



SUICIDE PREVENTION PRIMER



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Module 1 – Prevalence and Comorbidity

Prevalence of Suicide



More than 38,000 deaths by suicide occur each year in the U.S.¹

Suicide rates across demographic groups are higher in rural counties than in urban counties.²

Suicide is the second leading cause of death in persons 25-34 years old in the U.S.

Suicide is the third leading cause of death in persons 15-24 years old in the U.S.

Suicide is the tenth leading cause of death (all ages) in the U.S.³

In Primary Care:⁴

Up to 90% of people who die by suicide had contact with their primary care provider (PCP) in the year prior to their death.

Up to 76% had contact with their PCP in the month prior to their suicide.

These same individuals were more than twice as likely to have seen their PCP than a mental health professional in the year and month prior to their suicide.

Comorbidity

Mental illness is neither a necessary nor sufficient condition for suicide, but is strongly associated with suicide:

More than 90% of people who die by suicide have a mental health disorder or substance abuse disorder, or both. (For youths under 16, that percentage is much lower, but still significant.)

More than 50% of suicides are associated with a major depressive episode.

At least 25% of suicides are associated with a substance abuse disorder, especially with alcohol abuse or dependence.

Ten percent of suicides are associated with a psychotic disorder such as schizophrenia.⁵

Aggressive treatment of psychiatric and substance use disorders is an important part of a comprehensive, primary-care based approach to suicide prevention.

Module 2 – Epidemiology

High Risk Populations:⁶

All demographic groups have some level of risk. It is important not to dismiss any individual as being free of risk because they belong to a low-risk demographic group. There are some demographic groups that are at relatively greater risk than others.

Adults

Aging white males have the highest suicide rate of all demographic groups. Though males in all age groups die by suicide four times as frequently as females, females attempt suicide much more frequently.⁷ Therefore, it is important to consider both males and females as targets for suicide prevention.

Adolescents⁸

Suicide rates rise rapidly during adolescence; rates are very low before age 14 and approach adult levels by age 19. Adolescents in general have high rates of suicide attempts; most are not fatal, but may be harbingers of future, lethal attempts. **Adolescent males complete suicide at a rate four times that of females; however, females have much higher rates of suicide attempts.** Hispanic females have the highest rates of suicide attempts among all youth. **The use of firearms accounts for approximately 60% of completed suicide among male adolescents.**



American Indians and Alaska Natives

For ages 10-39, Native American and Alaska Natives have the highest suicide rates of all races and ethnicities.⁹

Lesbian, Gay, Bisexual, and Transgendered Individuals

These groups have **disproportionately high rates of suicide attempts.**¹⁰ This is likely due to being victims of discrimination and having increased risk of social isolation and depression. **Whether LGBT youths perceive their parents as being accepting or rejecting appears to play a major role.**¹¹

Veterans

U.S. veterans often have multiple risk factors for suicide, including: male gender, elderly, diminished social support, medical and psychiatric conditions associated with suicide, and knowledge of and access to lethal means.¹² **Veterans in the general population are twice as likely to die by suicide as non-veterans.** Veterans who die by suicide are also more likely than non-veterans to own firearms and to use firearms to end their lives.¹³

Three-quarters of U.S. veterans receive their healthcare from primary care providers outside of the VA.¹⁴ Additionally, veterans frequently return to rural home towns far from military or veterans services.

Module 3 – Effective Prevention Strategies

Primary care providers can implement some of the most effective strategies for suicide prevention. These include training staff to identify and respond to warning signs of suicide, training providers to recognize and effectively treat depression, and taking measures to limit access to lethal means.¹⁵ Ideally, a primary care clinic would plan a comprehensive suicide prevention approach that includes all the strategies in the box below. We will discuss the strategies in five sections: staff training, screening and management of depression, screening for suicide risk, patient education, and restricting means for lethal self-harm. Assessing and managing patients at risk for suicide are discussed in Modules 4 and 5 of this Primer.

Suicide Prevention Strategies in Primary Care

- ▶ Training staff to recognize and respond to warning signs of suicide
- ▶ Universal screening for depression
- ▶ Aggressive treatment of depression
- ▶ Screening for suicidality in patients with key risk factors
- ▶ Educating patients about warning signs for suicide
- ▶ Restricting means for lethal self-harm

1. Training Staff to Recognize Warning Signs of Suicide

As workers in primary care settings interact with their patients they may observe many of the common warning signs for suicide, but only if they know what to look for.

Suicide prevention trainings that teach recognition and response to suicide warning signs can be provided to clinic staff as an in-service. In most areas trainers are available to teach these important skills. Training is also available online. (See the Resource List for some of the national vendors of these programs or www.sprc.org for the suicide prevention coordinator in your state.) After even minimal training, staff can observe warning signs of suicide in patients while talking with them on the phone or in the office. When they detect a warning sign, staff can immediately alert office clinicians who are prepared to ask the patient about suicidal ideation. Though these trainings require a modest investment of time and money, they may save lives.

Identify Warning Signs

People who are in danger of harming themselves may reach out to their primary care providers – sometimes directly, sometimes indirectly. **Rarely will patients immediately volunteer the information that they are thinking of harming themselves or ending their lives.** Be alert for warning signs that a patient may be at risk of imminent suicide. Warning signs include:¹⁶

Strongest Warning Signs – Take Immediate Action to Protect Person–Full Risk Assessment Warranted

- ▶ Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- ▶ Looking for ways to kill him/herself 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

Other warning signs of suicide

- ▶ Anxiety, agitation
- ▶ Insomnia or sleep disturbance
- ▶ Increased alcohol or drug use
- ▶ Purposelessness – no reason for living
- ▶ Hopelessness
- ▶ Withdrawing from friends, family and society
- ▶ Rage, uncontrolled anger, seeking revenge
- ▶ Acting reckless or engaging in risky activities, seemingly without thinking
- ▶ Dramatic mood changes
- ▶ Feeling trapped – like there's no way out



2. Screening For and Managing Depression

Training providers to recognize and treat depression increases prescription rates for antidepressants and decreases suicidal ideation and completed suicides in their patients.¹⁷

A key factor in reducing suicidal behaviors is the effective diagnosis and management of major depression. Tools for screening and managing depression within a primary care setting have been developed by The MacArthur Initiative on Depression and Primary Care and are available free of charge online. **A downloadable toolkit can be found at:**

<http://prevention.mt.gov/suicideprevention/13macarthurtoolkit.pdf>

Keep in mind that the best approach to treating major depressive disorder (as well as many other mental illnesses) uses a **combination of medication and psychotherapy whenever possible.**^{18,19,20}

3. Screening for Suicide Risk

Screening for suicidal thinking appears to be an effective and efficient means of identifying individuals at risk when conducted on people who have key risk factors. Patients in whom warning signs or other risk factors are detected should be asked about suicidal thoughts as well. In other words, **it is essential to screen for suicidality if there is any suspicion that a patient might be suicidal.** Using screening tools such as the 9-item Depression scale of the Patient Health Questionnaire (the PHQ-9) can be an effective and time-efficient way to screen patients. **The PHQ-9 is a self-report measure, and the final item screens specifically for the presence of suicidal ideation.** If screening tools such as the PHQ-9 are used, providers must be diligent about reviewing patient responses and specifically monitoring whether patients endorse items related to suicidality. The PHQ-9 may be downloaded free of charge as part of the MacArthur Initiative Toolkit discussed above.

Key Risk Factors

- ▶ Prior suicide attempt
- ▶ Major depression
- ▶ Substance use disorders

Other Risk Factors

- ▶ Other mental health or emotional problems
- ▶ Chronic pain
- ▶ Insomnia
- ▶ PTSD
- ▶ Traumatic Brain Injury (TBI)
- ▶ Events or recent losses leading to humiliation, shame or despair

Some or all of the Sample Questions in Module 4 for inquiring about thoughts of suicide can be used for informal screening of patients. **The key is to ask directly about thoughts of suicide or ending one's life as part of the screening. Practice asking the question(s) several times before trying it in a clinical situation.**

Sample screening question:

Sometimes people with your condition (or in your situation) feel like they don't want to live anymore, or sometimes they think about killing themselves. Have you been having any thoughts like these?

A positive response to this screening requires additional assessment (Module 4). More formal suicide screening instruments, such as paper and pencil questionnaires, are also available for use in primary settings or can be devised using the question above or questions in Module 4. These instruments should always be used as an augment to the clinical interview.

4. Educating Patients about Suicide Warning Signs

Just as we educate the public on the warning signs of strokes and heart attacks, we should provide basic information to the public on the warning signs of suicide. For severe warning signs, the appropriate response may be to call 911 or go to a hospital emergency department. For other situations it may be appropriate to call the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). Calls to this number are routed to a nearby certified crisis center with trained counselors. Counselors are available 24/7 and provide services in English or Spanish language. Veterans calling the line may press "1" and be directed to a crisis center run by the Department of Veterans Affairs. The service is free anywhere in the United States.

This Toolkit contains wallet cards for consumers that list the most recognizable warning signs and the number of the national crisis line. These cards are available free and can be provided to all primary care patients through the clinic. For information on ordering the wallet cards for consumers, see the "National Suicide Prevention Lifeline Resources" web address in the Resource List of the Toolkit.

5. Restricting Means of Lethal Self-Harm

Youths have increased rates of suicide and suicide attempts if they live in homes where guns and ammunition are present and available.²¹ Furthermore, when primary care providers recommend that parents restrict access of their children to guns and medications in the home, most of them do.²²

Primary care providers should counsel parents or guardians of children and adolescents to either remove firearms from the home entirely or securely lock guns and ammunition – in separate locations. Anecdotal evidence suggests young people frequently know where guns and keys to gun cabinets are kept, even though parents may think they do not. Resource materials accompanying this Toolkit aid in educating patients and parents.

The same recommendation applies to restricting access to potentially lethal prescription and over the counter (OTC) medications (including containers of more than 25 acetaminophen tablets), and alcohol.

Module 4 – Suicide Risk Assessment

About 3% of adults (and a much higher percentage of youths) are entertaining thoughts of suicide at any given time; however, there is no certain way to predict who will go on to attempt suicide.

Key components of a suicide risk assessment

1. Assess risk factors
2. Suicide Inquiry: thoughts/plan /intent/access to means
3. Assess protective factors
4. Clinical judgment
5. Document

1. Risk Factors

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.²⁵

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt.

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.²⁶

Individual Risk Factors

- ▶ Previous suicide attempt
- ▶ Major physical illnesses, especially with chronic pain
- ▶ Central nervous system disorders, including TBI
- ▶ Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and certain alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD). In youths: ADHD and conduct disorders (antisocial behavior, aggression, impulsivity)
- ▶ Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate
- ▶ Impulsive and/or aggressive tendencies
- ▶ History of trauma or abuse
- ▶ Family history of suicide
- ▶ Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated)

Social/Environmental Risk Factors

- ▶ Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- ▶ Lack of social support and increasing isolation
- ▶ Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- ▶ Local clusters of suicide that have a contagious influence
- ▶ Legal difficulties/contact with law enforcement/incarceration
- ▶ Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- ▶ Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)²⁷
- ▶ Exposure to, including through the media, and influence of others who have died by suicide

2. Suicide Inquiry

- ▶ If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted. Patients will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. **Ask patients directly about suicide and seek collateral information** from other clinicians, family members, friends, EMS personnel, police, and others.²⁸ How you ask the question affects the likelihood of getting a truthful response. **Use a non-judgmental, non-condescending, matter-of-fact approach.**
- ▶ **NEVER ask leading questions like:**
“You’re not thinking of suicide, are you?”
- ▶ **Practice questions several times prior to a clinical encounter;** asking about suicide for the first time may be harder than you think.



Thoughts of Suicide

Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Sample questions to uncover suicidal thinking:²⁹

- Sometimes, people in your situation (describe the situation) lose hope; I’m wondering if you may have lost hope, too?
- Have you ever thought things would be better if you were dead?
- With this much stress (or hopelessness) in your life, have you thought of hurting yourself?
- Have you ever thought about killing yourself?

► **Prior Attempt**

A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Sample question to assess prior attempt:

- Have you ever tried to kill yourself or attempt suicide?

- **If your questioning reveals no evidence of suicidal ideation, you may end the inquiry here and document the finding.**
- **If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you see and what the patient says.**
- **If your patient is having suicidal thoughts, ask specifically about frequency, duration, and intensity.**

Sample questions to assess suicidal ideation:

- 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 they?
- 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?

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.³⁰ **Ask whether the patient has a plan and, if so, get the specifics.**

Sample questions to assess suicidal planning:

- 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?

Intent

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient's reasons to die vs. reasons to live. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan.³¹ Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

Sample questions to assess 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 this 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 the 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?

Look for disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with adolescents, seek to confirm the patient's reports with information from a family member, spouse, or close friend. **Patients are more likely to tell a family member than a PCP that they are suicidal.**³² It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.³³

3. Protective Factors

While protective factors provide a poor counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment), **protective factors can mitigate risk in a person with moderate to low suicide risk.** Strengthening protective factors can be a part of safety planning, which will be discussed in Module 5.

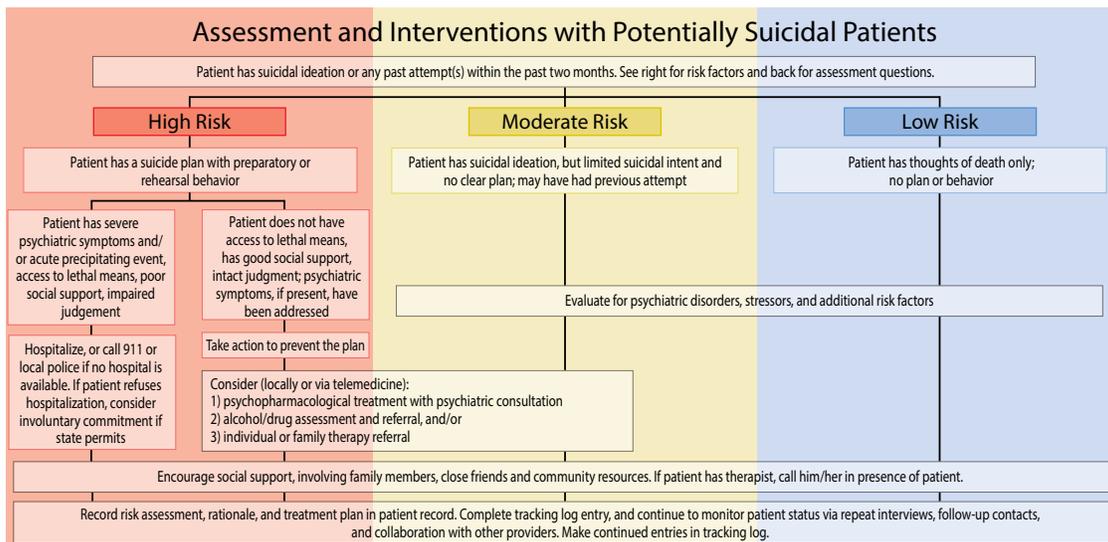
Some important protective factors are:³⁴

- ▶ Sense of responsibility to family
- ▶ Life satisfaction
- ▶ Social support; belongingness

- ▶ Coping skills
- ▶ Problem-solving skills
- ▶ Strong therapeutic relationship
- ▶ Reality testing ability
- ▶ Religious faith

4. Clinical Judgment of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients with thoughts of death or wanting to die, but without suicidal thoughts, intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can accurately predict which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for use by primary care professionals in assessing suicide risk and determining appropriate interventions (covered in Module 5). The copy of the pocket guide is also available as a separate document/tool for reference.



Suicide Risk and Protective Factors¹

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.

Module 5 – Intervention

Taking appropriate action following a suicide risk assessment is critical and may save lives. The decision tree presented in the previous module will help determine appropriate interventions with potentially suicidal patients.

1. Referral

For patients in the moderate and high risk categories and who have symptoms of a psychiatric disorder, consider a referral to a **psychiatrist for a medication evaluation**. (Telemedicine is increasingly becoming an option for accessing psychiatric services in rural locations. See the Resource List in the Patient Education Tools section of this toolkit for more information about establishing telemedicine services in your area.) For patients with **alcohol or substance use issues**, **consider a referral for alcohol/drug assessment and treatment**.

For patients in any risk category who are having significant thoughts of death or suicide, consider a referral for **individual or family therapy**. For all patients at increased risk, be sure to provide information about the **National Suicide Prevention Lifeline**, 1-800-273-TALK (8255). By calling the Lifeline, patients are connected to the nearest certified crisis center, usually within the state. Counselors at these centers are skilled in suicide crisis intervention and have access to information about many local resources for individuals contemplating suicide. The centers can also activate 911 rescue when indicated. The Lifeline offers free materials, including posters and pocket cards with the Lifeline number (www.suicidepreventionlifeline.org).

For patients in the high risk group who are an imminent danger to themselves, hospitalization is necessary. Patients can be **psychiatrically hospitalized** voluntarily or involuntarily. **Locate specific information about your state's involuntary treatment laws** and have this in the office as well as contact information and appropriate expectations for mental health professionals who are responsible for making these determinations in your area.

Criteria for involuntary commitment for 48-120 hours (depending on the state):

- ▶ Imminent danger to self or others
- ▶ Grave disability - Inability to provide for his/her own basic needs
- ▶ A psychiatric diagnosis (in most states)

Developing an office protocol for hospitalization

- ▶ Having an office protocol to follow once you have determined that a patient is high risk for suicide can ease the process of hospitalization. Some important questions to answer in developing your office protocol are:

- ▶ What are the laws in your state regarding involuntary psychiatric admission?
- ▶ Where will all necessary forms for hospitalizing suicidal patients be kept? (It is assumed that the patient's provider will fill out all necessary papers for hospitalization.)
- ▶ What emergency department is nearest to your clinic/facility?
- ▶ What transportation options are available for transporting suicidal patients to the nearest emergency department?
- ▶ Is there a mental health provider in your area who can assist in an involuntary psychiatric admission? How can you contact him/her?

See the full "Office Protocol" worksheet in this toolkit for more information about developing a protocol for your clinic.

2. PCP Intervention

Primary care providers, especially in rural areas, are invaluable in the treatment of potentially suicidal patients. Important interventions that can be carried out in a primary care office include treatment of psychiatric symptoms, including depression and severe anxiety, strengthening the support network, developing a safety plan, and helping the patient practice coping strategies in the plan.

Depression treatment

Most antidepressant prescriptions in the United States are written by primary care providers. Prescribing providers should monitor patients to ensure their symptoms are responding to treatment as expected. **Medication adherence** may be improved by addressing concerns regarding medication side effects when they are initially prescribed and as needed thereafter. Patients should also be informed that many antidepressant medications take 4-6 weeks before their onset of action; this information will help patients to continue taking the medication even if they do not initially notice any benefit. If the patient has been referred to a mental health provider, obtain a release of information from the patient and seek **ongoing collaboration** with that provider in order to coordinate care and to share information about the patient's mental health status. **Follow-up care** should be documented carefully in order to ensure that the patient continues to receive recommended services.

Studies indicate that a small portion of children, adolescents, and young adults may experience an increase in suicidal thoughts upon introduction of an antidepressant medication (SSRIs); therefore, close monitoring of suicide risk during the first months of antidepressant treatment is essential. The United States Food and Drug Administration (FDA) requires that manufacturers of antidepressant medications include a Black Box Warning on prescription labels warning consumers that the use of antidepressant medications may increase the risk of suicidal thoughts and behaviors in individuals ages 24 years and younger. The FDA's labeling recommends that providers balance these risks against clinical need when considering the use of antidepressants in children.³⁵ **The general consensus of experts has been that the benefits of prescribing antidepressants to adolescents and young adults for treatment of depression far outweighs the risk of inducing suicidal thoughts.** Studies have found no evidence that antidepressants increase the risk of suicidal thinking in adults over age 24.³⁶

Encourage a support network

Helping patients to identify and utilize a support network is a key component of suicide prevention. Patients may need assistance with identifying the supportive individuals in their lives. Having a predetermined list of supportive individuals and their contact information will increase the likelihood that the patient will seek help before or during a crisis. The support network may include friends, family members, clergy/minister, co-workers, a therapist, primary care doctor, or a suicide prevention hotline. Encouraging the patient to utilize their support network even when they are not feeling suicidal can help reduce the number of suicidal crises they experience.



Safety Planning

A safety plan (also referred to as a “crisis response plan”) is developed *collaboratively* with the patient and is designed to decrease the probability that the patient will attempt suicide in the near future. The plan is developed in six steps:³⁷

- ▶ Recognizing warning signs that a suicide crisis may be approaching
 - ▶ Identifying coping strategies that can be used by the patient to soothe the emotions and avert the crisis
 - ▶ Utilizing friends and family members that can be contacted in order to distract from suicidal thoughts and urges without discussing suicidal thoughts
- ▶ Contacting friends and family members who may help to resolve a crisis and with whom suicidal thoughts can be discussed
 - ▶ Contacting health professionals or agencies, including dialing the National Suicide Prevention Lifeline (800-273-TALK [8255]), 911, or going to a local hospital emergency room
 - ▶ Reducing access to lethal means

The first step in safety planning is to help patients become aware of their own triggers and the cues that signal that a suicidal crisis may be developing. For example, a patient might start to feel very angry, anxious, or alienated before a suicidal crisis. Patients who are familiar with their own personal triggers and cues can utilize coping strategies and may be able to prevent themselves from reaching a point where they feel out of control. To help patients determine their own unique triggers and cues you can ask patients such questions as:

- ▶ How do you feel in the hours or days before you first notice that you are feeling suicidal?
- ▶ What do you notice in your thoughts and feelings, or in your body?
- ▶ What are your triggers? What happens just before you start feeling or thinking this way?

If the patient is unable to answer these questions, family members and friends have likely noticed changes that occur before the patient enters into a crisis. With permission from the patient, you may be able to involve people close to the patient (their support network) in answering these questions.

The second step in safety planning is to help patients identify and practice coping strategies to help prevent or avert the development of a suicidal crisis. Coping techniques have different effects on different people; therefore, the provider should help the patient think through what really helps him or her feel better. Some examples of coping techniques are relaxation techniques, physical

activity, moving away from a stressor or stressful person, and distraction techniques. Some sample questions to get patients thinking about effective coping techniques are:

- ▶ What relaxes you?
- ▶ When was the last time you felt relaxed or peaceful? What were you doing?
- ▶ Are there any things that you do that help you take your mind off thinking about death and dying?
- ▶ Who do you spend time with that makes you feel good?

Once coping strategies are identified, they must be practiced. Practicing these strategies when the patient is calm helps make them more automatic for the patient and thus easier to employ when the patient is distressed.

The last step in safety planning addresses the issue of access to lethal means. This step is left for last because it is the hardest step for many patients, and perhaps the most critical. **The stronger the collaboration between the provider and the patient, the greater the likelihood the patient will relinquish his or her access to lethal means.** If the patient has described a specific plan to use lethal means or has experimented with lethal means (e.g., deliberate self-cutting) it is essential to inquire about whether those specific means are available and to eliminate access to them. Lethal means may include guns, ammunition, medications (prescription as well as over-the-counter), knives, razors, etc. It is important to help the patient identify whom they will entrust with these items until they can be safely returned. With the patient's permission, contact family members or other persons within the patient's support system in order to assist with limiting access.³⁸

As the plan is developed write each step on a paper the patient can take home. When it is clear the patient understands the plan, the patient should be able to commit to their clinician they will follow the plan, in sequence. **Rehearse with the patient how he/she will use the plan.** Where will the plan be kept? How will he/she know when to take the first step? What comes next? When implementing the plan, the patient builds coping skills and develops confidence that they can manage future crises when they occur. Patients should also have a supportive friend or family member who is aware that the patient is at risk for suicide and who is willing to help him or her follow the crisis plan. Both the patient and the support person should know the number for the Suicide Prevention Lifeline – 1-800-273-TALK (8255).

A pocket card developed by the Veterans Administration to guide the development of a safety plan is provided with this Toolkit and can be downloaded from the Department of Veterans Affairs at:

<http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf>

NOTE: No-suicide contracts have been found to be ineffective in preventing suicidal behavior. It is more important to make a plan with your suicidal patients concerning what they will do in the event that they feel suicidal and are worried about their safety, rather than what they won't do.

3. Documentation and Follow-up Care

Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist). In the case of hospitalization, it will be necessary to provide this information to the admitting facility. Thorough documentation will help ensure that the patient receives appropriate referrals and follow up.

Close follow up with a potentially suicidal patient is critical. Studies show that even very simple follow-up contacts with suicidal patients reduce their risk of repeat attempts and death. Every

follow up contact is an opportunity to **assess for recurrent or increased suicidality**. Flagging the records of patients at risk for suicide with color coded labels, as is frequently done for allergies or certain chronic diseases, may help insure suicide risk is reassessed on follow up visits.

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