

# Caring for Adult Patients with Suicide Risk



A Consensus Guide  
for Emergency  
Departments



***Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*** (the full and quick guide versions) is based upon the best information available at the time of publication. It is designed to provide information and assist decision-making and act as a guideline only. It is not intended to define a standard of care and should not be construed as one. Neither should it be interpreted as prescribing an exclusive course of management. Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every health care professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

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**“[I]t is important to recognize that suicidal experiences exist on a continuum. Some people have seriously considered suicide, some have made plans that were not carried out, and some have attempted suicide. Of the millions of people who have lived through a suicidal crisis, the vast majority recover.”**

*—The Way Forward: Pathways to Hope, Recovery, and  
Wellness with Insights from Lived Experience*



## 1.1 Introduction

*Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments* (the ED Guide) is designed to assist emergency department (ED) providers with decisions about the care and discharge of patients with suicide risk. Our main goal in developing and disseminating this guide is to improve patient outcomes after discharge.

Studies indicate that the risk of a suicide attempt or death is highest within the first 30 days after discharge from an ED or inpatient psychiatric unit. Yet for many reasons, up to 70 percent of patients who leave the ED after a suicide attempt never attend their first outpatient appointment (Knesper, 2010).

ED providers are in a unique position to improve outcomes and facilitate a safer discharge for patients with suicide risk by providing them with brief interventions, onsite mental health consultations when appropriate, and linkages to sources of follow-up care. Research suggests that ED-based interventions could reduce annual deaths from suicide by 20 percent (National Action Alliance for Suicide Prevention: Research Prioritization Task Force, 2014).

### WHAT'S INSIDE:

- » Key components of caring for adult patients with suicide risk in EDs
- » **Decision Support Tool** → Section 2
- » **ED-based interventions** → Section 3
- » **Discharge planning checklist** → Section 4
- » **Patient-centered care** guidelines → Section 5
- » Information on related topics, such as documentation, working with crisis centers, and intoxication and substance use disorders
- » Tools and resources to support implementation of the ED Guide

**The ED Guide provides information about decision support, brief interventions, and discharge planning with adult patients who have been identified as having some risk of suicide. It can also help answer the following questions:**

- » **Can this patient be discharged or is further evaluation needed?**
- » **How can I intervene while this patient is in the ED?**
- » **What will make this patient safer after leaving the ED?**

A [Quick Guide](#) version of this document is in Appendix A. We recommend providers read the complete version before using the Quick Guide.

A comprehensive set of external resources, referenced in this guide, can be accessed by clicking on the blue text or viewing the list of resources in Appendix B.

The ED Guide was written for health care professionals (e.g., physicians, nurses, mental health specialists, and other practitioners) who provide clinical care in EDs, although some topics may be appropriate for ED and hospital administrators. The authors recognize that clinical roles vary across EDs, therefore institutions can adapt the recommendations given here to their own organizational structures. In this guide, all relevant health care

professionals are referred to as “provider.” All clinical information provided in this guide is meant to complement, not replace, provider judgment.

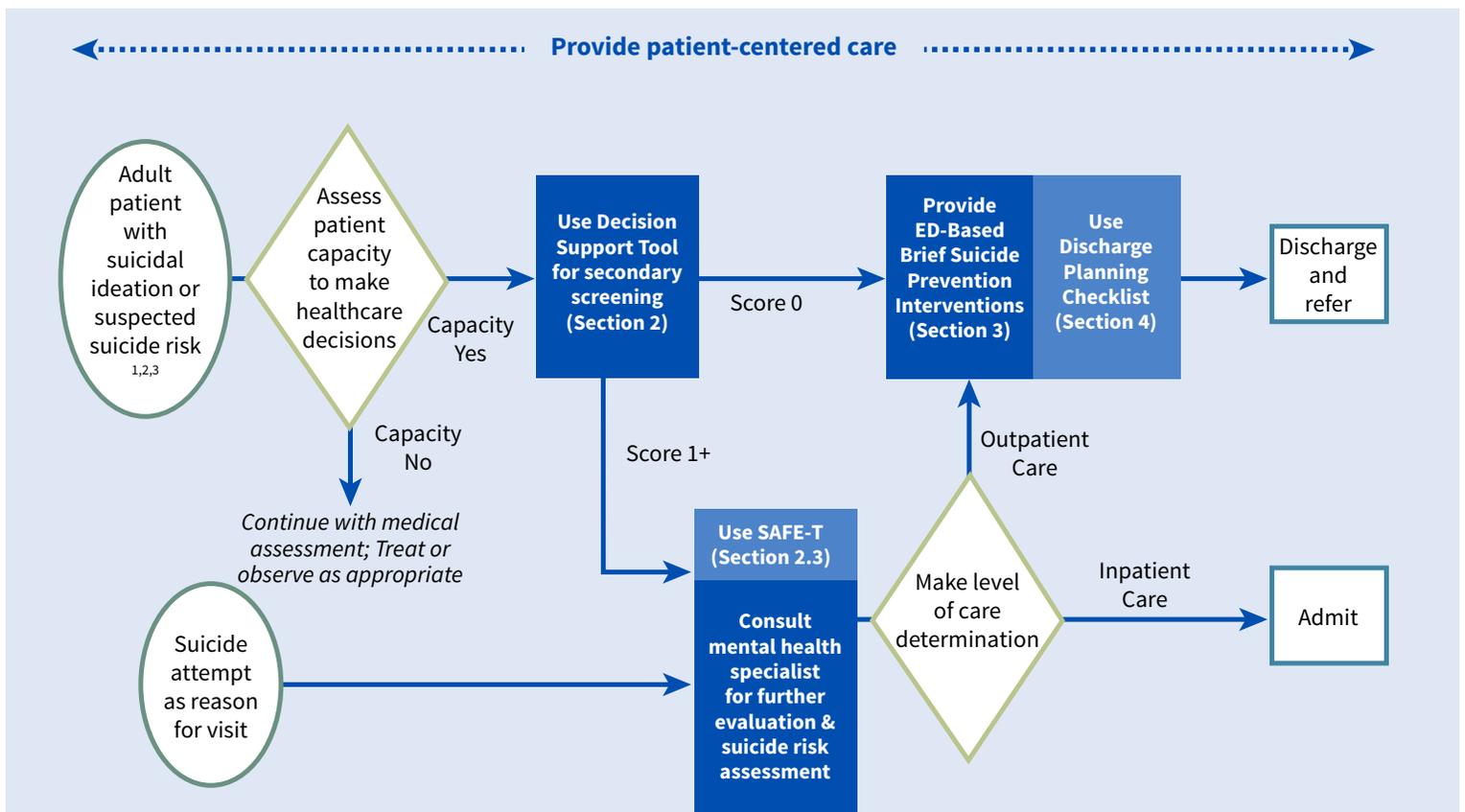
The ED Guide was developed with extensive input from a [consensus panel of experts](#) from emergency medicine and suicide prevention organizations, including people who lived through suicidal experiences (i.e., “lived experience.”). Recommendations in the ED Guide were developed using an iterative process that included both reviews of the literature and expert panel consensus. For more on how the ED Guide was developed, see the companion paper, [Technical Report: Developing Caring for Adult Patients at Risk of Suicide: A Consensus Guide for Emergency Departments](#).



## 1.2 Key Components of Caring for Adult Patients with Suicide Risk in EDs

Figure 1 illustrates one process for the care and discharge of adult patients with suicide risk from EDs. This process emphasizes the actions and decisions that are most relevant for the discharge of patients in lower-risk categories. The items shaded blue are consensus-based tools and resources provided in this guide. Broader topics, such as the utility of universal screening or appropriate medical screening of mental health patients in EDs, are available from other authoritative sources and may be consulted by EDs developing suicide care protocols.

**Figure 1. Process for Care and Discharge of Patients with Suicide Risk for EDs**



<sup>1</sup> Identification of individuals at risk may occur as a result of (1) patient disclosure; (2) reports by family, friends, or other collaterals; (3) individual indicators such as depression, substance use or debilitating illness; or (4) primary screening.

<sup>2</sup> See Appendix C for information on primary screening.

<sup>3</sup> Consult your ED's policies to determine how medical clearance applies to this diagram.



## 2.1 About the Decision Support Tool

### What is the Decision Support Tool?

The Decision Support Tool is a secondary screening instrument developed by expert consensus to help ED providers make decisions about the care and discharge of adult patients with suicide risk. It indicates whether a patient's health and safety needs may be met in the outpatient environment following a brief ED-based intervention or whether evaluation from a mental health specialist may be needed first. The Decision Support Tool is designed for use with adult patients who have been identified as having suicide risk (i.e., suicidal ideation or suspected suicide risk) and who have the capacity to make health care decisions. Identification of these patients may occur as a result of (1) patient disclosure; (2) reports by family, friends, police, or other collaterals; (3) individual patient presentations, such as depression, substance use, or debilitating illness; or (4) primary screening. The Decision Support Tool does not replace a provider's best judgment or experience.

### Who should use the Decision Support Tool?

Clinical staffing roles vary in EDs, and the Decision Support Tool may be used by ED physicians, nurses, and mental health specialists.

### How does the Decision Support Tool differ from primary screening and suicide risk assessment tools?

The Decision Support Tool is a *secondary screening tool* that helps providers with practical decisions, such as “Can I make a disposition decision without consulting a mental health specialist?” and “Is it appropriate to discharge this patient after providing a brief ED-based intervention?”

In the ED, *primary screening tools* are used to detect possible suicide risk in every ED patient (universal screening) or in patients belonging to groups shown to be at a higher-than-average risk of suicide (selective screening), such as patients with depression. Primary screening does not uncover the nature of suicide risk that may be present.

A *comprehensive suicide risk assessment* is used to collect detailed information about a patient's suicide risk (e.g., risk and protective factors), to detect the possibility of imminent risk, and to inform treatment decisions.

Table 1 describes the relationships among these different tools. For more information on Suicide Risk Assessment see Appendix C.

**The Decision Support Tool is a secondary screening tool that helps providers with practical decisions such as, “Can I make a disposition decision without consulting a mental health specialist?”**



**Table 1. Using Primary, Secondary, and Risk Assessment Tools in the ED**

TYPE OF TOOL	USED WITH	TELLS YOU	LOCATION IN THE ED GUIDE
<b>Primary Screening Tool (universal or selective)</b>	Every ED patient or patients with known risk factors	Whether suicide risk is present or absent	Appendix C
<b>Secondary Screening Tool (Decision Support Tool)</b>	Patients with some suicide risk as identified through universal screening, patient disclosure, or other indicators	Whether discharge following ED-based interventions may be appropriate or further assessment by a mental health specialist is needed to make a disposition determination	Section 2.2
<b>Comprehensive Suicide Risk Assessment</b>	Patients with suicide risk who score positive ( $\geq 1$ ) on the Decision Support Tool  Note: If resources permit, a suicide risk assessment may be used with any patient with suicide risk.	Information about a patient's risk and protective factors, immediate danger, and treatment needs	Appendix C

### How does the Decision Support Tool inform inpatient admission decisions?

The Decision Support Tool indicates which patients with suicide risk may need a mental health evaluation (which should include a suicide risk assessment) during the ED visit. Informed decisions about admission combine the results of a comprehensive suicide risk assessment, the provider's clinical judgment, input from the patient and his or her social supports, input from the team of professionals caring for the patient, and the institution's policies and procedures for suicide evaluation and management.



**Primary screening, secondary screening, and suicide risk assessment are distinct but related practices designed to help providers understand the nature of their patients' suicide risk.**



## 2.2 Using the Decision Support Tool

The Decision Support Tool is a six-item, yes/no response tool (Figure 2). The first item, with no number, is unscored and is designed to confirm that suicide risk exists and to transition into the topic of suicide. Items numbered 1 through 6 are scored. Step-by-step instructions follow the tool.

### Decision Support Tool

Transition question: Confirm Suicidal Ideation <i>Have you had recent thoughts of killing yourself?</i> <i>Is there other evidence of suicidal thoughts, such as reports from family or friends?</i> <b>Not part of scoring.</b>		Y	
1	Thoughts of carrying out a plan <i>Recently, have you been thinking about how you might kill yourself?</i> <b>If yes, consider the immediate safety needs of the patient.</b>	Y	N
2	Suicide intent <i>Do you have any intention of killing yourself?</i>	Y	N
3	Past suicide attempt <i>Have you ever tried to kill yourself?</i>	Y	N
4	Significant mental health condition <i>Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?</i>	Y	N
5	Substance use disorder <i>Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?</i>	Y	N
6	Irritability/agitation/aggression <i>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?</i>	Y	N

#### STEP 1: Inform the patient.

Tell your patient that you will be asking a few questions to help you consider next steps.

#### STEP 2: Review the patient's suicidal ideation.

If this is your first interaction with the patient, begin by confirming that he or she has suicidal ideation. Ask the patient directly<sup>1</sup> or state your understanding of the nature of his or her suicide risk. This will facilitate a smooth transition to item number 1 (plan).

<sup>1</sup> If the patient says that he or she does not have suicidal ideation and there is no evidence to suggest that he or she may be at risk, this tool is not needed. Review the reasons why he or she was identified as having suicide risk.

**Use available data (e.g., patient observation, medical records) and consult with available collaterals (e.g., friends, family members, and outpatient providers) to corroborate the patient's report.**

### **STEP 3: Ask questions for items 1 through 6.**

The tool includes example questions to ask. Use an open, nonjudgmental style to overcome social response bias and encourage honest answers.

### **STEP 4: Review other available information.**

Use available data (e.g., patient observation, medical records) and consult with available collaterals (e.g., friends, family members, and outpatient providers) to corroborate the patient's report. Let the patient know you would like to contact his or her collaterals, and that the visit may be delayed while you are awaiting corroborating information.

#### **Can ED providers share patient health information with others?**

**Yes. For patients with concerning risk factors who minimize or deny suicide risk, it may be life-saving to contact collaterals for corroborating information.** First request the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines to consent after reasonable attempts have been made to obtain permission, there are circumstances in which collaterals may be contacted without the patient's permission. HIPAA permits such contacts when the clinician, in good faith, believes that the patient may be a danger to self or others.

» For more information see [Appendix D: Sharing Patient Health Information](#)

### **STEP 5: Check the score.**

A "yes" response is equal to 1. Total the number of "yes" responses on items 1–6.<sup>2</sup>

**Score 0.** If the response to every item (1–6) is "no," discharge may be appropriate following the provision of one or more ED-based brief suicide prevention interventions.<sup>3</sup> These are described in Section 3, ED-Based Brief Suicide Prevention Interventions.

**Score ≥1.** If the responses to the transition question (i.e., suicidal ideation) **and** any item 1–6 are "yes," consider consulting a mental health specialist<sup>4</sup> during the ED visit for further evaluation, including a comprehensive suicide risk assessment. Consider the immediate safety needs of the patient as you determine next steps. If the evaluation points to discharge as the recommended disposition, provide the ED-based brief suicide prevention interventions listed in Section 3.

### **STEP 6: Tell the patient what happens next.**

Explain next steps. For example:

**Score 0.** Say that you are considering discharging him or her to an outpatient care setting and would first like to provide a brief intervention. Describe the intervention you plan to use. Ask for the patient's feedback on this plan and discuss any reservations he or she may have about it.

**Score ≥1.** Say that you would like him or her to see a specialist for further evaluation as part of the ED visit. Explain that the specialist may repeat some of the questions that you've

<sup>2</sup> Suicidal ideation is an unscored item and should not be included in the scoring.

<sup>3</sup> In settings where a mental health specialist is readily available, consider referring all patients with any suicidal ideation or suspected suicide risk to the mental health specialist for further evaluation, including suicide risk assessment.

<sup>4</sup> The availability of mental health specialists varies in EDs. Some hospitals use telepsychiatry to provide this service (see Section 6.3).

already asked. Be familiar with the type of suicide risk assessment used in the mental health specialist's evaluation.

Involve the patient in the decision-making process. Research suggests that shared decision making lowers patient stress, gives patients a sense of control, and leads to better outcomes (Durand et al., 2014; Hamann, Leucht, & Kissling, 2003; Priebe et al., 2007; Loh et al., 2007). Patients with suicide risk report higher satisfaction when they are involved in decisions about their care.

Provide a wait time *estimate*. If wait times are significant, ask what will increase the patient's comfort.



## 2.3 Comprehensive Suicide Risk Assessment

Mental health evaluations conducted during the ED visit should include a comprehensive suicide risk assessment that goes beyond the secondary screening performed using the Decision Support Tool. The purposes of the risk assessment are to determine whether the patient is in immediate danger and to make decisions about treatment. It is also an opportunity to form a therapeutic relationship with the patient.

With ED patients whose primary diagnosis or primary complaint is an emotional or behavioral disorder, the Joint Commission's [National Patient Safety Goal 15.01.01](#) calls for a comprehensive risk assessment that identifies patient and environmental characteristics that may increase or decrease his or her suicide risk. The [SAFE-T Guide](#) (Suicide Assessment Five-step Evaluation and Triage), developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), may be used in conjunction with the Decision Support Tool to meet this objective (Fowler, 2012). [Suicide Safe](#): the suicide prevention App for health care providers is also available free from SAMHSA. To facilitate adoption of screening and risk assessment protocols, EDs can post [suicide prevention education materials](#) in clearly visible locations. Posting these materials increases provider knowledge of suicide risk and skills in managing suicidal patients (Currier, 2012). More information on comprehensive suicide risk assessment and ways to improve your institution's current risk assessment practices are provided in Appendix C.



**Although precisely who may die by suicide cannot be known, suicide risk assessment is a valuable clinical tool because it can ensure that those requiring more services get the help they need. In other words, it is not necessary to have a crystal ball. If the assessment information shows that a client fits the profile of an individual at significant risk, appropriate actions should be taken.**

—SAMHSA Treatment Improvement Protocol (TIP) 50

# 3

## ED-Based Brief Suicide Prevention Interventions

This section provides a menu of ED-based brief suicide prevention interventions<sup>5</sup> that may be performed in an ED by specialist or non-specialist ED providers.<sup>6</sup> The interventions are geared toward patients who will be discharged and given prior to a patient’s discharge.

Brief interventions can help decrease suicide risk, help patients manage suicide-related symptoms after discharge, and promote continued engagement with treatment. This section provides a short description, action steps, and related resources for each of the ED-based brief suicide prevention interventions listed in Table 2.

When appropriate, it is recommended that ED providers bundle these interventions, providing them jointly rather than individually. When implemented as a group, the interventions have a greater effect on outcomes than when presented individually (Hampton, 2010). Resources for implementing these interventions may vary in different hospitals and communities. When choosing interventions, identify the combination of strategies that best fit your patients’ clinical needs and your facility’s resources.

**Table 2 . ED-Based Brief Suicide Prevention Interventions**

Incorporate <a href="#">crisis center/hotline information</a> into any intervention selected <sup>(3)</sup>	
→	Brief Patient Education <sup>(1)</sup>
→	Safety Planning <sup>(1,2)</sup>
→	Lethal Means Counseling <sup>(2)</sup>
→	Rapid Referral <sup>(1)</sup>
→	Caring Contacts <sup>(1)</sup>
Recommended by: (1) ED Consensus Panel, (2) Suicide Prevention Resource Center <a href="#">Best Practices Registry</a> , (3) The Joint Commission <a href="#">guidance</a> on preventing suicide in emergency departments	

As this chart suggests, including crisis center/hotline information (e.g., give the patient the hotline number with information about the service) with every brief intervention provided is essential. Whenever possible incorporate motivational interviewing techniques (Britton, 2012), shared decision making, and peer support services. The patient and provider should work together to make decisions about intervention, discharge planning, and next steps. View these interventions as an opportunity to form a therapeutic relationship with the patient.

5 This guide does not cover pharmacologic or psychotherapy-based treatments. For more information on these, see the following resources: [VA/DoD Clinical Practice Guideline for Assessment and Management of Patients At Risk for Suicide](#), American Psychiatric Association [Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors](#), and American Association for Emergency Psychiatry [Treatment of Behavioral Emergencies](#) Guidelines.

6 As with other sections in this Guide, ED-based brief suicide prevention interventions may be provided by ED physicians, nurses, or mental health specialists.



### 3.1 Brief Patient Education

The Brief Patient Education intervention helps the patient understand his or her condition and treatment options and may facilitate patient and family adherence to the follow-up plan. As patients with suicide risk often do not attend follow-up mental health appointments after discharge, the ED visit may be the best—or only—opportunity to provide these patients and their family members with important suicide prevention information. Written materials may complement, but not replace, direct, one-on-one communication between provider and patient.

#### Action Steps

- » Ask the patient for permission to include his or her family members, close friends, and/or a certified peer specialist in the intervention. A peer specialist is a person with lived experience who is trained and certified to provide services to others.
- » Discuss the following:
  - ✓ Patient's current [condition](#)
  - ✓ [Risk and protective factors](#)
  - ✓ Type of treatment and treatment options
  - ✓ Medications and adherence
  - ✓ Substance use
  - ✓ Home care
  - ✓ Lethal means restriction
  - ✓ Follow-up recommendations
  - ✓ Signs of a worsening condition (e.g., increased frequency of suicidal thoughts, increased trouble sleeping) and how to respond (e.g., ask friends or family to help keep you safe, remove access to lethal means).
- » Communicate that treatment is effective. For example, tell the patient, “Research shows that mental health treatment helps people recover from suicidal thoughts or feelings (Brown et al., 2005; Linehan et al., 2006). If you follow-up with treatment, you will feel better.”
- » Explain when a return visit to the ED is warranted.
- » Provide verbal and written information identifying the local crisis center or [crisis line](#). Assist the patient in making a call to the crisis center before leaving the ED.
- » Use [teach-back techniques](#) to ensure the patient and his or her family understand the information provided. For example:
  - “We talked about important next steps. Can you tell me what you’ll do when you get home?”
  - “I want to be sure I explained everything clearly. Can you please explain it back to me in your own words?”
- » Show empathy and respect for patient autonomy and privacy. The goal of the Brief Patient Education intervention is to instill hope of recovery and to reduce stigma and shame.
- » Provide written educational materials, including a list of community resources.



**Communicate that treatment is effective. For example, tell the patient, “Research shows that mental health treatment helps people recover from suicidal thoughts or feelings.”**

### Patient Education Resources

- » [Suicide in America](#)—FAQs brochure, National Institute of Mental Health
- » [NIMH Publications](#)—Webpage of National Institute of Mental Health; order free brochures and booklets on depression and other topics
- » [Treatments and Services](#)—Informational webpage, National Alliance on Mental Illness
- » [After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department](#)—Brochure, Substance Abuse and Mental Health Services Administration, also available in Spanish.
- » [After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department](#)—Brochure, Substance Abuse and Mental Health Services Administration, also available in Spanish.
- » [With Help Comes Hope](#)—Support webpage for persons living with suicidal thoughts and suicide attempts

**“It has long been recognized that the absence of hope (i.e., hopelessness) is a major risk factor for suicidal thinking and behavior. More recently, studies have found that hope and optimism can help guard against suicide. Hope is also linked to self-esteem and self-efficacy, as well as improved problem-solving. The pursuit of meaning can help a person cope with pain and suffering . . . When we find hope, we are less suicidal. Hope is a key protective factor against suicidal behavior, and it is a catalyst for the recovery process.”**

—*The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience*



## 3.2 Safety Planning

In the Safety Planning intervention, the provider works with the patient to develop a list of coping strategies and resources that he or she can use before or during suicidal crises. The plan is brief, in the patient’s own words, and easy to read. Topics addressed in most safety plans include:

- » The patient’s individual warning signs
- » Internal coping strategies
- » Ways to distract oneself from the crisis
- » Family members or friends who can provide support
- » Professionals and agencies to contact for help
- » Ways to make the environment safe

Safety plans may be done on paper or using a mobile phone app—if the patient has a mobile device and is comfortable using it for this purpose (see Safety Planning Resources). The Safety Planning Intervention was developed by Barbara Stanley, PhD, and Gregory K. Brown, PhD.

**Important**

Safety planning should not be confused with contracts for safety or no-suicide contracts. There is no evidence that these contracts are effective, and they can provide a false sense of security (Rudd, Mandrusiak, & Joiner, 2006; Stanley & Brown, 2012).

**Action Steps**

- » Review the [Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version](#) for an orientation to this intervention. The guidance in this manual is suitable for all patient populations.
- » Tell the patient that you recommend developing a safety plan. Decide together if you will develop it jointly or if he or she will develop the plan independently and then review it with you before discharge. With the patient's permission, involve his or her family, friends, and/or a peer specialist.
- » Use one of the tools listed under Safety Planning Resources (following) to develop a safety plan.
- » Identify potential barriers or obstacles to using the safety plan and determine how to overcome them.
- » Tell the patient that although safety plans are important for coping with suicidal thoughts or feelings outside of the treatment setting, getting outpatient mental health care can address what's making him or her feel suicidal.
- » Instruct the patient to review the safety plan with an outpatient provider. Provide a copy for each.

**Safety Planning Resources**

- » [Safety Planning Guide: A Quick Guide for Clinicians](#)—G. Brown and B. Stanley, Department of Veterans Affairs
- » [Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version](#)—G. Brown and B. Stanley, Department of Veterans Affairs
- » [Patient Safety Plan template](#)—G. Brown and B. Stanley, Department of Veterans Affairs
- » [MY3 Support System and Safety Planning Mobile App](#)—Link2Health Solutions and the California Mental Health Services Authority
- » [Safety Plan Mobile App](#)—New York State Office of Mental Health
- » [ED-SAFE Materials](#)—Safety Planning Resources
- » [SuicideSafe Mobile App](#)—Substance Abuse and Mental Health Services Administration



### 3.3 Lethal Means Counseling

In the Lethal Means Counseling intervention, the provider assesses whether a patient at risk for suicide has access to firearms or other lethal means (e.g., prescription medications), and works with the patient and his or her friends, family, or outpatient provider to discuss ways to limit this access until the patient is no longer feeling suicidal.

#### Action Steps

- » Tell the patient and his or her friends or family that suicide risk can sometimes escalate rapidly, so it is important to consider the patient’s access to lethal means during these periods of increased risk.
- » Ask the patient and his or her supports about the patient’s access to lethal means, particularly firearms. If the patient has access to firearms, ask about the location (e.g., closet, car, attic).
- » Provide appropriate counseling to patients who report having access to lethal means. For a list of points to cover in a brief counseling session, view the [Lethal Means Counseling Recommendations for Clinicians](#) sheet available from Means Matter.
- » Identify strategies for limiting access to lethal means, such as storing firearms at a friend’s house until the suicidal crisis has passed, and allowing a family member to keep medications under lock and key and dispense them as necessary in order to prevent self-poisoning.

#### Lethal Means Counseling Resources

- » [Recommendations for Clinicians](#)—Lethal means counseling, Means Matter, Harvard School of Public Health
- » [Recommendations for Families](#)—Information on lethal means, Means Matter, Harvard School of Public Health
- » [Counseling on Access to Lethal Means \(CALM\)](#)—Online training course, Suicide Prevention Resource Center
- » [Firearm Safety and Injury Prevention](#)—Policy, American College of Emergency Physicians (ACEP)

#### Guns at Home: How You Raise the Issue Can Make a Difference

*Instead of:*

“Do you have access to a gun?”

*Consider:*

“Lots of us in (name your state) have guns at home.\* Research shows that a suicidal person is safer if they don’t have access to guns. What some gun owners in your situation do is store their guns away from home until they’re feeling better, or lock them and ask someone they trust to hold the keys. If you have guns at home, I’m wondering if you’ve thought of a strategy like that.”

\*You may substitute this sentence with “I don’t know if you have guns at home, but if you do . . .”

—Catherine Barber, Means Matter



### 3.4 Rapid Referral

The Rapid Referral intervention involves obtaining a follow-up appointment for the patient that occurs within seven days of discharge—ideally, within 24 hours of discharge. Developing referral agreements with outpatient providers may facilitate this process. A sample letter is provided in Appendix E to facilitate developing these agreements. Consider the patient's needs and troubleshoot barriers to accessing outpatient services when choosing a referral.

#### Action Steps

- » Develop a community resource list that ED personnel can use for making referral appointments to outpatient providers. Use the template in Appendix F or request a copy of a list used by a local community-based organization. Highlight providers on the list who are skilled in suicide assessment, management, and treatment.
- » Request the patient's consent to provide clinical information about the ED visit to the referral provider. See Appendix D to learn about sharing protected health information with other providers. Use a two-way release if possible.
- » Before the patient is discharged, call an outpatient provider to schedule an urgent outpatient appointment for a date within a week of discharge. If the outpatient provider is unavailable, plan for a second call during regular business hours or leave a message requesting priority scheduling for the patient. If these steps fail, and with the patient's permission, enlist a trusted caregiver or peer specialist to help schedule the appointment.
- » For patients who present to the ED during off-hours, identify other ED personnel to schedule the follow-up appointment during regular business hours.
- » If you are unable to schedule the first follow-up appointment for a date within a week of discharge, consider these options:
  - Refer the patient for a follow-up appointment with a primary care provider (PCP). With the patient's permission, contact the PCP to discuss the patient's condition and reason for the referral. Most PCPs are not aware of their patients' suicidal ideation or attempts (Riihimaki, Vuorilehto, Melartin, Haukka, & Isometsa, 2014). Ask for help in securing outpatient mental health treatment.
  - Develop a protocol for working with a local crisis center to provide follow-up support for these patients. Some crisis centers make follow-up contacts with patients who have recently been discharged from EDs to facilitate linkages to care and provide additional support. Crisis center services are free and open to the public.
- » Troubleshoot the patient's access-to-care barriers (e.g., lack of health insurance or transportation) using information from the community resources list.



**Consider the patient's needs and troubleshoot barriers to accessing outpatient services when choosing a referral.**

### Rapid Referral Resources

- » [HelpPRO Therapist Finder](#)
- » [Therapy Finder](#)—National Suicide Prevention Lifeline
- » [Care Transitions: Best Practices and Evidence-based Programs](#)—Center for Healthcare Research & Transformation
- » [Continuity of Care for Suicide Prevention: The Role of Emergency Departments](#)—Suicide Prevention Resource Center



## 3.5 Caring Contacts

Caring contacts are brief communications with the patient after discharge from the ED. They may be made by the ED provider or other personnel, be one-time or recurring contacts, and involve one-way or two-way communication. These contacts are meant to facilitate adherence to the discharge plan and promote a feeling of connectedness by demonstrating continued interest in the patient. Caring contacts may be especially helpful for patients who have barriers to outpatient care or are unwilling to access this care.

### Action Steps

- » Follow up with discharged patients via postcards, letters, e-mail, text messages, or phone calls. See sample messages in Appendix G. These contacts can be made by clinical staff or non-medical ED personnel and may be automated. Phone calls will require training.
- » Use automated systems for providing caring contacts, such as mailed or e-mailed postcards or text messages (Berrouiguet, Gravey, Le Galudec, Alavi, & Walter, 2014). Some electronic health record systems can perform these functions.
- » Consider establishing an agreement with a local crisis center that allows its staff to make caring contacts with recently discharged patients.

### Caring Contacts Resources

- » [Postcards from the EDge: 5-Year Outcomes of a Randomised Controlled Trial for Hospital-Treated Self-Poisoning](#)—Journal article, G. L. Carter, K. Clover, I. M. Whyte, A. H. Dawson and C. D’Este
  - » [Tool 5: How to Conduct a Postdischarge Followup Phone Call](#)—Re-Engineered Discharge (RED) Toolkit, Project RED, Agency for Healthcare Research and Quality (AHRQ), Hospital Resources webpages
  - » [Post-Visit Patient Contact Improves Patient Satisfaction](#)—Program overview, Robert Wood Johnson Foundation
- » For sample messages, see Appendix G.



### 3.6 Crisis Center Information

It is essential to incorporate information about crisis center services into ED-based brief suicide prevention interventions. The Suicide Prevention Lifeline and the Veterans Crisis Line are accessible across the nation and provide help 365 days a year, 24/7, even in communities without a local crisis center resource. For more information on how to utilize crisis center services, see Section 6.2 Working with Crisis Centers.



# 4

## Discharge Planning Checklist

Discharge planning provides an important opportunity to link patients with suicide risk to sources of follow-up care. Well-conceived discharge planning can improve transitions from hospital to community, reduce readmissions, and increase patient satisfaction.

Patients with suicide risk may face multiple barriers to getting follow-up care, including financial problems, insurance coverage gaps, lack of transportation, stigma, scheduling conflicts, and limited treatment capacity in the community. Anticipate and troubleshoot problems by involving the patient and his or her support system as partners in the discharge planning process.

Use the discharge planning checklist with patients with suicide risk. Items in the checklist may be incorporated into your facility's existing discharge planning protocols and electronic health record system.

### Discharge Planning Checklist for Patients with Suicide Risk

This checklist highlights 10 best practices for planning the discharge of patients with suicide risk. Some items also appear in the ED-based brief suicide prevention interventions. The checklist may be adapted according to the staffing structures, available resources, and needs of patients in your ED.

✓ **Involve the patient as a partner.**

Involve the patient and his or her family and friends in developing the discharge plan. Sample questions to ask include, “What will being home be like for you?” and “What do the next few days look like to you?”

✓ **Make follow-up appointments.**

Schedule an urgent follow-up appointment (when feasible within seven days of discharge; ideally within 24 hours) with a mental health care provider, primary care provider, or other outpatient provider.

✓ **Review and discuss the patient care plan<sup>7</sup> (an element of the discharge plan).**

Verbally review the patient care plan, including a review of medications, with the patient. A safety plan (see section 3.2 Safety Planning) may be used to address elements of the patient care plan related to suicide risk. Appendix H lists patient care plan recommendations for patients with suicide risk.

✓ **Discuss barriers.**

Discuss potential barriers (e.g., lack of health insurance) to following the patient care plan and identify possible solutions or alternatives.

✓ **Provide a crisis center phone number.**

Provide the patient with the phone number of a local crisis hotline or the [National Suicide Prevention Lifeline](https://www.18002738255.org/): 1-800-273-8255 (TALK).

Use the discharge planning checklist with patients with suicide risk. Items in the checklist may be incorporated into your facility's existing discharge planning protocols and electronic health record system.



<sup>7</sup> Some hospitals use patient care plans as one component of a broader discharge plan. For more information on patient care plans, see Appendix H.

- ✓ **Discuss limiting access to lethal means.**  
Discuss ways to limit the patient's access to lethal means (see section 3.3 Lethal Means Counseling).
- ✓ **Provide written instructions and education materials.**  
Give the patient a written version of the patient care plan and educational resources (e.g., brochures, booklets) about his or her condition and treatment recommendations. Provide information on what to do if the patient's condition worsens, including when to return to the ED.
- ✓ **Confirm that the patient understands the patient care plan.**  
Use [teach-back techniques](#) to make sure the patient understands the patient care plan.
- ✓ **Share patient health information with referral providers.**  
Obtain the patient's consent for sharing his or her health information with referral providers. Send the referral provider a copy of the patient's discharge summary.
- ✓ **Communicate care and concern.**  
Show care and concern, and encourage the patient to follow his or her patient care plan.

### Discharge Planning Resources

*For hospitals and providers:*

- » [Recommendations for Inpatients and Residential Patients Known to be at Elevated Risk for Suicide](#)—American Association of Suicidology
- » [Safe Discharge from the Emergency Setting](#)—Position statement, Emergency Nurses Association (click webpage to activate resource)
- » [Re-engineered Discharge Planning \(RED\) Toolkit](#)—Hospital Resources webpage, Agency for Healthcare Research and Quality
- » [Transition of Care Resources](#)—Webpage with the 2012 Transitions of Care Task Force Report, American College of Emergency Physicians
- » [Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning](#)—Overview, process, and checklist, Agency for Healthcare Research and Quality

*For patients and family or friends:*

- » [SPEAK UP: Planning Your Follow-up Care](#)—Patient guide, Joint Commission
- » [Ask Me 3](#)—Patient education program, National Patient Safety Foundation
- » [After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department](#)—Brochure, Substance Abuse and Mental Health Services Administration, also available in Spanish.



The ED can be a challenging environment for the patient with suicide risk. Its fast pace and lack of privacy may contribute to a difficult experience that could worsen the patient’s mood and increase feelings of hopelessness or isolation. ED providers can help create a more positive and hopeful experience for these patients by providing patient-centered care.<sup>8</sup>

The [Institute of Medicine](#) defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Providing patient-centered care does not have to be time-consuming, and it has been linked to many positive outcomes, such as increased patient satisfaction, a greater likelihood of obtaining follow-up care, and fewer readmissions. There is also evidence that by providing patient-centered care, providers may decrease legal risks.

### Action Steps

- » Treat patients with suicide risk in the same manner you would treat those with other medical emergencies.
- » Express care for his or her comfort and dignity, such as allowing a person to wear “street clothes” unless it is necessary to disrobe.
- » Build rapport. This increases trust and may help patients share information more readily and honestly. The BATHE technique is one example for building rapport (Figure 4).

#### Figure 4. The BATHE Technique

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**The BATHE technique is a five-step process for building rapport with patients (Lieberman & Stuart, 1999). The mnemonic stands for the following:**

---

1. **B**ackground: “*What is going on in your life?*”
  2. **A**ffect: “*What is that like for you?*”
  3. **T**rouble: “*What troubles you the most about that situation?*”
  4. **H**andle: “*What helps you handle that?*”
  5. **E**mpathy: “*That must be very difficult.*”
- 

- » Collaborate with the patient. Ask for his or her opinion. Attempt to engage patients in decision making even if they don’t initially agree, and only make promises you can keep.
- » Check in with the patient regularly to see how the ED visit is going. Provide information about what to expect during the visit and patient rights.
- » When possible maintain provider continuity for suicidal patients or notify the patient in advance when provider assignments change.

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<sup>8</sup> For patients with aggression, refer to the American Association for Emergency Psychiatry’s [Behavioral Emergencies: Best Practices in Evaluation and Treatment of Agitation](#) (Project BETA).

**Offer the support of a certified peer specialist for the patient during his or her visit. Consult the [National Empowerment Center Directory of Peer-Run Crisis Services](#) to learn how to connect your hospital with these services.**

- » With the patient’s permission, involve trusted informal caregivers (e.g., family, friends) and outpatient providers in treatment decisions and discharge planning.
- » Offer the support of a certified peer specialist for the patient during his or her visit. Consult the [National Empowerment Center Directory of Peer-Run Crisis Services](#) to learn how to connect your hospital with these services.
- » If the patient is in an acute crisis, request his or her [psychiatric advance directive](#), a legal document that describes a person’s instructions and preferences regarding treatment if he or she is in an acute mental health crisis.
- » Pay careful attention to establishing a collaborative rapport with older adults who are often less likely to report suicidal ideation or to have experience receiving mental health services. Depression symptoms can be mistaken as natural experiences of aging—careful attention to and assessment of depressive symptoms is important with older patients.
- » Review Appendix I: Examining Your Views about Suicide.

#### Patient-Centered Care Resources

- » [The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience](#)—Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention
- » [National Resource Center on Psychiatric Advance Directives](#) (NRC-PAD)—Website; to download forms, visit the NRC-PAD’s State by State Info page
- » [Behavioral Emergencies: Best Practices in Evaluation and Treatment of Agitation](#)—American Academy of Emergency Psychiatry
- » [Tips on Building Doctor/Patient Relations](#)—American Academy of Family Physicians
- » [Competent Caring: When Mental Illness Becomes a Traumatic Event](#)—National Alliance on Mental Illness
- » [Suicide Attempt Survivors](#)—Resources webpage, American Association of Suicidology
- » [Now Matters Now](#)—Videos and skill-building resources for people with suicidal thoughts, feelings, or actions
- » [Talkingaboutsuicide.com](#) and [Livethroughthis.org](#)—Suicide attempt survivors’ webpages
- » [With Help Comes Hope](#)—Webpage for persons living with suicidal thoughts and suicide attempts



**There are effective ways to demonstrate concern for a patient even when you're trying to do things fast. Make eye contact and shake everyone's hand as you introduce yourself. Apologize for the wait. Sit down, as this reassures the patient that you're really paying attention. Let the patient talk for a minute without interruption—it increases patient satisfaction and you'll also get information you otherwise might have missed in your usual questioning. Give the patient and the family a reasonable expectation of how much time everything will take. If it will be a while, suggest that family members eat, rest or take a break. Everyone is happier when they know what to expect.**

—Dr. Todd Beel, American College of Emergency Physicians, [Efficiency in the Emergency Department](#)

This section provides additional information that may help ED providers adopt the recommendations in this guide. It covers the following topics:

- » Documenting the ED visit
- » Working with crisis centers
- » Addressing intoxication and substance use disorders
- » Reducing liability concerns

Consider working with your hospital to incorporate this guidance into existing policies and procedures.



## 6.1 Documenting the ED Visit

Fully documenting the care provided to patients with suicide risk improves quality of care and can demonstrate provider and hospital efforts to meet national care standards. Assuming that patients are provided with high-quality, patient-centered care, full documentation is the key factor for preventing and addressing potential legal problems related to caring for these patients. As described below, every step in the decision-making process and all communication with the patient, his or her family members and significant others, and other caregivers should be recorded. ED providers may also consider ways to embed these and other suicide prevention data elements into hospital electronic medical records and practice management systems to facilitate the documentation process.

### Action Steps

When documenting information about the patient and his or her visit, indicate that you reviewed or attempted to review the records from other providers who interacted with the patient before you. Use descriptive terms that show that you can identify the patient from among others seen in that shift, use nonjudgmental terms, and include quotes (e.g., “I’m not suicidal”).

### What to document

- » How the patient arrived (e.g., “drove,” “brought by family”)
- » The specific reason for the patient’s visit, stated in a clear way (e.g., “visiting nurse was concerned about a reference to death;” not, for example, “decompensating schizophrenic”)
- » The patient’s account of what happened—the reason for the visit
- » Communication or attempted communication with the patient’s family, supports, previous providers, and outpatient providers
- » What was offered, including access to a mental health consultation and brief suicide prevention interventions
- » Screenings and assessments performed and their results, including the Decision Support Tool (Section 2.2) and the patient’s risk and protective factors

- » Key considerations made for admission or discharge decisions, including the reasons why any decisions or actions were considered but rejected
- » Information about the patient's medications
- » Interventions provided onsite, including simple supportive and problem-solving efforts
- » The patient's stated preferences regarding treatment
- » Any challenges encountered during the visit
- » Concerns and actions taken to mitigate these concerns
- » Assessment of the patient's access to lethal means and provision of related counseling
- » Patient care plan for discharge or safety plan
- » Type of referral given, including provider contact information
- » Any subsequent contacts with the patient



## 6.2 Working with Crisis Centers

Crisis centers, also referred to as suicide hotlines or helplines, can be partners to EDs in caring for patients with suicide risk. They provide confidential services 24/7, including assessment and referrals, at no cost to the individual. Crisis center members of the [National Suicide Prevention Lifeline](#) (NSPL) follow best practices in assessing suicide risk and imminent risk and have access to a national network of crisis center peers and resources. Crisis lines for veterans, people who are deaf or hard-of-hearing, and Spanish speakers are also available. Some crisis lines provide translation for a number of different languages; based on the linguistic groups in your area, you may be able to find local partners who provide crisis services to these groups.

[The Joint Commission](#) (goal 15, page 12) and the [National Strategy for Suicide Prevention](#) recommend that every ED patient with suicide risk be handed written information with the phone number of the nearest crisis center before discharge. Hospitals may also consider making formal agreements with crisis centers to provide follow-up services for these patients. For example, the hospital may obtain patient consent for the crisis center to provide follow-up support in the form of phone calls. These services can be particularly helpful for patients with barriers to accessing outpatient mental health services.

### Crisis Center Resources

- » [Suicide Warning Signs wallet card](#)—Includes crisis center phone number, National Suicide Prevention Lifeline
- » [Coping Wallet Card](#)—Includes National Suicide Prevention Lifeline number
- » [National Suicide Prevention Lifeline website](#)—Includes Veterans Crisis Line, online chat, Spanish language line, and services for deaf and hard-of-hearing individuals
- » [Veterans Crisis Line](#)—Includes the crisis center phone number, as well as a link to an online chat and a number for text messaging



## 6.3 Using Telepsychiatry with Suicidal Patients

Telepsychiatry uses electronic communication, such as two-way video, to provide clinical mental health services at a distance. EDs can use these services to provide emergency assessments—particularly for patients located in remote geographic regions. Telepsychiatry has been shown to improve outcomes in general medical settings for patients with behavioral health conditions (Fortney et al., 2013). In addition to emergency assessments, telepsychiatry services may include medication management, clinical therapeutic treatments, and provider-to-provider consultation.

Telepsychiatry may also be a good option for EDs with limited mental health staffing resources. The South Carolina Department of Mental Health [Telepsychiatry Program](#) offers a model for improving the quality and timeliness of psychiatric services provided in EDs and reducing costs and length of stays.



### Telepsychiatry Resources

- » [Telemental Health Guide: Clinicians and Administrators](#)—Online guide, University of Colorado, Denver
- » [Practice Guidelines for Videoconferencing-based Telemental Health](#)—Booklet, American Telemedicine Association
- » [Evidence-Based Practice for Telemental Health](#)—Downloadable booklet, American Telemedicine Association



## 6.4 Suicide Risk Associated with Intoxication and Substance Use Disorders

Substance use disorders (SUDs) are a major risk factor for suicide attempts and death (Rodgers, 2011). One-third of all suicides in the United States involve acute use of alcohol before the suicide (Kaplan et al., 2013) and intentional overdose is the most common method of attempting suicide (CDC, 2014). In fact, the number of ED visits for drug-related suicide attempts is growing (SAMHSA, 2014). Adults with a past year SUD are more likely than other adults to have serious thoughts of suicide, make plans, and attempt suicide (SAMHSA, 2013).

Some patients with suicide risk may show signs of intoxication when they arrive at the ED. Encourage these patients to stay in the ED until they are sober and a mental health specialist can perform a suicide risk assessment.

The following recommendations apply to patients with suicide risk who are intoxicated when they come to the ED or who may have a substance use disorder:

- » Provide medical management and/or observation. Ask if the patient has someone (e.g., family member, friend) who can stay with him or her in the ED. Wait until the patient is sober to perform assessments.
- » Find out more about possible links between the patient's SUD and suicide risk by gathering information from various sources (e.g., the patient, his or her friends, family, and outpatient providers). Ask the following:
  - ✓ What is the relationship between the patient's intoxication and suicidal statements or behaviors? Note: Some patients disclose suicidal ideation while intoxicated but deny it when sober. Consulting with family, friends, and outpatient providers is key to determining these patients' suicide risk.
  - ✓ What are the circumstances surrounding intoxication?
  - ✓ Has the patient had problems lately? Social risk factors, such as relationship problems and legal or financial difficulties, are common precipitants for people with SUDs. This information can help you assess the potential relationship between the patient's substance use and his or her suicide risk.
- » When discussing lethal means, include conversations about limiting access to firearms and prescribed medications (dosage and quantities).
- » Do not discharge the patient or make treatment plans while he or she is intoxicated. Upon discharge, enlist a driver to take the patient home (even if the patient is sober).
- » If the patient is admitted to a detoxification unit, communicate information about the patient's suicide risk to the detoxification provider and consider the patient's needs for psychotropic medications.
- » For patients who have an SUD, consider providing a brief intervention, such as psychoeducation about SUDs or [Screening Brief Intervention Referral and Treatment](#), a 5- to 10-minute evidence-based substance abuse prevention intervention (Bernstein & D'Onofrio, 2013). These interventions may reduce harmful substance use (Pasic & Cashman, 2013), thereby reducing suicide risk. When appropriate, provide a referral to specialized SUD treatment services and ensure that these services are coordinated with treatment for suicide risk.

### Resources for Addressing Intoxication and SUDs

- » [K4. Treatment of High Risk for Suicide and Comorbid Substance Use Disorder \(SUD\)](#)—Section in VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (pp. 105–106); see also section D4. Substance Abuse and Disorder (pp. 40–43)
- » [Screening, Brief Intervention, and Referral to Treatment](#)—Information on a public health approach, Substance Abuse and Mental Health Services Administration
- » [Results from the 2012 National Survey on Drug Use and Health](#)—Substance Abuse and Mental Health Services Administration
- » [Alcohol Screening and Brief Intervention in the ED](#)—Resource kit, American College of Emergency Medicine
- » [Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department](#)—Clinical policy, American College of Emergency Physicians
- » Relevant book chapters: (1) *Treatment of Behavioral Emergencies*, Guideline 6: Initial Interventions for Agitation Due to Substance Intoxication, American Association of Emergency Psychiatry; (2) *Behavioral Emergencies for the Emergency Physician*, Chapter 6: Drug Intoxication in the Emergency Department; (3) Tintinalli's *Emergency Medicine*, 8th Edition, Chapter 289: Alcohol and Other Drugs of Abuse



## 6.5 Reducing Liability Concerns

Caring for patients with suicide risk may raise questions and concerns about liability and ethics. In the ED setting, factors that may increase these concerns include barriers to patients following up with outpatient care and a lack of capacity in the mental health service system. The ED Consensus Panel identified several strategies to minimize legal actions against a provider or a hospital. In general, these strategies focus on following national guidelines, providing patient-centered care, and fully documenting each visit and decision-making process.

Specific recommendations include the following:

**Increase patient choice to demonstrate respect for patients' autonomy.**

- » Provide humane and patient-centered care that reduces the need for patient restraint and uses the least restrictive methods possible for keeping patients safe.
- » Increase patient choice to demonstrate respect for patients' autonomy.
- » Obtain informed consent for medical treatments from all patients who are able to provide it. Being in a crisis or disagreeing with the proposed treatment plan is not the same as being clinically incompetent.
- » Confirm patients' history with their collaterals and involve them in treatment and discharge planning.
- » Fully document evaluations, results, and decisions leading to patient discharge.
- » For administrators, review the following publications:
  - [Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs](#) (p. 98), Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol (TIP) 50.
  - Stefan, S. (2006). *Emergency department treatment of the psychiatric patient, policy issues and legal requirements*. New York, NY: Oxford University Press.
  - Zun, L.S. (2013). *Behavioral emergencies for the emergency physician*. New York, NY: Cambridge University Press.

For more information and resources, see *Providing Patient-Centered Care* (Section 5) and *Documenting the Visit* (Section 6.1).

# Appendices

[Appendix A: Quick Guide](#)

[Appendix B: Guide Resources and URLs](#)

[Appendix C: Primary Screening and Suicide Risk Assessment](#)

[Appendix D: Sharing Patient Health Information](#)

[Appendix E: Sample Letter to Outpatient Mental Health](#)

[Appendix F: Community Resource List Template](#)

[Appendix G: Caring Contacts Sample Materials](#)

[Appendix H: Key Elements of a Patient Care Plan](#)

[Appendix I: Examining Your Views about Suicide](#)

# Appendix A: Quick Guide

See [www.sprc.org/ed-guide](http://www.sprc.org/ed-guide)

## Caring for Adult Patients with Suicide Risk

### A Consensus Guide for Emergency Departments



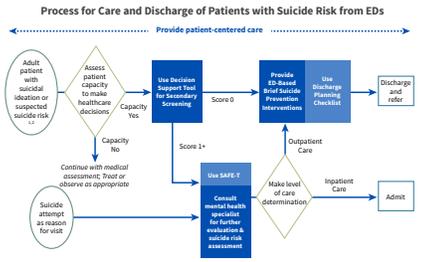
**QUICK GUIDE FOR CLINICIANS**

This guide assists Emergency Department (ED) health care professionals with decisions about the care and discharge of patients with suicide risk with a focus on improving patient outcomes after discharge. It is a companion resource to the full guide, [Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments](#).

**Questions answered by Quick Guide:**

- Can this patient be discharged or is further evaluation needed?
- How can I intervene while this patient is in the ED?
- What will make this patient safer after leaving the ED?

**Process for Care and Discharge of Patients with Suicide Risk from EDs**



\* Identification of individuals at risk may occur as a result of (1) patient disclosure, (2) reports by family, friends, or other collateral, (3) individual indicators such as depression, substance use, or debilitating illness, or (4) primary screening.  
 † Consult your ED's policies to determine how medical clearance applies to this diagram.

**Step 4: Review other available information.** Use available data (e.g., patient observation, medical records) and consult with available collaterals (e.g., friends, family members, and outpatient providers) to corroborate the patient's report. This step is essential.

**Q: Can ED providers share patient health information with others?**

**A: Yes. For patients with concerning risk factors who minimize or deny suicide risk, it may be life-saving to contact collaterals for corroborating information.** First request the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines to consent after reasonable attempts have been made to request permission, there are circumstances in which collaterals may be contacted without the patient's permission. HIPAA permits such contacts when the clinician, in good faith, believes that the patient may be a danger to self or others.

**Step 5: Check the score.** A "yes" response is equal to 1. Total the "yes" responses on items 1–6.

**Score 0.** If every item (1–6) is "no," discharge may be appropriate following one or more ED-based brief suicide prevention interventions.<sup>†</sup> These are described on the next page.

**Score ≥1.** If the responses to the transition question (i.e. suicidal ideation) and any item 1–6 are "yes," consider consulting a mental health specialist during the ED visit for further evaluation, including a comprehensive suicide risk assessment. Be familiar with the type of suicide risk assessment used in the mental health specialist's evaluation. Consider the immediate safety needs of the patient in next steps.

**Step 6: Explain next steps.** For example: **Score 0.** Say that you are considering discharging him or her to outpatient care and would first like to provide a brief intervention. Ask for the patient's feedback and discuss reservations he or she may have about this plan. **Score ≥1.** Say that you would like him or her to see a specialist for further evaluation as part of the ED visit. Explain that the specialist may repeat some questions.

Involve the patient in the decision-making process. Shared decision making lowers patient stress, gives patients a sense of control, and leads to better outcomes. Patients with suicide risk report higher satisfaction when they are involved in decisions about their care.

**Risk Assessment**



Mental health evaluations provided during the ED visit should include comprehensive suicide risk assessment. The [SAFE-T Guide](#), developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), may be used in conjunction with the Decision Support Tool to meet this objective.

\* Suicidal ideation is an unscored item and should not be included in the scoring.  
 † In settings where a mental health specialist is readily available, consider referring all patients with any suicidal ideation or suspected suicide risk to the mental health specialist for further evaluation, including suicide risk assessment.

## Decision Support Tool



This tool is a secondary screening that informs disposition decisions for patients with suicidal ideation. Use it with adult patients with decision-making capacity identified as having suicide risk through (1) patient disclosure; (2) family, friend, or other collateral report; (3) patient presentations such as depression, substance use, or debilitating illness; or (4) primary screening.

<b>TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION</b>			
Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? <b>(NOTE: Not part of scoring.)</b>			Y
<b>THOUGHTS OF CARRYING OUT A PLAN</b>			
<b>1</b>	Recently, have you been thinking about how you might kill yourself? <b>If yes, consider the immediate safety needs of the patient.</b>	Y	N
<b>SUICIDE INTENT</b>			
<b>2</b>	Do you have any intention of killing yourself?	Y	N
<b>PAST SUICIDE ATTEMPT</b>			
<b>3</b>	Have you ever tried to kill yourself?	Y	N
<b>SIGNIFICANT MENTAL HEALTH CONDITION</b>			
<b>4</b>	Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?	Y	N
<b>SUBSTANCE USE DISORDER</b>			
<b>5</b>	Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?	Y	N
<b>IRRITABILITY/AGITATION/AGGRESSION</b>			
<b>6</b>	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?	Y	N

**Step 1: Inform the patient.** Tell patient you will be asking a few questions to help you consider next steps.

**Step 2: Review the patient's suicidal ideation.** Confirm the patient has suicidal ideation. Ask directly or state your understanding of the nature of his or her suicide risk. This will facilitate a smooth transition to item one (plan).

**Step 3: Ask questions regarding items 1 through 6.** Example questions are provided. Use an open, nonjudgmental style to encourage honest answers.

## Brief Suicide Prevention Interventions



For all patients with suicidal ideation who are being discharged: (1) Provide at least one of the following brief suicide prevention interventions prior to discharge. (2) Include crisis center/hotline information with every brief intervention provided. (3) Involve significant other(s) in the intervention if present.

- † Brief Patient Education:** Discuss the **condition, risk and protective factors**, type of treatment and treatment options, medication instructions, home care, lethal means restriction, follow-up recommendations, and signs of a worsening condition and how to respond. Provide verbal and written information on the [nearest crisis hotline](#).
- † Safety Planning:** Work with the patient to develop a list of coping strategies and resources that he or she can use during or before suicidal crises. Use the Safety Planning resources (paper version or mobile app) provided in the [full guide](#).
- † Lethal Means Counseling:** Assess whether the patient has access to firearms or other lethal means (e.g., prescription medications), and discuss ways to limit access until the patient is no longer feeling suicidal. Follow the [Lethal Means Counseling Recommendations for Clinicians](#) sheet available from Means Matter.
- † Rapid Referral:** During the ED visit, schedule an outpatient mental health appointment for the patient within seven days of discharge. If no appointments are available, review additional suggestions in the [full guide](#) and/or refer the patient for a follow-up with a primary care provider.
- † Caring Contacts:** Follow up with discharged patients via postcards, letters, e-mail or text messages, or phone calls. See sample messages in the [full guide](#). These communications can be automated.

**Discharge Planning Checklist**

- Patient involved in planning
- Follow-up appointment scheduled for a date within one week of discharge
- Discharge plan reviewed verbally and understood by patient
- Barriers and solutions discussed
- Crisis center phone number provided
- Access to lethal means reviewed and discussed
- Written instructions and education materials provided, **including what to do if the patient's condition worsens and when to return to the ED**
- Patient confirms his or her understanding of the patient care plan
- Relevant health information transmitted to referral providers
- Patient senses the provider's care and concern

 **SPRC - Suicide Prevention Resource Center** [www.sprc.org/ed-guide](http://www.sprc.org/ed-guide)

## Appendix B: Guide Resources and URLs

[http://www.sprc.org/sites/sprc.org/files/EDGuide\\_AppendixB.pdf](http://www.sprc.org/sites/sprc.org/files/EDGuide_AppendixB.pdf)

### **After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department**

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf>

### **After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department**

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/shin/content/SMA08-4355/SMA08-4355.pdf>

### **Alcohol Screening and Brief Intervention in the ED**

American College of Emergency Physicians

<http://www.acep.org/Clinical--Practice-Management/Alcohol-Screening-and-Brief-Intervention-in-the-ED/>

### **A Resource Guide for Implementing The Joint Commission 2007 Patient Safety Goals on Suicide**

Screening for Mental Health and Suicide Prevention Resource Center

<http://www.sprc.org/sites/sprc.org/files/library/jcsafetygoals.pdf>

### **Ask Me 3**

National Patient Safety Foundation

<http://www.npsf.org/?page=askme3>

### **Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals**

Suicide Prevention Resource Center

<http://www.sprc.org/bpr/section-III/assessing-and-managing-suicide-risk-core-competencies-mental-health-professionals-am>

### **Attachment-Based Family Therapy (ABFT)**

National Registry of Evidence-based Programs and Practices

<http://www.sprc.org/bpr/section-I/attachment-based-family-therapy-abft>

### **Behavioral Emergencies: Best Practices in Evaluation and Treatment of Agitation (Project BETA)**

American Association for Emergency Psychiatry

[http://escholarship.org/uc/uciem\\_westjem?volume=13;issue=1](http://escholarship.org/uc/uciem_westjem?volume=13;issue=1)

### **Best Practices Registry**

Suicide Prevention Resource Center

<http://www.sprc.org/bpr>

### **Brief Psychological Intervention after Deliberate Self-Poisoning**

Suicide Prevention Resource Center and American Foundation for Suicide Prevention

<http://www.sprc.org/bpr/section-I/brief-psychological-intervention-after-deliberate-self-poisoning>

**Care Transitions: Best Practices and Evidence-based Programs**

Center for Healthcare Research and Transformation

<http://www.chrt.org/publication/care-transitions-best-practices-evidence-based-programs/>

**Care Transitions from Hospital to Home: IDEAL Discharge Planning**

Agency for Healthcare Research and Quality

<http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html>

**Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments**

Suicide Prevention Resource Center

[http://www.sprc.org/sites/sprc.org/files/EDGuide\\_fullversion.pdf](http://www.sprc.org/sites/sprc.org/files/EDGuide_fullversion.pdf)

**Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments — Quick Guide Version**

Suicide Prevention Resource Center

[http://www.sprc.org/sites/sprc.org/files/EDGuide\\_quickversion.pdf](http://www.sprc.org/sites/sprc.org/files/EDGuide_quickversion.pdf)

**Clinical Practice Guideline: Suicide Risk Assessment**

Emergency Nurses Association

<http://www.ena.org/practice-research/research/cpg/documents/suicideriskassessmentcpg.pdf>

**Competent Caring: When Mental Illness Becomes a Traumatic Event**

National Alliance on Mental Illness

[http://www.nami.org/Template.cfm?Section=Provider\\_Education&Template=/ContentManagement/ContentDisplay.cfm&ContentID=166062](http://www.nami.org/Template.cfm?Section=Provider_Education&Template=/ContentManagement/ContentDisplay.cfm&ContentID=166062)

**Continuity of Care for Suicide for Suicide Prevention and Research**

Suicide Prevention Resource Center

[http://www.sprc.org/library\\_resources/items/continuity-care-suicide-prevention-and-research](http://www.sprc.org/library_resources/items/continuity-care-suicide-prevention-and-research)

**Continuity of Care for Suicide Prevention: The Role of Emergency Departments**

Suicide Prevention Resource Center

[http://www.sprc.org/library\\_resources/items/continuity-care-suicide-prevention-role-emergency-departments](http://www.sprc.org/library_resources/items/continuity-care-suicide-prevention-role-emergency-departments)

**Counseling on Access to Lethal Means**

Suicide Prevention Resource Center

<http://training.sprc.org/>

**Crisis Center Hotline Information**

National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org/>

**Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department**

American College of Emergency Physicians

<http://www.acep.org/content.aspx?id=48427>

**Crossing the Quality Chasm: A New Health System for the 21st Century**

Institute of Medicine

<http://www.iom.edu/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>

**Depression Wellness Guide for Adults with Depression and their Family and Friends**

Families for Depression Awareness

<http://www.sprc.org/bpr/section-III/depression-wellness-guide-adults-depression-and-their-family-and-friends>

**Dialectical Behavior Therapy**

National Registry of Evidence-based Programs and Practices

[www.sprc.org/bpr/section-I/dialectical-behavior-therapy](http://www.sprc.org/bpr/section-I/dialectical-behavior-therapy)

**Directory of Peer-run Crisis Services**

National Empowerment Center

<http://www.power2u.org/peer-run-crisis-services.html>

**DMH Telepsychiatry Program**

South Carolina Department of Mental Health

<http://www.state.sc.us/dmh/telepsychiatry/>

**Dynamic Deconstructive Psychotherapy (DDP)**

National Registry of Evidence-based Programs and Practices

<http://www.sprc.org/bpr/section-I/dynamic-deconstructive-psychotherapy-ddp>

**Efficiency in the Emergency Department: Doing Things Faster Without Sacrificing Quality**

American College of Emergency Physicians

<http://www.acep.org/content.aspx?id=29876>

**Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) Study Materials**

Emergency Medicine Network

<http://www.emnet-usa.org/EDSAFE/materials.htm>

**Evidence Based Practice for Telemental Health**

American Telemedicine Association

[http://www.americantelemed.org/resources/telemedicine-practice-guidelines/telemedicine-practice-guidelines/evidence-based-practice-for-telemental-health#.VSg\\_GfChHCd](http://www.americantelemed.org/resources/telemedicine-practice-guidelines/telemedicine-practice-guidelines/evidence-based-practice-for-telemental-health#.VSg_GfChHCd)

**Experiential Training in the Chronological Assessment of Suicide Events (CASE Approach)**

Training Institute for Suicide Assessment and Clinical Interviewing

<http://www.sprc.org/bpr/section-III/experiential-training-chronological-assessment-suicide-events-case-approach>

**Firearm Safety and Injury Prevention**

American College of Emergency Physicians

<http://www.acep.org/Clinical---Practice-Management/Firearm-Safety-and-Injury-Prevention/>

**Forced Treatment**

Bazelon Center for Mental Health Law

<http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment.aspx>

**Guideline 6: Initial Interventions for Agitation Due to Substance Intoxication (Page 39)**

American Association of Emergency Psychiatry

<http://www.emergencypsychiatry.org/data/CO%20Consensus%20guidelines%20treatment%20behavioral%20emergencies.pdf>

**Having Trouble Coping Wallet Card**

National Suicide Prevention Lifeline

<http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Having-Trouble-Coping-With-Help-Comes-Hope-/SVP13-0155R>

**HIPAA Privacy Rule and Sharing Information Related to Mental Health**

U.S. Department of Health & Human Services

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html>

**How to Conduct a Postdischarge Followup Phone Call**

Project RED, Agency for Healthcare Research and Quality

<http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html>

**How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations**

Institute for Healthcare Improvement

<http://www.ihl.org/resources/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx>

**Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs (Page 98)**

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/shin/content//SMA09-4381/TIP50.pdf>

**Live Through This: A Collection of Portraits and Stories of Suicide Attempt Survivors**

Developed by Dese'Rae L. Stage

<http://livethroughthis.org/>

**Means Matter: Recommendations for Clinicians**

Harvard School of Public Health

<http://www.hsph.harvard.edu/means-matter/recommendations/clinicians/>

**Means Matter: Recommendations for Families**

Harvard School of Public Health

<http://www.hsph.harvard.edu/means-matter/recommendations/families/>

### **Motivational Interviewing**

SAMHSA-HRSA Center for Integrated Health Solutions

<http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing>

### **Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)**

National Registry of Evidence-based Programs and Practices

<http://www.sprc.org/bpr/section-I/multisystemic-therapy-psychiatric-supports-mst-psychiatric>

### **MY3 Support System and Safety Planning Mobile App**

Link2Health Solutions and the California Mental Health Services Authority

<http://www.my3app.org/>

### **National Patient Safety Goals: Goal 15**

[http://www.jointcommissionconnect.org/NR/rdonlyres/F4F18DC6-5DA8-4695-94BA-6E384E250540/0/NPSG\\_15\\_01\\_01\\_finallinked.pdf](http://www.jointcommissionconnect.org/NR/rdonlyres/F4F18DC6-5DA8-4695-94BA-6E384E250540/0/NPSG_15_01_01_finallinked.pdf)

### **National Resource Center on Psychiatric Advance Directives**

National Resource Center on Psychiatric Advance Directives

<http://www.nrc-pad.org/>

### **National Strategy for Suicide Prevention: Goals and Objectives for Action**

U.S. Department of Health & Human Services

[http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full\\_report-rev.pdf](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf)

### **Now Matters Now**

Now Matters Now

<http://www.nowmattersnow.org/skills>

### **NIMH Publications**

National Institute of Mental Health

<http://www.nimh.nih.gov/health/publications/index.shtml>

### **Patient Safety Plan Template**

Suicide Prevention Resource Center

<http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf>

### **Peer Providers**

Substance Abuse and Mental Health Services Administration

<http://www.integration.samhsa.gov/workforce/peer-providers>

### **Postcards from the EDge: 5-year outcomes of a randomised controlled trial for hospital-treated self-poisoning**

British Journal of Psychiatry

<http://bjp.rcpsych.org/content/early/2013/03/12/bjp.bp.112.112664.abstract>

### **Post-Visit Patient Contact Improves Patient Satisfaction**

Robert Wood Johnson Foundation

<http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2013/04/post-visit-patient-contact-improves-patient-satisfaction.html>

**Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors**

American Psychiatric Association

[http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/suicide.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf)

**Practice Guidelines for Videoconferencing-based Telemental Health**

American Telemedicine Association

<http://www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-videoconferencing-based-telemental-health.pdf?sfvrsn=6>

**Preventing Suicide: Following up After the Crisis**

Substance Abuse and Mental Health Services Administration

[http://beta.samhsa.gov/samhsaNewsLetter/Volume\\_22\\_Number\\_2/preventing\\_suicide/](http://beta.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/preventing_suicide/)

**Project BETA: Best Practices in Evaluation and Treatment of Agitation**

American Academy of Emergency Psychiatry

<http://escholarship.org/uc/item/4kz5387b>

**Project RED (Re-engineered Discharge Planning) Toolkit**

Agency for Healthcare Research and Quality

<http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>

**Psychiatric Advance Directives**

National Resource Center on Psychiatric Advance Directives

<http://www.nrc-pad.org/getting-started>

**QPRT Suicide Risk Assessment and Management Training**

QPR Institute

<http://www.sprc.org/bpr/section-III/qprr-suicide-risk-assessment-and-management-training>

**Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians**

American Association of Suicidology

<http://www.sprc.org/bpr/section-III/recognizing-and-responding-suicide-risk-essential-skills-clinicians>

**Recommendations for Inpatients and Residential Patients Known to be at Elevated Risk for Suicide**

American Association of Suicidology

<http://www.suicidology.org/Portals/14/docs/Survivors/Clinician%20Survivors/AASRecommendationsforImpatientandResidentialPatientsKnownToBeAtElevatedRiskforSuicide.pdf>

**Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings and Detailed Tables**

Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/Index.aspx>

**Safe Discharge from the Emergency Setting: Position Statement**

Emergency Nurses Association

<https://www.ena.org/SiteCollectionDocuments/Position%20Statements/SafeDischarge.pdf>

**Safety Plan Mobile App**

New York State Office of Mental Health

<https://itunes.apple.com/us/app/safety-plan/id695122998?mt=8>

**Safety Planning Guide: A Quick Guide for Clinicians**

Suicide Prevention Resource Center

[http://www.sprc.org/library\\_resources/items/safety-planning-guide-quick-guide-clinicians](http://www.sprc.org/library_resources/items/safety-planning-guide-quick-guide-clinicians)

**Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version**

Department of Veterans Affairs

[http://www.mentalhealth.va.gov/docs/VA\\_Safety\\_planning\\_manual.pdf](http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf)

**Screening, Brief Intervention, and Referral to Treatment**

Substance Abuse and Mental Health Services Administration

<http://samhsa.gov/sbirt>

**Sentinel Event Alert**

The Joint Commission

[http://www.jointcommission.org/assets/1/18/SEA\\_46.pdf](http://www.jointcommission.org/assets/1/18/SEA_46.pdf)

**SMART Discharge Protocol**

The Picker Institute

<http://www.ihl.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx>

**SPEAK UP: Planning Your Follow-up Care**

The Joint Commission

[http://www.jointcommission.org/assets/1/18/speakup\\_recovery.pdf](http://www.jointcommission.org/assets/1/18/speakup_recovery.pdf)

**SPRC Emergency Department Consensus Panel**

Suicide Prevention Resource Center

<http://www.sprc.org/sites/sprc.org/files/consensuspanelroster.pdf>

**State by State Info**

National Resource Center on Psychiatric Advance Directives

<http://www.nrc-pad.org/state-by-state>

**Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): Pocket Card for Clinicians**

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432>

**Suicide Attempt Survivors**

American Association of Suicidology

<http://www.suicidology.org/suicide-survivors/suicide-attempt-survivors>

**Suicide in America: Frequently Asked Questions**

National Institute of Mental Health

<http://www.nimh.nih.gov/health/publications/suicide-in-america/index.shtml>

**Suicide-Proofing Your Home**

Rhode Island Department of Health

[http://www.suicideproof.org/download/SuicideProof\\_Brochure\\_English.pdf](http://www.suicideproof.org/download/SuicideProof_Brochure_English.pdf)

**Suicide Risk Factors and Risk Assessment Tools: A Systematic Review**

Department of Veterans Affairs

<http://www.ncbi.nlm.nih.gov/books/NBK92671/pdf/TOC.pdf>

**Suicide Safe Mobile App**

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1>

**Suicide Warning Signs Wallet Card**

National Suicide Prevention Lifeline

<http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Suicide-Prevention-Learn-the-Warning-Signs/SVP13-0126>

**Talking About Suicide**

Cara Anna

<http://talkingaboutsuicide.com/>

**Teach-Back**

Project RED, Agency for Healthcare Research and Quality

<http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool3a.html#Component7>

**Technical Report: Developing Caring for Adult Patients at Risk of Suicide: A Consensus Based Guide for Emergency Departments**

Suicide Prevention Resource Center

[http://www.sprc.org/sites/sprc.org/files/ED\\_DevelopmentCaringPatientSuicideRisk.pdf](http://www.sprc.org/sites/sprc.org/files/ED_DevelopmentCaringPatientSuicideRisk.pdf)

**Telemental Health Guide for Clinicians and Administrators**

University of Colorado Denver

<http://www.tmhguide.org/clinicians-administrators/>

**Therapy Finder**

National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org/learn/therapy.aspx>

**Therapist Finder**

HelpPRO

<http://www.helppro.com/>

**The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience**

Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention  
<http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf>

**Tips on Building Doctor/Patient Relations**

American Academy of Family Physicians  
[http://www.aafp.org/dam/AAFP/documents/medical\\_education\\_residency/fmig/tips\\_relationships.pdf](http://www.aafp.org/dam/AAFP/documents/medical_education_residency/fmig/tips_relationships.pdf)

**Transitions of Care Resources**

American College of Emergency Physicians  
<http://www.acep.org/transitionsincare/>

**Treatments and Services**

National Alliance on Mental Illness  
[http://www.nami.org/template.cfm?section=About\\_Treatments\\_and\\_Supports](http://www.nami.org/template.cfm?section=About_Treatments_and_Supports)

**Treatment of Behavioral Emergencies**

American Association for Emergency Psychiatry  
<http://www.emergencypsychiatry.org/data/CO%20Consensus%20guidelines%20treatment%20behavioral%20emergencies.pdf>

**Understanding Risk and Protective Factors for Suicide: A Primer for Preventing Suicide**

Suicide Prevention Resource Center  
[http://www.sprc.org/library\\_resources/items/understanding-risk-and-protective-factors-suicide-primer-preventing-suicide](http://www.sprc.org/library_resources/items/understanding-risk-and-protective-factors-suicide-primer-preventing-suicide)

**Understanding What HIPAA Means for Mental Illness**

National Alliance on Mental Illness  
[http://www.nami.org/template.cfm?Section=Top\\_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=167363](http://www.nami.org/template.cfm?Section=Top_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=167363)

**Using the “Is your patient suicidal?” poster and Triage Guide**

Suicide Prevention Resource Center  
[http://www.sprc.org/library\\_resources/items/using-your-patient-suicidal-poster-and-triage-guide](http://www.sprc.org/library_resources/items/using-your-patient-suicidal-poster-and-triage-guide)

**VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide**

Department of Veterans Affairs, Department of Defense  
[http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP\\_SuicideRisk\\_Full.pdf](http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf)

**Veterans Crisis Line Website**

Department of Veterans Affairs  
<http://www.veteranscrisisline.net/Default.aspx>

**With Help Comes Hope**

National Suicide Prevention Lifeline  
<http://lifelineforattemptsurvivors.org/>

## Appendix C: Primary Screening and Suicide Risk Assessment

As discussed in Section 2.1, primary screening, secondary screening, and suicide risk assessment are distinct but related practices designed to help providers understand the nature of their patients' suicide risk. Primary screening tools can be used to detect the presence of suicide risk in all ED patients (universal screening) or in patients with known risk factors (selective screening), such as all patients with depression. Primary screening may be conducted verbally (with the screener asking questions), using pencil and paper, or using a computer.

The Decision Support Tool introduced in the ED Guide is a secondary screening tool that addresses practical decisions, such as, "Can I make a disposition decision without consulting a mental health specialist?" and "Is it appropriate to discharge this patient after providing a brief ED-based intervention?"

Suicide risk assessment is a comprehensive evaluation performed by a trained clinician to accomplish the following:

- » Confirm suspected suicide risk
- » Estimate the immediate danger to the patient based on the patient's risk and protective factors and other information
- » Decide on a course of treatment

Risk assessments can involve structured questionnaires or be open-ended conversations with patients and their supports to gain insight into the patient's thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

The Joint Commission's National Patient Safety Goal [NPSG 15.01.01](#) (goal 15, page 12) recommends that behavioral health care programs and psychiatric hospitals, as well as general hospitals treating patients for emotional or behavioral disorders, "*conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk of suicide.*"

The ED Guide recommends that patients who score positive on the Decision Support Tool receive a suicide risk assessment as part of their ED-based mental health evaluation. The SAFE-T, which can be used in conjunction with the Decision Support Tool, offers a framework for performing suicide risk assessments in ED settings. In EDs where mental health specialists are readily available, consider referring all patients with any suicidal ideation or suspected suicide risk to a mental health specialist for further evaluation, including suicide risk assessment.

### Where can I learn more?

The following resources can help your hospital make decisions about using suicide risk assessment with suicidal patients and inform the hospital's process of developing a protocol. Information about training for ED providers can be found in the [Best Practices Registry](#) on the Suicide Prevention Resource Center website.

**SAFE-T Suicide Assessment Five-step Evaluation and Triage (2009)**

<http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432>

This card assists clinicians in conducting a suicide assessment to identify risk factors and protective factors, conduct a suicide inquiry, determine risk level and potential interventions, and document a treatment plan.

**Suicide Prevention Trainings for Emergency Medicine Providers**

[www.sprc.org/search/bpr/?filters=sm\\_resource\\_type%3Abpr\\_listing%20sm\\_program\\_type%3Aeducation\\_training%20tid%3A29](http://www.sprc.org/search/bpr/?filters=sm_resource_type%3Abpr_listing%20sm_program_type%3Aeducation_training%20tid%3A29)

Suicide prevention trainings for ED providers listed in the SPRC Best Practices Registry.

**Is Your Patient Suicidal? Tools to Help ED Providers When the Answer is “Yes”**

[http://www.sprc.org/library\\_resources/items/using-your-patient-suicidal-poster-and-triage-guide](http://www.sprc.org/library_resources/items/using-your-patient-suicidal-poster-and-triage-guide)

A four-color poster that provides ED professionals with information on recognizing and responding to acute suicide risk. Designed to be posted in staff-only areas.

**Clinical Practice Guideline: Suicide Risk Assessment (2012)**

[www.ena.org/practice-research/research/cpg/documents/suicideriskassessmentcpg.pdf](http://www.ena.org/practice-research/research/cpg/documents/suicideriskassessmentcpg.pdf) or use search term *suicide risk assessment*

The Emergency Nurses Association Clinical Practice Guideline evaluates the research literature on the initial assessment and evaluation of ED patients who have suicidal ideation, have attempted suicide, or are at high risk for future suicide attempts. It evaluates screening tools and scales used to assess potentially suicidal patients and the suicide risk of emergency patients.

**Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) Study Materials**

[www.emnet-usa.org/EDSAFE/edsafe.htm](http://www.emnet-usa.org/EDSAFE/edsafe.htm)

ED-SAFE is an eight-site NIMH-funded study.

**Suicide Risk Factors and Risk Assessment Tools: A Systematic Review (2012)**

[www.ncbi.nlm.nih.gov/books/NBK92671/pdf/TOC.pdf](http://www.ncbi.nlm.nih.gov/books/NBK92671/pdf/TOC.pdf)

This report reviews recent evidence about suicide risk factors and suicide risk assessment tools to inform practice guidelines for clinicians serving veterans and military populations. However, much of the information is also applicable to the general adult population.

**VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013)**

[www.healthquality.va.gov/guidelines/MH/srb/VADODCP\\_SuicideRisk\\_Full.pdf](http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf)

This guideline outlines a framework for a structured assessment of adults suspected to be at risk for suicide and describes the immediate and long-term management and treatment that should follow if an individual is found to be at risk.

**A Resource Guide for Implementing the Joint Commission 2007 Patient Safety Goals on Suicide (2007)**

[www.sprc.org/sites/sprc.org/files/library/jcsafetygoals.pdf](http://www.sprc.org/sites/sprc.org/files/library/jcsafetygoals.pdf)

This document serves as a resource guide, using the SAFE-T as a centerpiece to facilitate implementation of the Joint Commission patient safety goal on suicide.

## Appendix D: Sharing Patient Health Information

### Understanding What HIPAA Means for Mental Illness, National Alliance on Mental Illness (NAMI)

[www.nami.org/template.cfm?Section=Top\\_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=167363](http://www.nami.org/template.cfm?Section=Top_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=167363). Reproduced with permission from NAMI.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that helps protect the privacy of individual health information. For individuals living with mental illness, this law is important, because it helps protect confidential mental health treatment records.

Over the years, however, there have been many misunderstandings about the type and range of information that mental health treatment providers are allowed to share with others. This often resulted in situations where family and friends of a person living with mental illness were unable to communicate with healthcare providers, often to the detriment of a loved one.

The federal Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) has enforcement authority over HIPAA. On Feb. 21, 2014, OCR released guidance clarifying how and when healthcare providers may share an individual's mental health treatment information with others. Open communication between a mental health provider and family members or friends of a person living with mental illness can help make sure that the individual receives the best treatment and care possible. Below is a set of questions and answers to make sure you know what HIPAA means for you.

#### **Can healthcare providers share mental health treatment information to family members and friends of a person living with mental illness?**

Yes, healthcare providers may share information about treatment with a person's family or friends if the person with mental illness does not object.

#### **Are health care providers required to obtain a signed informed consent release before sharing information with family and friends?**

No, citing the "integral role that family and friend's play in a patient's health care," OCR's guidance states that providers may ask for permission to share relevant information, may tell the person that they intend to discuss information and give him or her the chance to object, or may infer from the circumstances, using professional judgment, that the person does not object. For example, if a person receiving treatment invites a family member and friend to be present in a treatment situation, the provider may assume that the person does not object to disclosure of information.

#### **What happens if the person living with mental illness objects to information sharing?**

If the person receiving treatment is an adult, objects to the release of information, and is deemed capable of making healthcare decisions by the healthcare provider, then the healthcare provider may not share information with family or friends. If the healthcare provider determines that a person does not have the capacity to make healthcare decisions, then the provider may choose to share information with family, friends, or other individuals involved in the person's care if the provider believes it is in the person's best interest. A court order is not required for a determination that a person lacks capacity. Discretion lies with the treatment provider, based on professional judgment.

**How much information can the healthcare provider share with a person’s family members or friends?**

Healthcare providers should exercise professional judgment and disclose only the information that is necessary or directly related to the family member or friend’s involvement in care. Psychotherapy notes—notes that are written by a provider during counseling sessions detailing specific conversations—are treated differently than other healthcare information because they may contain especially private or sensitive information. In most instances, a provider must have a patient’s permission before sharing information contained in psychotherapy notes.

**May family members or friends communicate with a healthcare provider if they are worried about a person’s health or wellbeing?**

Yes, family members or friends may share information that they believe might be relevant or helpful to a treatment provider. Healthcare providers are not required to disclose this communication to the individual receiving treatment.

**Can healthcare providers share information with parents or guardians of children?**

Generally speaking, yes, a healthcare provider may share treatment information with a parent, guardian, or an individual acting as a personal representative for a child.

**At what age is a child considered an adult for the purposes of healthcare decisions?**

Generally, age 18, but HIPAA defers to state law if a state has a different standard.

**Are there any other restrictions on how and when a healthcare provider may share information with parents or guardians?**

HIPAA establishes a floor for the privacy of health information. State laws that are more protective of privacy supersede HIPAA. State laws vary and it is important to become familiar with the laws in your state.

In addition, there are some federal laws that may have additional restrictions on sharing treatment information with parents or guardians. For example, the federal confidentiality statute that applies to federally-funded drug and alcohol treatment programs has standards that are stricter than HIPAA.

**Can healthcare providers share protected mental health information with law enforcement officials?**

Yes, in certain circumstances, particularly if the person living with mental illness poses a danger to self or others, then healthcare providers may disclose necessary information.

**See also:**

**HIPAA Privacy Rule for Sharing Information Related to Mental Health, U.S. Department of Health and Human Services**

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html>

This guidance clarifies when HIPPA permits health care providers to:

- » Communicate with a patient's family members, friends, or others involved in the patient's care
- » Communicate with family members when the patient is an adult
- » Communicate with the parent of a patient who is a minor
- » Consider the patient's capacity to agree or object to the sharing of their information
- » Involve a patient's family members, friends, or others in dealing with patient failures to adhere to medication or other therapy
- » Listen to family members about their loved ones receiving mental health treatment
- » Communicate with family members, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others
- » Communicate to law enforcement about the release of a patient brought in for an emergency psychiatric hold

## Appendix E: Sample Letter to Outpatient Mental Health Providers

**Adapted from the Suicide Prevention Toolkit for Rural Primary Care**

[www.sprc.org/library\\_resources/items/suicide-prevention-toolkit-rural-primary-care](http://www.sprc.org/library_resources/items/suicide-prevention-toolkit-rural-primary-care)

Date

Name

Address

Address

Dear [Mental Health Professional Name]:

We at [Name of ED] are implementing changes in our department to help us better identify and treat patients who are at elevated risk for suicide. We are training our staff to better recognize the common warning signs of suicide and to screen patients for suicidal ideation. As we step up our vigilance for suicide risk, we would like to explore how we might partner with you to improve continuity of care for our patients with suicide risk who are discharged from our emergency department.

A resource developed by the Suicide Prevention Resource Center, *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*,\* is helping us with this effort. The guide highlights the importance of linking patients with follow-up care within seven days of ED discharge for increased safety and to improve patient outcomes. It also suggests we share with you tools and resources developed by the nation's leading mental health experts. Although you may already know this information, having it concisely presented in an organized way may be useful. We will also be using tools from the guide that have been developed specifically for emergency medicine professionals. Page two of this letter contains a resource list.

We would like to work with you to assure the best access for our patients to your specialized knowledge and expertise. Since collaborative care requires strong communication, I would like to propose that we set up a meeting or phone call to share perspectives and develop a model for collaboration. I would also like to explore the feasibility of developing a referral protocol that would facilitate access to follow-up care within seven days of ED discharge for patients with suicide risk. I will be contacting your office in the near future to explore this possibility.

Sincerely yours,

\*To view *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*, visit: [www.sprc.org/ed-guide](http://www.sprc.org/ed-guide)

**Resources for Mental Health Providers—Page Two of Sample Letter to Outpatient Mental Health**

Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals

[www.sprc.org/bpr/section-III/assessing-and-managing-suicide-risk-core-competencies-mental-health-professionals-am](http://www.sprc.org/bpr/section-III/assessing-and-managing-suicide-risk-core-competencies-mental-health-professionals-am)

Attachment-Based Family Therapy (ABFT)

[www.sprc.org/bpr/section-I/attachment-based-family-therapy-abft](http://www.sprc.org/bpr/section-I/attachment-based-family-therapy-abft)

Brief Psychological Intervention after Deliberate Self-Poisoning

[www.sprc.org/bpr/section-I/brief-psychological-intervention-after-deliberate-self-poisoning](http://www.sprc.org/bpr/section-I/brief-psychological-intervention-after-deliberate-self-poisoning)

Experiential Training in the Chronological Assessment of Suicide Events (CASE Approach)

[www.sprc.org/bpr/section-III/experiential-training-chronological-assessment-suicide-events-case-approach](http://www.sprc.org/bpr/section-III/experiential-training-chronological-assessment-suicide-events-case-approach)

Depression Wellness Guide for Adults with Depression and their Family and Friends

[www.sprc.org/bpr/section-III/depression-wellness-guide-adults-depression-and-their-family-and-friends](http://www.sprc.org/bpr/section-III/depression-wellness-guide-adults-depression-and-their-family-and-friends)

Dialectical Behavior Therapy

[www.sprc.org/bpr/section-I/dialectical-behavior-therapy](http://www.sprc.org/bpr/section-I/dialectical-behavior-therapy)

Dynamic Deconstructive Psychotherapy (DDP)

[www.sprc.org/bpr/section-I/dynamic-deconstructive-psychotherapy-ddp](http://www.sprc.org/bpr/section-I/dynamic-deconstructive-psychotherapy-ddp)

Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)

[www.sprc.org/bpr/section-I/multisystemic-therapy-psychiatric-supports-mst-psychiatric](http://www.sprc.org/bpr/section-I/multisystemic-therapy-psychiatric-supports-mst-psychiatric)

QPRT Suicide Risk Assessment and Management Training

[www.sprc.org/bpr/section-III/qprt-suicide-risk-assessment-and-management-training](http://www.sprc.org/bpr/section-III/qprt-suicide-risk-assessment-and-management-training)

## Appendix F: Community Resource List Template

Community resource lists can facilitate making referrals to services in the local community. This template may be used to develop a complete local list. To get started, consult with a community human services agency such as 211 that may have an existing list to share. Update this list annually to maintain accuracy.

HEALTH CARE, MENTAL HEALTH, AND SUBSTANCE ABUSE RESOURCES	
Community Mental Health Agencies	Community Health Centers
Private Practice Mental Health Providers	Private Practice Primary Care Providers
Mental Health Crisis Services	Tribal Health/Traditional Healers
Peer Support Services (e.g., NAMI, Wellness Centers)	Health Insurance Connector
VA Suicide Prevention Coordinator	VA Clinic
Substance Abuse Treatment	HIV/AIDS Information and Testing Sites
Alcoholics Anonymous/Narcotics Anonymous	Diabetes Prevention and Support
Hospital/Emergency Services	Paramedic Emergency Medical Services Unit
Children/Youth Psychiatric Clinic	Other
OTHER RESOURCES	
911/211 Information Services	Children's Services Office/Social Services
Emergency Shelter	Child Care Referrals
Housing Services	Parent Training/Elder/Health and Wellness Center
Youth Shelter/Safe House	Parent Helpline
LGBT Services	Transportation Providers
Domestic Violence Services	Senior Services
Domestic Violence Helpline	Commodity Programs
Religious/Spiritual Support	Self-Help Groups/Prayer Lodges/Talking Circles
Legal Assistance/Legal Aid/Tribal Courts	Food Bank
WIC and/or Indian Health Services Nutrition	School Student Services/Tribal Education Department
Job Training and Placement Programs	Other
ESL Services	Other

## Appendix G: Caring Contacts Sample Materials

Caring contacts is an evidence-based intervention covered in Section 3 ED-Based Brief Suicide Prevention Interventions. For hospitals wishing to implement this intervention, a few samples of caring contact materials are provided below. These samples are based on the work of suicide prevention professionals and researchers using caring contacts in crisis centers, hospitals, and VA settings across the United States. They can be adapted for use in your ED and for current technology options (e.g., text messaging, e-mail).

### Sample 1.

Dear <<First Name>>

It has been a little while since you were at University Hospital, and we hope things are going well for you.

If you would like to send us a note we would enjoy hearing from you.

Best wishes,

Dr. Smith

### Sample 2.

Dear <<First Name>>

It was great to meet you at University Hospital. We hope you are doing well. We remember that you said you enjoy being a grandparent. We hope you're getting time to spend with your grandchildren this Spring.

We just wanted to send a quick note to let you know we are thinking about you and wish you well. If you'd like to reply to us and send us an update, we would be happy to hear from you.

Sincerely,

Sandra Lamont, LCSW

Please note the following resources are available to you:

<<Enter resources locally and nationally available including National Suicide Prevention Lifeline>>

### Sample 3. Oklahoma City VA Medical Center

This program sends quarterly newsletters to patients at risk of suicide with information about health and mental health. The caring note is hand-written by the case manager in a space in the newsletter provided for this purpose.

Hi <<Mr. or Ms.>> <<Last Name>>,

I hope you have been doing well since we last spoke. Give me a call if there's anything I can do for you.

Bryan Stice, PhD

Suicide Prevention Case Manager

<<Phone>>

This message is in keeping with the spirit of the examples used in published studies of caring contacts, where there is an expression of concern and no demands are made on the recipient. To learn more, contact Bryan Stice, PhD, Suicide Prevention Case Manager, Department of Veterans Affairs, 921 N.E. 13th Street, Oklahoma City, OK, 73104, Bryan.Stice@va.gov, 405-456-5206.

#### **For other examples of caring contacts see:**

Carter, G. I., Clover, K., Whyte, I. M., Dawson, A. H., & D'Este, C. (2005). Postcards from the EDge project: Randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *BMJ*, doi: 10.1136/bmj.38579.455266.E0.

Luxton, D. D., Thomas, E. K., Chipps, J., Relova, R. M., Brown, D., McLay, R., . . . Smolenski, D. J. (2014). Caring letters for suicide prevention: Implementation of a multi-site randomized clinical trial in the U.S. military and Veteran Affairs healthcare systems. *Contemporary Clinical Trials*, 37(2), 252–260. doi: 10.1016/j.cct.2014.01.007

## Appendix H: Key Elements of a Patient Care Plan

Discharge planning centers around a patient care plan, which combines standards for general ED patients and those for patients with suicide risk. Recommended elements of a patient care plan for patients with suicide risk are listed below. Some elements of a [safety plan](#) may be substituted for the following items:

1. Diagnosis, expected course
2. The risk of suicide during the post-discharge timeframe
3. Warning signs for suicide, signs of worsening condition, and what to do
4. When to return to the ED
5. Patient instruction for reducing [risk factors and increasing protective factors](#) for suicide, including plans for limiting access to lethal means
6. Plans for how to avoid the use of intoxicants and an explanation of how intoxicants increase risk
7. Treatment adherence and follow-up appointments (e.g., provider name, appointment date, provider location)
8. Medications list and instructions
9. Outstanding tests

The patient care plan should be documented in the patient's chart.

Sources: Agency for Healthcare Research and Quality [IDEAL Discharge Planning](#), Agency for Healthcare Research and Quality [Project RED](#) (Re-Engineered Discharge), Institute for Healthcare Improvement [SMART Discharge Protocol](#), Suicide Prevention Resource Center [Continuity of Care for Suicide Prevention and Research](#), [VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide](#), and recommendations made by the Emergency Department Consensus Panel.

## Appendix I: Examining Your Views about Suicide

*Adapted for ED providers from TIP 50: Addressing Suicidal Thoughts and Behaviors of People in Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration*

Attitudes toward suicide vary widely. Some people hold religious, spiritual, or cultural views that strongly oppose suicidal behavior. Others see suicide as a viable option for ending unmanageable suffering. Some believe it is all right to think about suicide but not to act on those thoughts. Our attitudes are influenced by our culture, childhood influences, and professional and personal experiences with suicidal thinking and behavior.

Some ED providers may have trouble reconciling their views of themselves as life-saving medical providers and may feel unskilled at helping patients who have emotional or psychiatric problems. They may see suicidal patients as people trying to kill themselves rather than as having what they might consider to be “real” emergencies. Being aware of your views about suicide can help you improve your interactions with suicidal patients and, in turn, improve how suicidal patients experience the care they receive from you.

Below is an inventory that will help you assess your attitudes toward suicide. The goal is not to change your views but rather to make you aware of those views and how they can positively or negatively affect your interactions with patients at risk for suicide.

### Inventory

Consider the following questions:

- » What is my personal and family history with suicidal thoughts and behaviors?
- » What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal patients?
- » What is my emotional reaction to patients who are suicidal?
- » How do I feel when talking to patients about their suicidal thoughts and behaviors?
- » What did I learn about suicide in my formative years?
- » How does what I learned then affect how I relate today to people who are suicidal?
- » What beliefs and attitudes, including cultural or religious values, do I hold today that might limit me or help me in working with people who are suicidal?

It may be useful to further clarify your views in consultation with your clinical supervisor or with your peers. A negative attitude may cause you to miss opportunities to offer hope and help, or you may overreact when patients are in a suicidal crisis. An empathic attitude can help you understand and engage these patients.

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# Acknowledgements

## Acknowledgements

*Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments* was developed by the Suicide Prevention Resource Center (SPRC) and co-authored by Lisa Capoccia and Magdala Labre.

The following people contributed their time and expertise to the development of this resource:

Members of the Consensus Panel, Zoe Baptista, Catherine Barber, Sara Burke, Colleen Carpenter, Gregory Carter, Robin Cheung, Laurie Davidson, Rebecca Driscoll, Scott Formica, Barbara Gay, Julie Goldstein Grumet, Stephen Hargarten, Bradley Karlin, Dmitry Khodyakov, Patty Konarski, Faren Levell, Joanne Matthews, Chris Miara, Kimberly Nordstrom, MaryJo Oster, Jane Pearson, Chelsea Pepi, Cheryl Puntil, Jennifer Roscoe, Amanda Ruiz, Skip Simpson, Karen Solis, Bryan Stice, Jeanelle Sugimoto-Matsuda, Diana Weisner, and Eileen Zeller.

The Suicide Prevention Resource Center is supported by a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 5U79SM059945.

## Endorsements

**The following organizations have endorsed the material covered in this guide:**

American Academy of Emergency Medicine  
American Association of Emergency Psychiatry  
American Association of Suicidology  
American Foundation for Suicide Prevention

## Suggested citation

Suicide Prevention Resource Center. (2015). *Caring for adult patients with suicide risk: A consensus guide for emergency departments*. Waltham, MA: Education Development Center, Inc.

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June 2015

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