**
  - **Collaboratively developed with patient**
  - **Template that is filled out and posted**
  - **Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers**

Stanley, B. & Brown, G.K. (2008). *Safety plan treatment manual to reduce suicide risk: Veteran version.* Washington, DC: U.S. Department of Veterans Affairs.

Rudd, M.D., Mandrusiak, M., & Joiner Jr., T.E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology, 62*(2), 243-51.

Safety Planning



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.

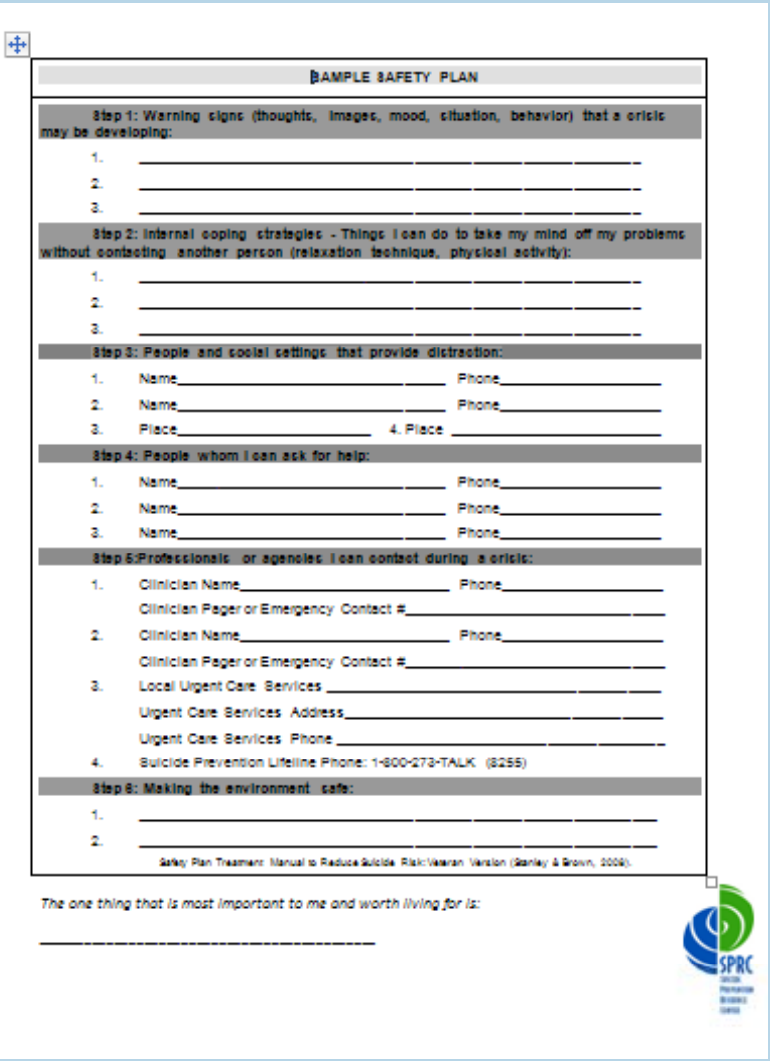
HOW SHOULD A SAFETY PLAN BE DONE?

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.

WICHE
Western Interstate Commission for Higher Education



SAMPLE SAFETY PLAN

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

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

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

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk:Veteran Version (Stanley & Brown, 2008).

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

_____

URL: http://www.sprc.org/library/SafetyPlanningGuide.pdf

Patient Management Tools

Crisis Support Plan

- Provider collaborates with Pt and support person
- Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed

Education Development Center, Inc. (2008). *Assessing and Managing Suicide Risk, Participant Manual*. Newton, MA: EDC, Inc.

Patient tracking

- Monitor key aspects of suicide risk at each visit

Jobes, D.A. (2006). *Managing suicidal risk: A collaborative approach.* New York, NY: Guilford Press.

Crisis Support Plan

CRISIS SUPPORT PLAN

FOR: _____ *DATE:* _____

I understand that suicidal 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 & ammunition
  2. Remove or lock up:
     - knives, razors, & other sharp objects
     - prescriptions & over-the-counter drugs (including vitamins & aspirin)
     - alcohol, illegal drugs & 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

URL: http://www.sprc.org/library/CrisisSupportPlan.pdf

ED Patient Engagement

❖ Brief Interventions

NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

Home | About | Find Interventions | Review Process | Submissions | Resources | ? Help | Contact

Home > Find Interventions > Find Results > Intervention Summary

Emergency Room Intervention for Adolescent Females

Date of Review: October 2007

Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts. A review of the literature suggests that factors related to treatment noncompliance following a suicide attempt include family discord, maternal psychopathology, attempter depression, and negative experiences with emergency room staff. The intervention consists of three components designed to improve the emergency room experience for the adolescent and family, thereby changing the family's conceptualization of the suicidal behavior and expectations about therapy. First, a 2-hour training is conducted separately with each of the six groups of staff working with adolescents who have attempted suicide. Second, the adolescents and their families watch a 20-minute videotape, filmed in Spanish and dubbed in English, that portrays the emergency room experience of two adolescents who have attempted suicide. Last, a bilingual crisis therapist delivers a brief family treatment in the emergency room.

Descriptive Info | Outcomes | Ratings | Study Populations | Studies/Materials | Contacts

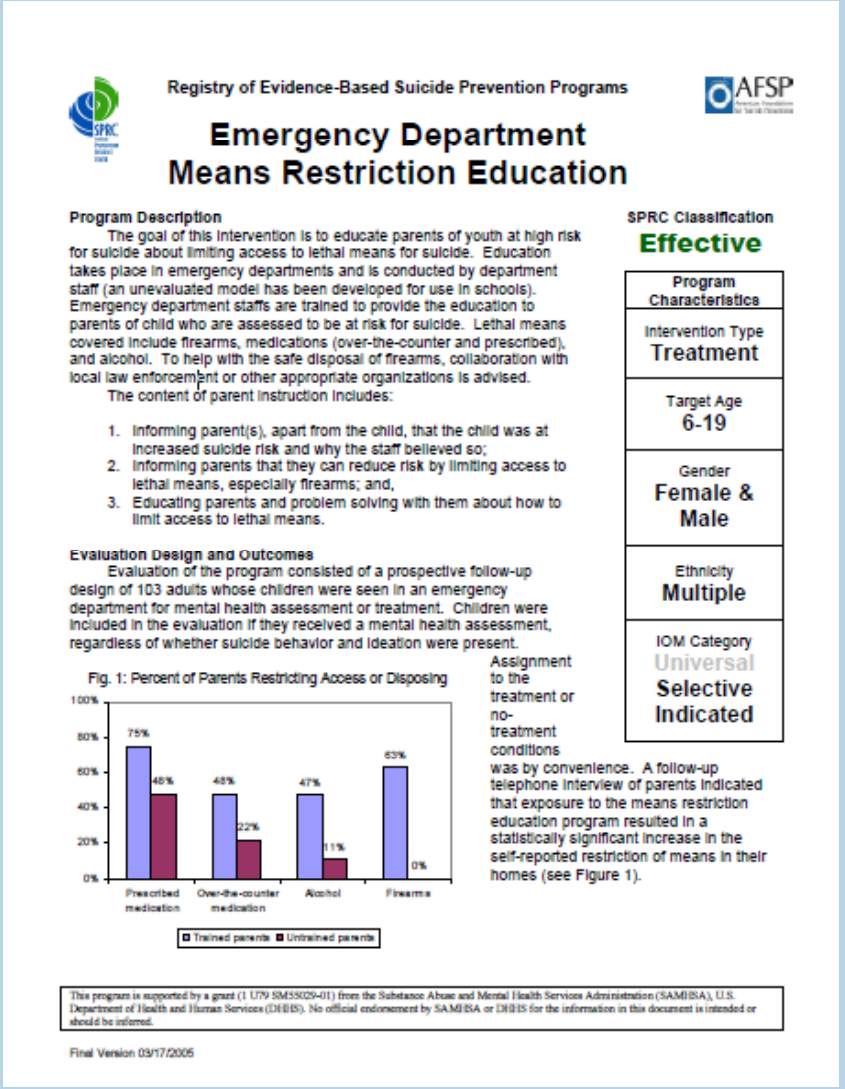
Descriptive Information

Topics	Mental health treatment
Areas of Interest	Suicide prevention
Outcomes	Outcome 1: Treatment adherence Outcome 2: Adolescent symptoms of depression Outcome 3: Adolescent suicidal ideation Outcome 4: Maternal symptoms of depression Outcome 5: Maternal attitudes toward treatment

URL: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=168

Emergency Departments

- **Brief Interventions**
  - **Motivational interviewing**
  - **Acute Cognitive Therapy***
  - **Safety planning; support planning**
  - **Means restriction ed.**



Registry of Evidence-Based Suicide Prevention Programs

Emergency Department Means Restriction Education

Program Description

The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools). Emergency department staffs are trained to provide the education to parents of child who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.

The content of parent instruction includes:

1. Informing parent(s), apart from the child, that the child was at increased suicide risk and why the staff believed so;
2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and,
3. Educating parents and problem solving with them about how to limit access to lethal means.

Evaluation Design and Outcomes

Evaluation of the program consisted of a prospective follow-up design of 103 adults whose children were seen in an emergency department for mental health assessment or treatment. Children were included in the evaluation if they received a mental health assessment, regardless of whether suicide behavior and ideation were present.

Fig. 1: Percent of Parents Restricting Access or Disposing

Assignment to the treatment or no-treatment conditions was by convenience. A follow-up telephone interview of parents indicated that exposure to the means restriction education program resulted in a statistically significant increase in the self-reported restriction of means in their homes (see Figure 1).

SPRC Classification

Effective

Program Characteristics	
Intervention Type	Treatment
Target Age	6-19
Gender	Female & Male
Ethnicity	Multiple
IOM Category	Universal Selective Indicated

This program is supported by a grant (1 U79 SM55029-01) from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). No official endorsement by SAMHSA or DHHS for the information in this document is intended or should be inferred.

Final Version 03/17/2005

* Catanese, A.A., John, M.S., di Battista, J., & Clarke, D.M. (2009). Acute cognitive therapy in reducing suicide risk following a presentation to an emergency department. *Behaviour Change, 26*(1), 16-26.

URL: http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf

Before discharging

Check that:

- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline **1-800-273-TALK (8255)** is available at any time, and understands the conditions that would warrant a return to the ED

Effective MH Therapies

- Lithium (bipolar disorder)
- Clozapine (schizophrenia)
- Dialectic Behavioral Therapy (Linehan)
  - ↓ in hospitalization and attempts for chronic suicidal behavior
- Brief intervention, cognitive-behavioral therapy (Brown)
  - 50% decrease in repeat attempts
  - ↓ depression
  - ↓ hopelessness
- Brief intervention, psychodynamic interpersonal therapy (Guthrie)

** Quality of the therapeutic relationship a key factor

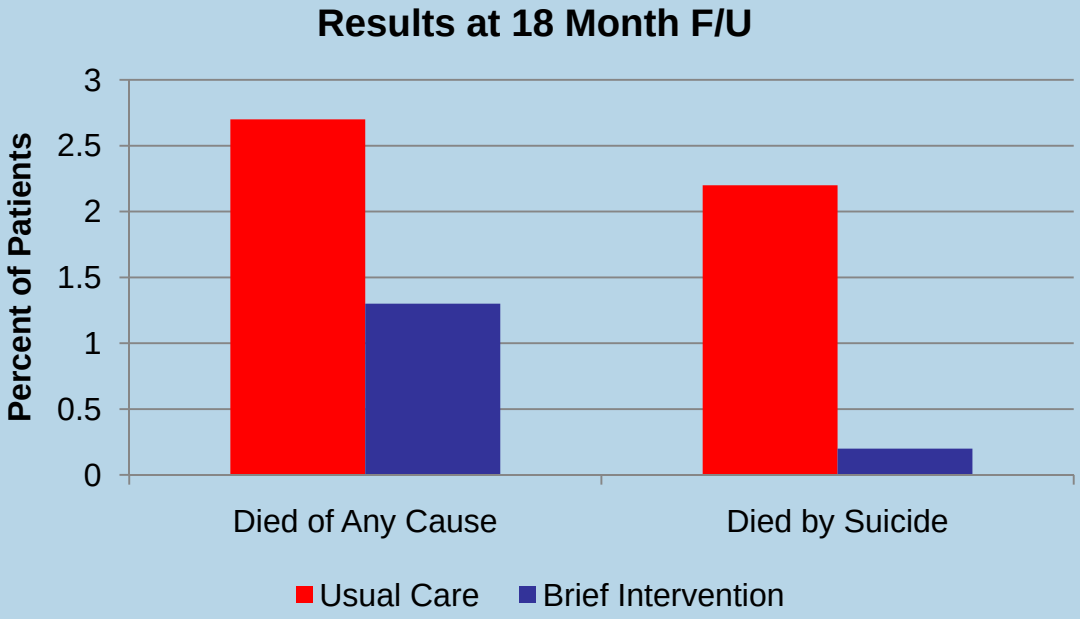
Goldsmith, S.E., Pellmar, T.C., Kleinman, A.M., & Bunney, W.E. (Eds.) (2002). *Reducing suicide: A national imperative.* Washington, DC: The National Academies Press.

Caring Follow-up Contact

- 605 Adults d/c from ED after attempt by o/d or poisoning (Vaiva et al., 2007)
  - Contact by phone one month after d/c ↓'d attempt by 45% during next year
- Patients who by 30 days after hospital d/c for suicide risk had dropped out of tx (Motto, 2001)
  - Randomized to receive f/u non-demanding post-cards
  - ↓ suicides for two years
- 394 randomized after a suicide attempt (Carter et al., 2005)
  - Those who rec'd 8 postcards during year ↓'d repeat attempt by 45%

Caring F/U Contact—ED

- **Brief intervention and f/u contact**
  - **Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)**
  - **Brief (1 hour) intervention as close to attempt as possible**
  - **9 F/u contacts (phone calls or visits) over 18 months**

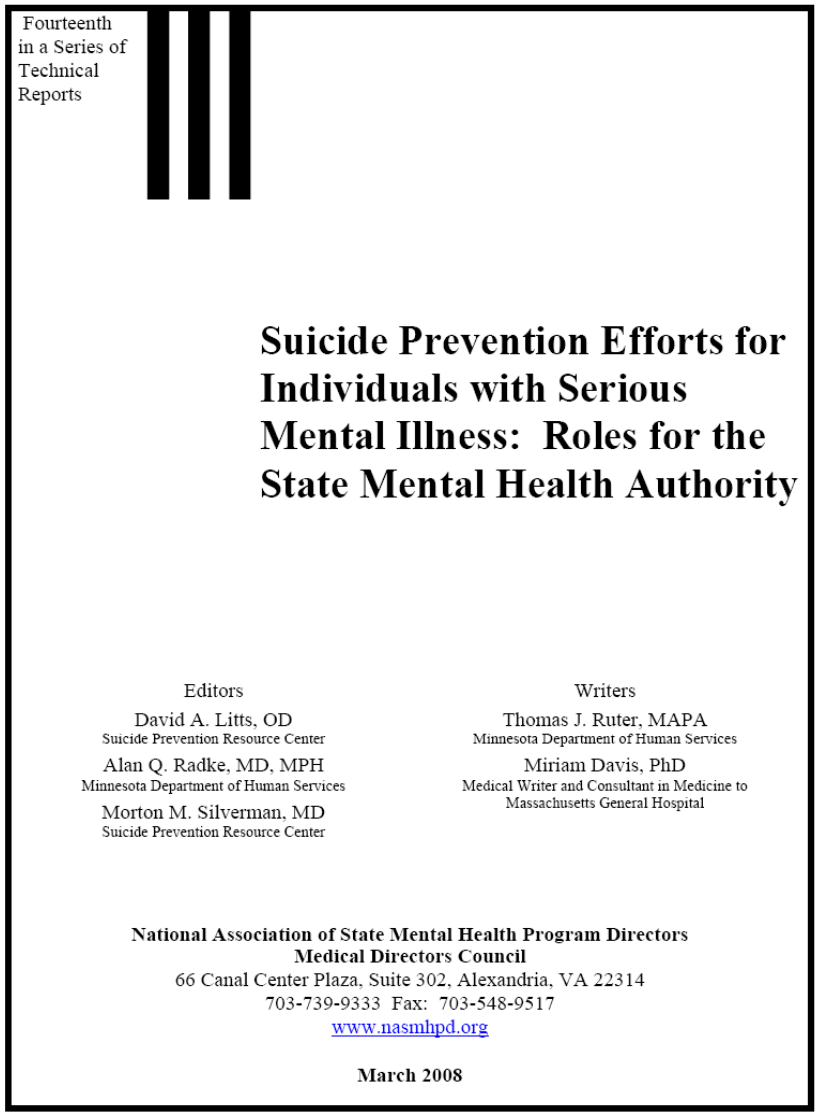


Fleischmann, A., Bertolote, J.M., Wasserman, D., DeLeo, D., Bolhari, J., Botega, N.J., DeSilva, D., Phillips, M., Vijayakumar, L., Schlebusch, L., & Thanh, H. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization, 86*(9), 703-709.

Crisis Lines

- Seriously suicidal callers reach out to crisis lines
- Effective outcomes– immediately following call and continuing weeks after
  - Decreased distress
  - Decreased hopelessness
  - Decreased psychological pain
  - Majority complete some or all of plans developed during calls
- Suicidal callers (11%) *spontaneously* reported the call prevented them from killing or hurting themselves
- Heightened outreach needed for suicidal callers
  - With a history of suicide attempt
  - With persistent intent to die at the end of the call

Kalafat, J., Gould, M.S., Munfakh, J.L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Non-suicidal crisis callers. *Suicide & Life-Threatening Behavior, 37*(3), 322-37.
Gould, M.S., Kalafat, J., Harrismunkfakh, J.L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior, 37*(3), 338-52.



Fourteenth in a Series of Technical Reports

Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority

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March 2008

Crisis Lines—New Roles

- Crisis hotlines can provide continuity of care for at risk persons outside of traditional BH system services
- Provide access to f/u in rural areas
- Monitor/track at risk persons after hospital discharge

Patient Education

Firearm Locking Devices

Which one is right for you?

LOK IT UP

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

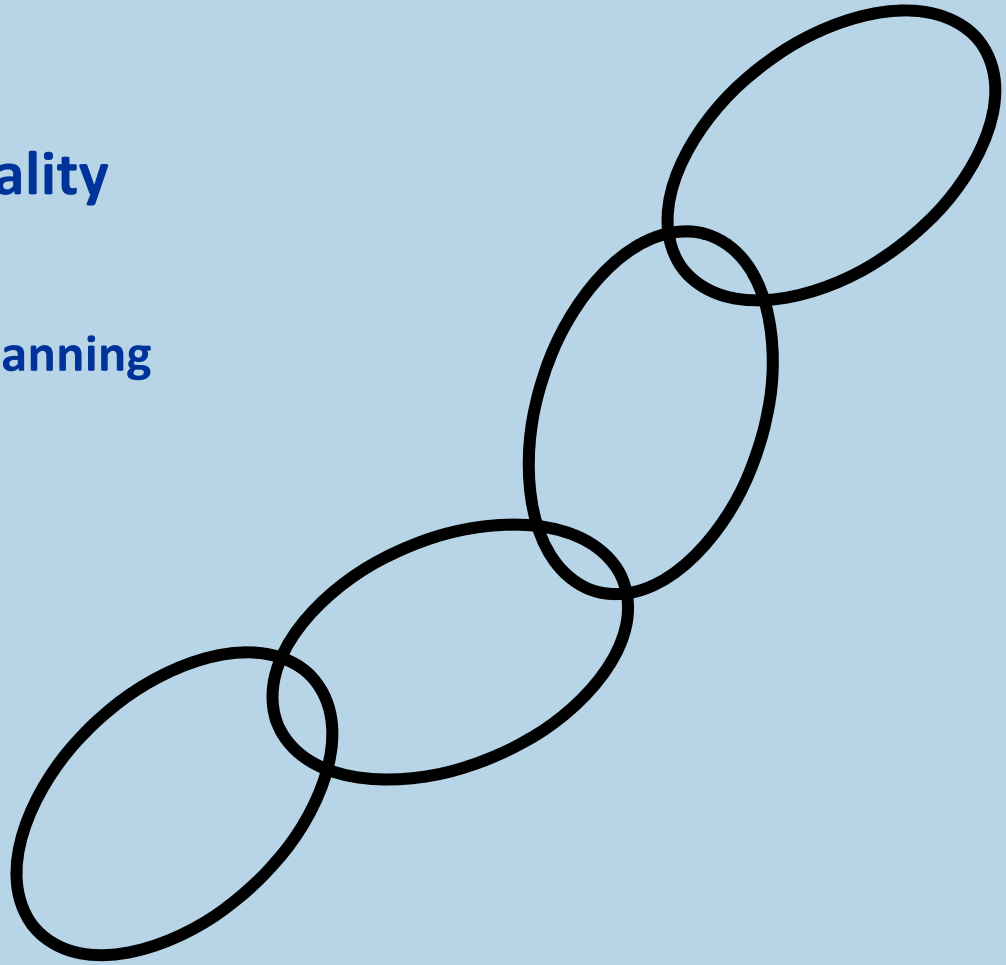
- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Sources:
http://depts.washington.edu/lokitup/
http://www.suicidepreventionlifeline.org/Materials/Default.aspx

Poll

Clinical Chain in Suicide Prevention

- Detecting potential risk
- Assessing risk
- Managing suicidality
  - Safety planning
  - Crisis support planning
  - Patient tracking
- Treatment
- F/U Contact



TRAINING IMPLICATIONS

Competency Chasm

- Large portions of mental health providers have had no formal training in the assessment and management of suicidal patients

Rudd, M.D., Cukrowicz, K.C., & Bryan, C.J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. *Training and Education in Professional Psychology, 2*(4), 219-228.

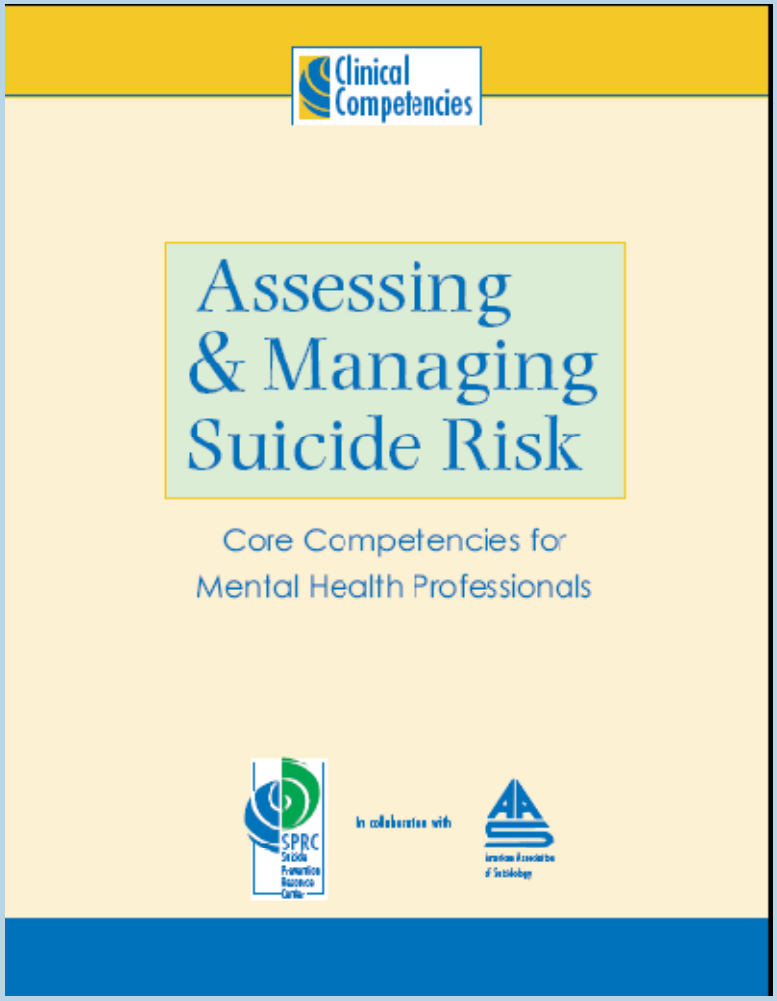
Competency Chasm

Chief Psychiatry Resident Survey

- Surveyed chief residents from all 181 U.S. residency programs (59% response rate)
- 19 of 25 topics were judged to require more attention by more than half of the respondents.

Melton, B.B. & Coverdale, J.H. (2009). What do we teach psychiatric residents about suicide? A national survey of chief residents. *Academic Psychiatry, 33*(1), 47-50.

Clinical Training for Mental Health Professionals



- One day workshop
- Developed by 9-person expert task force
- 24 Core competencies
- Skill demonstration through video of David Jobes, Ph.D.
- 175 Page Participant Manual with exhaustive bibliography
- 6.5 Hrs CE Credits
- ~100 Authorized faculty across the U.S.

Contact Isaiah Branton, AMSR Training Coordinator, SPRC Training Institute, at 202-572-3789 or ibranton@edc.org

Nationally Disseminated Curricula for MHPs

- ***Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.***
  - *A one-day workshop focusing on competencies*
  - http://www.sprc.org/traininginstitute/amsr/clincomp.asp
- ***QPRT: Suicide Risk Assessment and Management Training.***
  - **A 10 - hour course available either on-line or face-to-face**
  - **http://www.qprinstitute.com**
- ***Recognizing and Responding To Suicide Risk: Essential Skills for Clinicians.***
  - *Two-day advanced interactive training with post-workshop mentoring.*
  - **http://www.suicidology.org/web/guest/education-and-training/rrsr**
- ***Suicide Care: Aiding life alliances (Canada only)***
  - **One-day seminar on advanced clinical practices**
  - **http://www.livingworks.net/SC.php**

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