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
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.
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 judgment
- Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits

Moderate Risk
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
- Patient has good social support, intact judgment; psychiatric symptoms, if present, have been addressed
- Take action to prevent the plan

Low Risk
- Patient has thoughts of death only; no plan or behavior
- Evaluate for psychiatric disorders, stressors, and additional risk factors

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.

Assess suicide ideation and plans
- 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 suicidal thoughts?
- How strong are the thoughts of suicide?
- What is the worst you 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)?

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/pain, insomnia, command hallucinations, intoxication for children and adolescents: oppositionality and conduct problems.
- Precipitant stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationships, financial, or health status – real or anticipated).
- Chronic medical illness (e.g., NOS 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.

Screening: uncovering suicidality

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 transition 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. Rest 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 in 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. Intatitude/legation/agression. 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 answers to the transition question and any of the other six items is ‘Yes’, further intervention, including assessment by a mental health professional, is needed.

Endnotes:
1. SAFE pocket card. Suicide Prevention Resource Center & Mental Health Screening. (nd).

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www.wiche.edu/mentalhealth/

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

WICHE
Western Interstate Commission for Higher Education

Suicide Risk and Protective Factors

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/pain, insomnia, command hallucinations, intoxication for children and adolescents: oppositionality and conduct problems.
- Precipitant stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationships, financial, or health status – real or anticipated).
- Chronic medical illness (e.g., NOS 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

ACKNOWLEDGMENTS

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

http://www.sprc.org

SAMHSA

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)
- **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

- **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

- **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

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

(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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**Safety Planning Guide**

*A Quick Guide for Clinicians*

*may be used in conjunction with the “Safety Plan Template”*

**Safety Plan FAQs?**

**WHAT IS A SAFETY PLAN?**

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

**WHO SHOULD HAVE A SAFETY PLAN?**

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

**HOW SHOULD A SAFETY PLAN BE DONE?**

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

**IMPLEMENTING THE SAFETY PLAN**

There are 6 Steps involved in the development of a Safety Plan.
Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs
- Ask: “How will you know when the safety plan should be used?”
- Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient’s own words.

Step 2: Internal Coping Strategies
- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- Assess likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
- If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

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

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

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

Step 6: Making the Environment Safe
- Ask patients which means they would consider using during a suicidal crisis.
- Ask: “Do you own a firearm, such as a gun or rifle??” and “What other means do you have access to and may use to attempt to kill yourself?”
- Collaboratively identify ways to secure or limit access to lethal means: Ask: “How can we go about developing a plan to limit your access to these means?”
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 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 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: ____________________________