Suicide Prevention in Family Medicine

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THE WACO GUIDE
TO PSYCHOPHARMACOLOGY IN PRIMARY CARE

WACO FAMILY MEDICINE

Objectives

Identify	Identify patients at elevated risk for suicide
Recognize	Recognize warning signs of patients at risk for suicide and appropriately intervene
Intervene	Utilize the best evidence-based interventions (pharmacologic and non-pharmacologic) for interventions with patients at risk for suicide

Limitations

- Focus on adults
- Less emphasis on special populations
- Data on suicide risk assessment is fraught with complexity
- Robust systems level opportunities exist
  - Allied health training, clinical protocols/pathways
  - Beyond the scope of this discussion

Objective 1

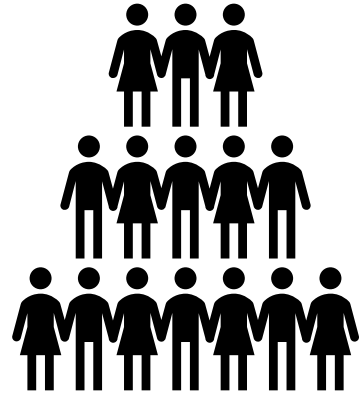
Identify: Identify patients at elevated risk for suicide

Suicide affects all ages

2020: suicide among the **top 9 leading causes of death** for ages **10-64**

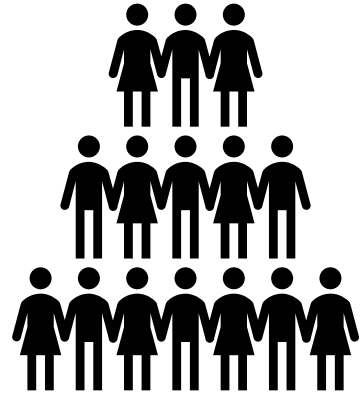
Suicide was the **2nd leading cause of death** for ages **10-14 and 25-34**

Epidemiology



- Age:
  - 45- 54 years and 75-84 years have the highest suicide rates
  - However, increases in other age groups have almost eliminated the age differences.
  - Suicidal thoughts, plans, and attempts are highest among people 18 to 25 years
- Race: White people 2X as likely to die by suicide as Black
- LGBTQ+:
  - Gay men and women 2X as likely to die by suicide
  - More than 40% of people who identify as transgender have attempted suicide
- Geography:
  - People living in rural areas are more likely to commit suicide
  - And to do so by firearm

Epidemiology



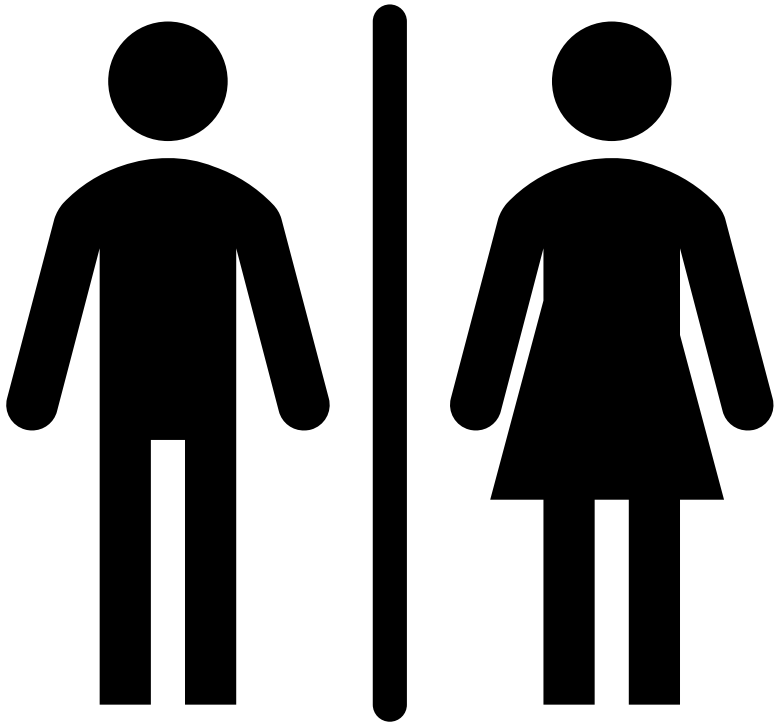
- 2023: more than 49,000 people died by suicide

- Rates briefly declined during the COVID-19 pandemic years (2020–2021),
  - **They have since rebounded**

CDC. Suicide Data and Statistics. Suicide Prevention. March 26, 2025. Accessed July 14, 2025. https://www.cdc.gov/suicide/facts/data.html

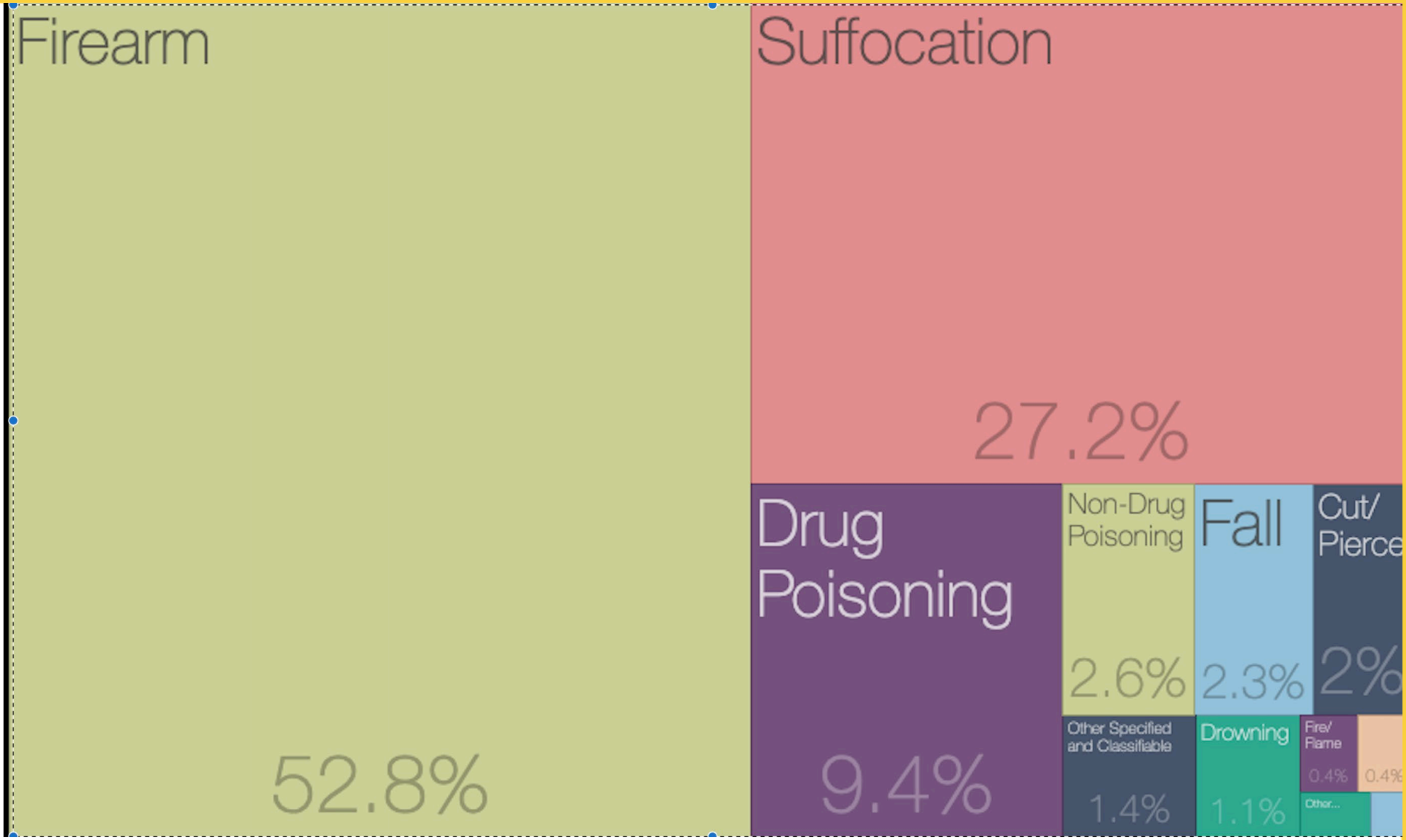
Epidemiology: Gender Differences

- Women are twice as likely as men to attempt suicide
- Men are nearly four times more likely to die by suicide
  - Men are more likely to use violent means, including firearms and hanging
  - Women more likely to use poisoning



Centers for Disease Control and Prevention, National Center for Injury Prevention and Control
Accessed March 10, 2022.
https://www.cdc.gov/suicide/facts/index.html

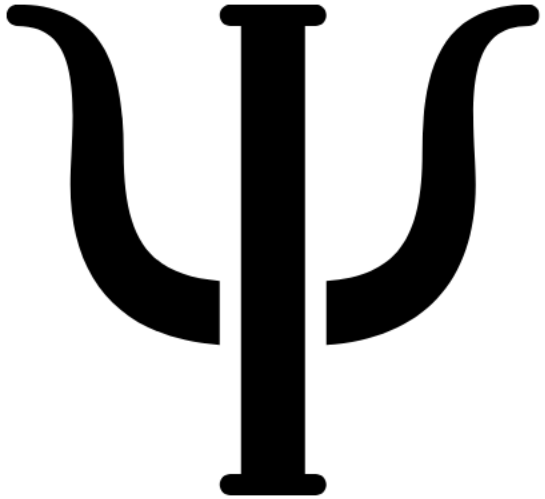
MEANS FOR SUICIDE **2020**



Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Web-based injury statistics query and reporting system (WISQARS). Accessed March 14, 2022. https://www.cdc. gov/injury/wisqars/index.html

Mental Disorders and Risk of Suicide

- 2018 Meta-Analysis: individuals with a mental disorder with nearly eight-fold increased risk of suicide compared with those without a mental disorder
  - Most mental health conditions were associated with an increased risk of suicide
- Large study (2019): Risk of suicide mortality was highest among those with:
  - schizophrenia spectrum disorder (adjusted odds ratio [aOR]=15.0)
  - bipolar disorder (aOR=13.2),
  - depressive disorders (aOR=7.2)
  - anxiety disorders (aOR=5.8)
  - ADHD (aOR=2.4)
- The risk of suicide death among those with a diagnosed bipolar disorder was higher in women than men.



Lay San Too, Matthew J. Spittal, Lyndal Bugeja, Lennart Reifels, Peter Butterworth, Jane Pirkis,
The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies,
Journal of Affective Disorders, Volume 259, 2019, Pages 302-313, ISSN 0165-0327, https://doi.org/10.1016/j.jad.2019.08.054.

Yeh HH, Westphal J, Hu Y, Peterson EL, Williams LK, Prabhakar D, Frank C, Autio K, Elsiss F, Simon GE, Beck A, Lynch FL, Rossom RC, Lu CY, Owen-Smith AA, Waitzfelder BE, Ahmedani BK. Diagnosed Mental Health Conditions and Risk of Suicide Mortality. Psychiatr Serv. 2019 Sep 1;70(9):750-757.

Why Primary Care?

Why Primary Care?

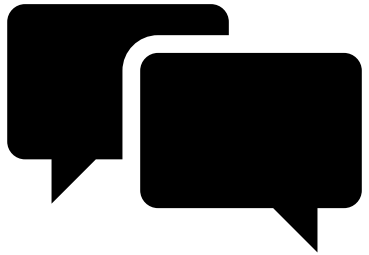
- Patients who die by suicide are more likely to have seen a PCP in the previous month before their death than any other health care provider
- Of those dying by suicide, **~45% will have seen their PCP within the month before their death**, while only 20% will have seen a mental health professional in that period
- For a patient at risk for suicide, a visit with the PCP may be the only chance to access needed care – especially in rural settings

ClLuoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159:909–91

Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. *J Gen Intern Med.* 2014;29:870–877.

Evaluation

Asking About Suicide



No Iatrogenic Effect: Asking patients at high risk about suicide does not increase suicidal ideation or attempts and leads to better outcomes

- Some studies suggest slight benefit
- It can help a patient feel less isolated and scared
- This is an important reminder for a patient's loved ones

Caroline A. Blades, Werner G.K. Stritzke, Andrew C. Page, Julia D. Brown,The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide-related content. Clinical Psychology Review, Volume 64, 2018, p. 1-12

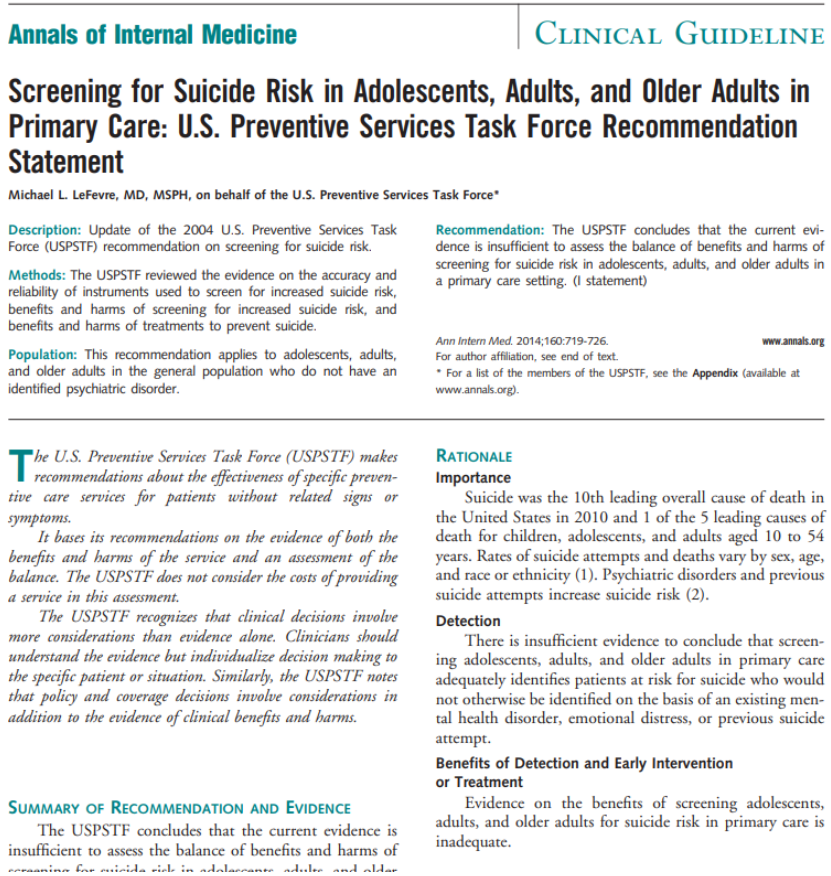
Mathias, C. W., Michael Furr, R., Sheftall, A. H., Hill-Kapturczak, N., Crum, P., & Dougherty, D. M. (2012). What's the harm in asking about suicidal ideation?. *Suicide & life-threatening behavior*, *42*(3), 341–351. https://doi.org/10.1111/j.1943-278X.2012.0095.x

Christine Polihronis, Paula Cloutier, Jaskiran Kaur, Robin Skinner & Mario Cappelli (2020) What's the harm in asking? A systematic review and meta-analysis on the risks of asking about suicide-related behaviors and self-harm with quality appraisal, Archives of Suicide Research

Sall J, Brenner L, Millikan Bell AM, et al. Assessment and management of patients at risk for suicide: synopsis of the 2019 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guide- lines. *Ann Intern Med*. 2019;171(5):343-353.

Screening- Insufficient Evidence for Universal Suicide Screening

USPSTF concluded there is insufficient evidence to demonstrate that routine screening for suicide risk in adolescents, adults, and older adults reduces **attempts** or **mortality** from suicide



Annals of Internal Medicine | CLINICAL GUIDELINE

Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: U.S. Preventive Services Task Force Recommendation Statement

Michael L. LeFevre, MD, MSPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for suicide risk.

Methods: The USPSTF reviewed the evidence on the accuracy and reliability of instruments used to screen for increased suicide risk, benefits and harms of screening for increased suicide risk, and benefits and harms of treatments to prevent suicide.

Population: This recommendation applies to adolescents, adults, and older adults in the general population who do not have an identified psychiatric disorder.

Recommendation: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in a primary care setting. (I statement)

Ann Intern Med. 2014;160:719-726. www.annals.org

For author affiliation, see end of text.

* For a list of the members of the USPSTF, see the **Appendix** (available at www.annals.org).

The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

SUMMARY OF RECOMMENDATION AND EVIDENCE

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of

RATIONALE

Importance

Suicide was the 10th leading overall cause of death in the United States in 2010 and 1 of the 5 leading causes of death for children, adolescents, and adults aged 10 to 54 years. Rates of suicide attempts and deaths vary by sex, age, and race or ethnicity (1). Psychiatric disorders and previous suicide attempts increase suicide risk (2).

Detection

There is insufficient evidence to conclude that screening adolescents, adults, and older adults in primary care adequately identifies patients at risk for suicide who would not otherwise be identified on the basis of an existing mental health disorder, emotional distress, or previous suicide attempt.

Benefits of Detection and Early Intervention or Treatment

Evidence on the benefits of screening adolescents, adults, and older adults for suicide risk in primary care is inadequate.

Depression Screening & Suicidal Ideation

Clinical Review & Education

Special Communication | USPSTF RECOMMENDATION STATEMENT

Screening for Depression in Adults

US Preventive Services Task Force Recommendation Statement

Albert L. Siu, MD, MSPH; and the US Preventive Services Task Force (USPSTF)

DESCRIPTION Update of the 2009 US Preventive Services Task Force (USPSTF) recommendation on screening for depression in adults.

METHODS The USPSTF reviewed the evidence on the benefits and harms of screening for depression in adult populations, including older adults and pregnant and postpartum women; the accuracy of depression screening instruments; and the benefits and harms of depression treatment in these populations.

POPULATION This recommendation applies to adults 18 years and older.

RECOMMENDATION The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

JAMA. 2016;315(4):380-387. doi:10.1001/jama.2015.18392

Editorial pages 349 and 351

Author Audio and Video Interviews and JAMA Report Video at jama.com

Related article page 388 and JAMA Patient Page page 428

CME Quiz at jamanetworkcme.com and CME Questions page 411

Related articles at jamapsychiatry.com, jamainternalmedicine.com, and jamaneurology.com

Author Affiliations: Author affiliations are listed at the end of this article.

Authors/Group Information: The USPSTF members are listed at the end of this article.

Corresponding Author: Albert L. Siu, MD, MSPH (albert.siu@mssm.edu).

- USPSTF Recommends screening all adults for depression
- Many primary care settings already rely on the PHQ-9 for screening all patients over age 12 for depression.
- Item 9 “Over the past two weeks, have you been bothered by… thoughts that you would be better off dead or of hurting yourself in some way.”
- If only PHQ-2 is used for routine screening, consider adding in question 9

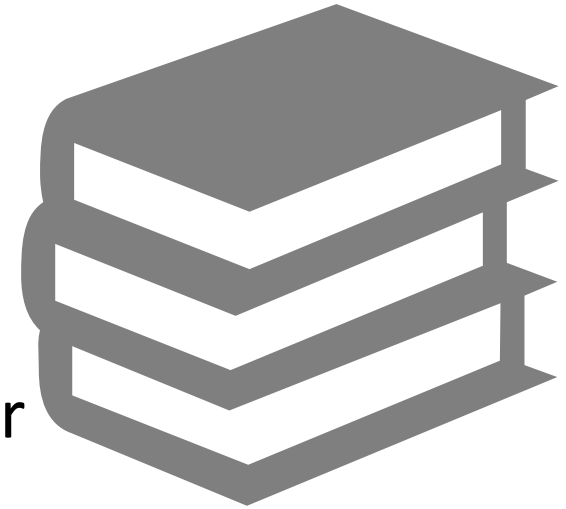
Sall J, Brenner L, Millikan Bell AM, et al. Assessment and management of patients at risk for suicide: synopsis of the 2019 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guide- lines. *Ann Intern Med*. 2019;171(5):343-353.

Objective 2

Recognize: Recognize warning signs of patients at risk for suicide and appropriately intervene

Differentiating Key Constructs

- **Morbid ideation** (morbid ruminations)
  - No personal agency
- **Suicidal ideation**
  - Personal agency
- **Self-harm or Nonsuicidal self-injury**
  - Underlying reason is emotion regulation or something other than death (Simon & Hales, 2012)



Uniform Definitions

- **Suicidal self-directed violence:** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
  - There is evidence, whether implicit or explicit, of suicidal intent.

- **Suicide attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.
  - A suicide attempt may or may not result in injury

Problematic Terms

- Suicide gesture
- Manipulative act
- Suicide threat
- Attention seeking

- Gives a value judgment with a pejorative or negative impression of the person's intent.
- A more objective description of the event is preferable
  - Non-suicidal self-directed violence
  - Suicidal self-directed violence.

Assessment

Evaluation

- No consensus recommendations to stratify risk for suicide
  - Recent meta-analyses found that approximately one-half of patients who were categorized as low risk ultimately died by suicide

- Current recommendations emphasize:
  - Individualized assessment of the seriousness of suicidal ideation
  - Identifying warning signs, incorporating known risk factors and understanding factors that may exacerbate thoughts of self-harm for the patient

Large MM, Ryan CJ, Carter G, et al. Can we usefully stratify patients according to suicide risk? *BMJ*. 2017;359:j4627.

Morriss R, Kapur N, Byng R. Assessing risk of suicide or self harm in adults. *BMJ*. 2013;347:f4572.

Kessler, R. C., Bossarte, R. M., Luedtke, A., Zaslavsky, A. M., & Zubizarreta, J. R. (2020). Suicide prediction models: a critical review of recent research with recommendations for the way forward. *Molecular psychiatry*, *25*(1), 168–179. https://doi.org/10.1038/s41380-019-0531-0

Norris DR, Clark MS. The Suicidal Patient: Evaluation and Management. Am Fam Physician. 2021 Apr 1;103(7):417-421.

Suicide Risk Assessment

- Warning Signs: indicate an immediate risk of suicide
- Risk Factors: stratifies level of risk
    - Static—Often of little use in treatment
    - Dynamic—potentially modifiable
- Protective Factors

Warning Signs of Acute Risk For Suicide

- Threatening to hurt or kill self, or talking of wanting to hurt or kill self
- Looking for ways to kill self by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary

American Association of Suicidology
https://suicidology.org/resources/warning-signs/

What are the Risk Factors and Protective Factors?

Risk Factors

Biologic

Age (45 to 54 years and 75 to 84 years)

Cisgender male

Race (White)

Recent illness diagnosis or chronic disease

Environmental/social

Access to means

Changes in future plans (e.g., changing or establishing a will; making funeral arrangements)

Recent suicide exposure

Stressful life event (e.g., death of loved one, unemployment, end of a relationship, legal issues)

Unmarried or limited social support

Risk Factors

Psychological

Feelings of social isolation (including members of the lesbian, gay, bisexual, transgender, queer+ community)

History of suicide attempts (personal or family)

Hopelessness

Insomnia

Irritability

Psychiatric history (personal or family), such as anxiety, mood disorders, schizophrenia, borderline personality disorder

Substance (including ethanol) misuse disorder

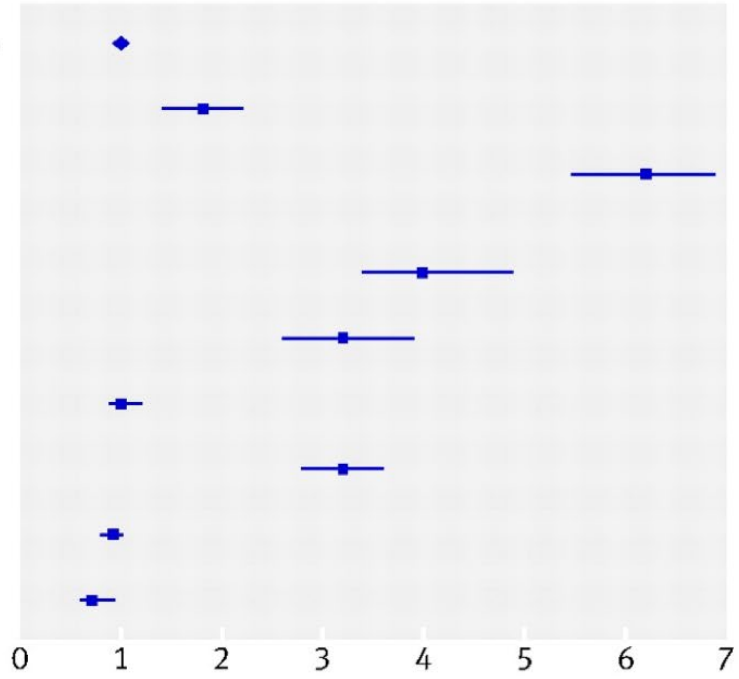
Norris DR, Clark MS. The Suicidal Patient: Evaluation and Management. Am Fam Physician. 2021 Apr 1;103(7):417-421.

Probert-Lindström S, Berge J, Westrin Å*, et al* Long-term risk factors for suicide in suicide attempters examined at a medical emergency in patient unit: results from a 32-year follow-up study *BMJ Open* 2020.

Nock MK, Borges G, Bromet EJ, Alonso J, Angermeyer M, Beautrais A, Bruffaerts R, Chiu WT, de Girolamo G, Gluzman S, de Graaf R, Gureje O, Haro JM, Huang Y, Karam E, Kessler RC, Lepine JP, Levinson D, Medina-Mora ME, Ono Y, Posada-Villa J, Williams D. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Br J Psychiatry. 2008 Feb;192(2):98-105

Method of attempted suicide as predictor of subsequent successful suicide

Method	No	Adjusted hazard ratio (95% CI)
Poisoning	40 746	Reference
Gassing	419	1.8 (1.4 to 2.2)
Hanging, strangulation, or suffocation	700	6.2 (5.5 to 6.9)
Drowning	326	4.0 (3.4 to 4.9)
Firearm or explosive	327	3.2 (2.6 to 3.9)
Cutting or piercing	2423	1.0 (0.9 to 1.2)
Jumping from a height	802	3.2 (2.8 to 3.6)
Other method	1982	0.9 (0.8 to 1.0)
Late effect of suicide attempt or other self inflicted harm	924	0.7 (0.6 to 0.9)
Total	48 649	



Bo Runeson et al. BMJ 2010;341:bmj.c3222

thebmj

Protective Factors

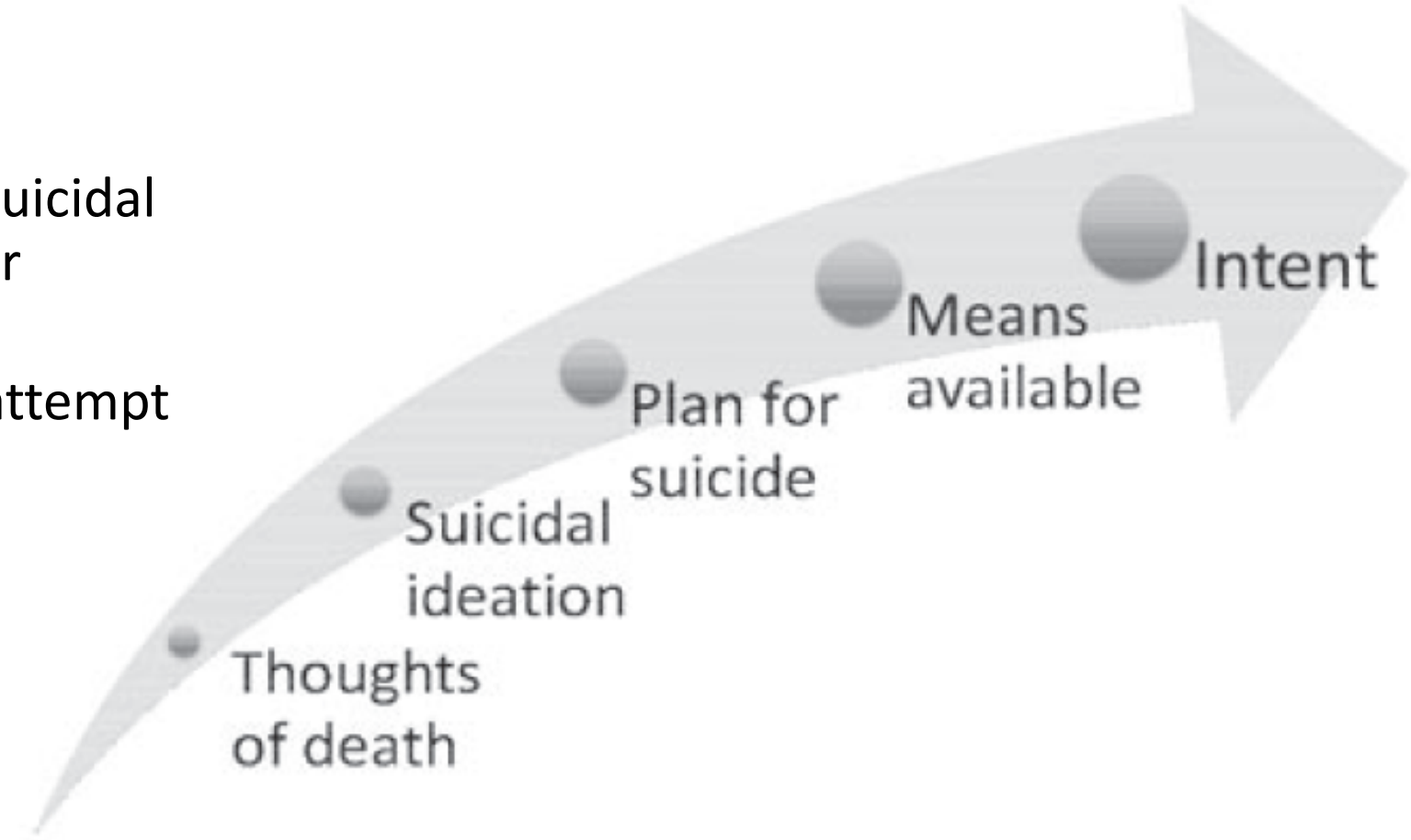
- Effective Behavioral Health Care
- Connectedness to individuals, family, community, and social institutions
- Life skills (including problem solving skills and coping skills, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide

Suicide Prevention Resource Center
https://www.sprc.org/about-suicide/risk-protective-factors
Accessed March 14, 2022

American Psychiatric Association
https://www.psychiatry.org/patients-families/suicide-prevention
Accessed March 15, 2022

Interviewing

- Interview tips:
  - Ask about the worst suicidal ideation or intent ever experienced
  - Ask about the worst attempt
  - Normalize



McDowell AK, Lineberry TW, Bostwick JM. Practical suicide-risk management for the busy primary care physician. Mayo Clin Proc. 2011 Aug;86(8):792-800. doi: 10.4065/mcp.2011.0076. Epub 2011 Jun 27. PMID: 21709131; PMCID: PMC3146379.

Objective 3

Intervene: Utilize the best evidence-based interventions (pharmacologic and non-pharmacologic) for interventions with patients at risk for suicide

VA/DoD Clinical Practice Guidelines

Assessment and Management of Patients at Risk for Suicide

Provider Summary

Version 3.0 | 2024

Acute Risk Stratification

https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskCPGProviderSummaryFinal5088212019.pdf

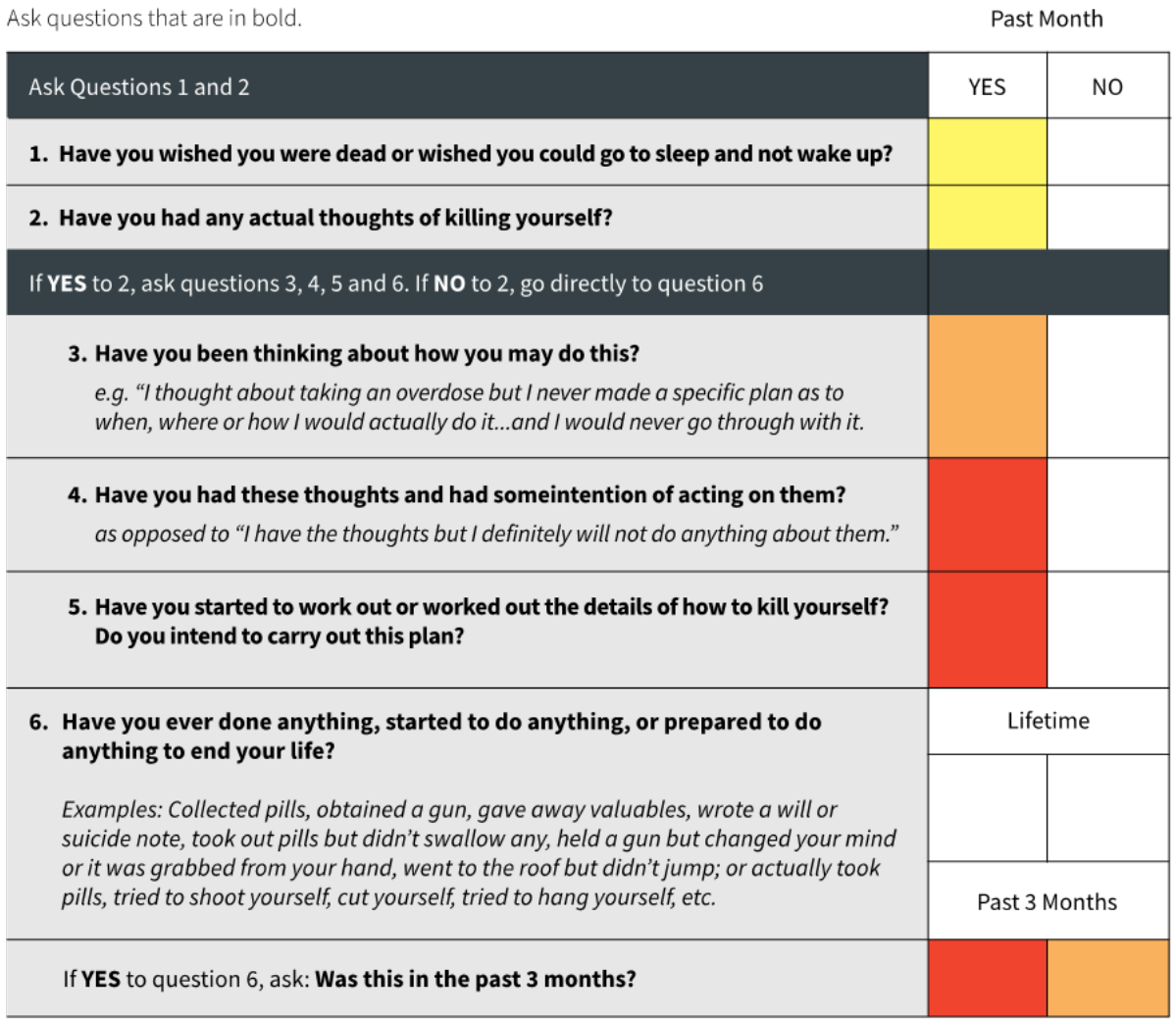
	Essential Features
High Risk	– Suicidal ideation with intent to die by suicide – Inability to maintain safety, independent of external support/help
Intermediate Risk	– Suicidal ideation to die by suicide – Ability to maintain safety, independent of external support/help
Low Risk	– No current suicidal intent AND – No specific and current suicidal plan AND – No recent preparatory behaviors AND – Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Measures to Consider for Stratifying Risk

Once screening shows some risk for suicide, additional instruments can then be deployed to get more detail and a better assessment of risk

Columbia-Suicide Severity Rating Scale (C-SSRS)

- For use in a multitude of community and healthcare settings
- The C-SSRS determined clinically meaningful points at which a person may be at risk for a suicide attempt.
- American Journal of Psychiatry (2011)

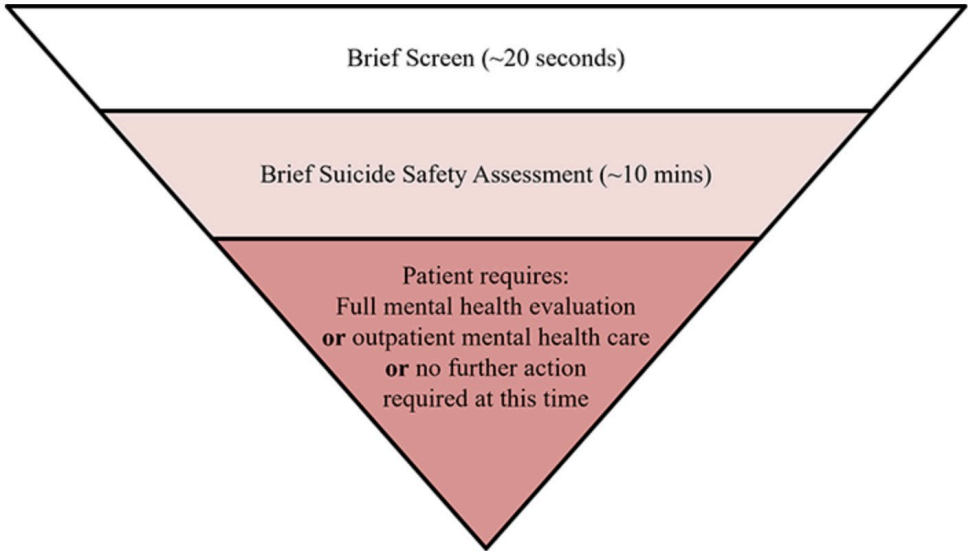


Ask questions that are in bold.

	Past Month	
Ask Questions 1 and 2	YES	NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual thoughts of killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Ask Suicide-Screening Questions (ASQ)

- Ask Suicide-Screening Questions (ASQ) tool is a set of four brief suicide screening questions that takes 20 seconds to administer



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

When? _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

ACUTE MANAGEMENT

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Department of Veterans Affairs

Department of Defense

Acute Management: High Risk

- When in doubt about the need for admission, inpatient care is the prudent option.
- Keep in mind that a patient referred for admission but not placed in the hospital may experience additional stress and increased feelings of helplessness
  - Close follow-up is critical

Action
– Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors – These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) – During hospitalization co-occurring conditions should also be addressed

Acute Risk Stratification: Intermediate Risk

- Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis)
- Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan
- Mental health treatment should also address co-occurring conditions

Acute Risk Stratification: Low Risk

Patients are appropriate for mental/behavioral health care as needed.

Some might be managed in primary care settings; others might require mental/behavioral health follow-up to continue successful treatments.

Brief Evidence-Based Interventions

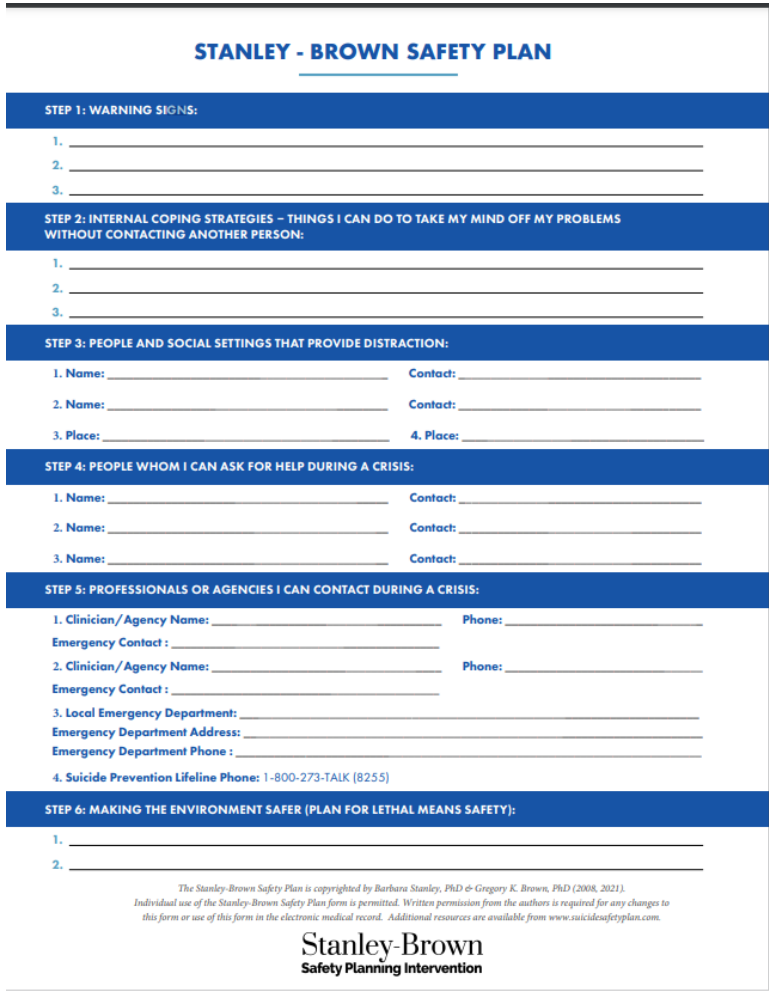
1. Creating a safety plan with the patient
2. Reducing access to lethal means
3. Implementing Caring Contacts

“No Harm Contracts”

- AKA “No Suicide Contracts”
- No empirical evidence supports the effectiveness of no-harm contracts in preventing suicide (VA/DoD 2019)
- Emphasis on what the patient should NOT DO
  - Provides little clarity on what to do to be safe

Safety Planning Intervention

A brief intervention to help those experiencing self-harm and suicidal thoughts with a concrete way to mitigate risk and increase safety



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

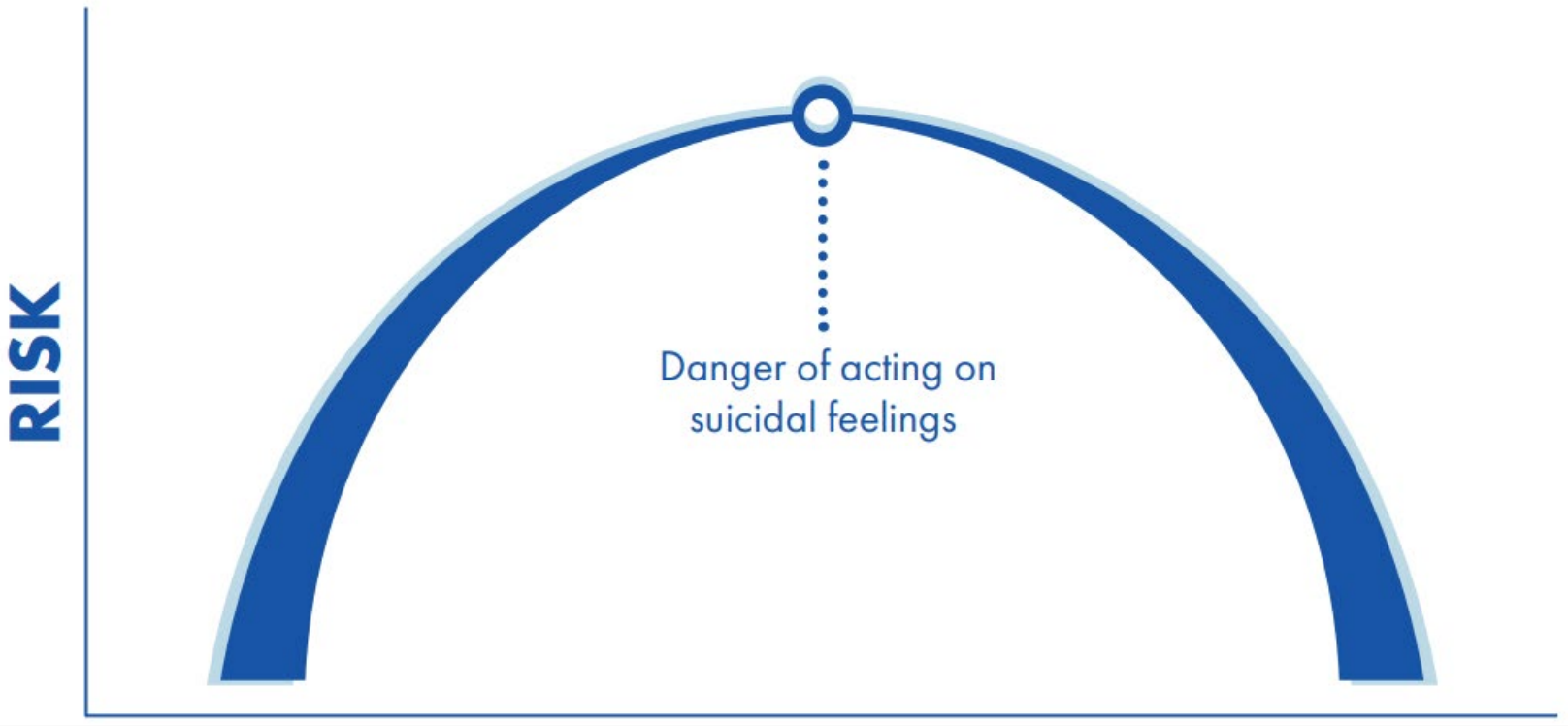
STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Ferguson M, Rhodes K, Loughhead M, McIntyre H, Procter N. The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review. *Archives of Suicide Research*. 2022;26(3):1022-1045.

SUICIDE RISK CURVE



(Stanley & Brown, 2021)

Safety Planning Intervention Steps

- Review Suicide Risk Curve
- Offer Rationale for Safety Planning
- Describe Collaborative Process of Safety Planning
- Complete Safety Plan Steps
- Review Use of the Safety Plan

Safety Plan

Step 1. Warning Signs

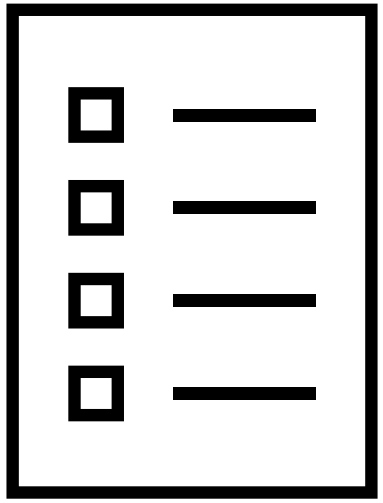
Step 2. Internal Coping Strategies

Step 3. People/Settings that provide distraction

Step 4. People Who I Can Ask for Help

Step 5. Professionals/Agencies I Can Contact During Crisis

Step 6. Making the Environment Safe



Reducing Access to Lethal Means

Lethal Means Counseling

Medications: Most common method of suicide attempts

- Safely dispose of medications no longer in use.
- Keep only small quantities on hand. Consult a pharmacist for safe dosing practices and safety packaging as appropriate.
- Lock up abuse-prone medicines, such as opiates, benzodiazepines, sedatives or hypnotics.

Firearms: Most common method of suicide

- Store firearms unloaded in a locked gun safe.
- Store ammunition separately from firearms.
- Ensure locking device on firearms (cable locks or trigger locks).
- Store disassembled firearms.

Psychological Health Center of Excellence (2020) https://www.healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf
Accessed March 15, 2022

✗ Don't

- Take possession of firearms.
- Encourage patient to bring firearms to medical clinics.
- Tell patients to "give away" their firearms.
- Imply that a patient is incapable of carrying a firearm.
- Imply that a patient is "mentally unsound" from a legal perspective.

Psychological Health Center of Excellence (2020)
https://www.healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf
Accessed March 15, 2022

Caring Contacts

- Brief, non-demanding messages expressing care and support
- Designed to reduce suicide risk during high-risk periods or after psychiatric hospitalization/ED visits
- Delivered via postcard, email, or text message
- Focus on connection and concern without requiring a response
- One of the few suicide prevention strategies to demonstrate reductions in suicide deaths in randomized trials

"Hi John, just a quick note to say we're thinking of you and hoping your week is going okay. You matter—and if you ever feel like checking in, we're here for you." - Jane

"Jenny- I'm glad you're persevering, and I hope things keep getting better for you. I'm sending good thoughts your way." - Jim (Dr. Smith's office)

CHRONIC MANAGEMENT

Family Medicine Chronic Management

- Close follow-up in primary care
- Low threshold for referral to community mental health care programs and mental health clinicians
- Patients with personality disorders (predominantly borderline, histrionic, and narcissistic disorders), suicidal behavior and intent may become common and chronic
- If patient is at high risk of self-harm, referrals to emergency services and specialty care are recommended

Norris DR, Clark MS. The Suicidal Patient: Evaluation and Management. Am Fam Physician. 2021 Apr 1;103(7):417-421.

Evidence-Based Psychological Treatment to Reduce Repetition of Suicide Behavior

- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP, sometimes referred to as CT-SP)
- Dialectical Behavior Therapy
- Brief Cognitive Behavioral Therapy (BCBT)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Problem-Solving Therapy-based interventions

Standard of Care in Family Medicine

"Family physicians who engage in patient-centered care by incorporating the patient's history, current stressors, and current data on risk factors for suicide, and by reducing access to means of self-harm such as firearms are following standards of care for patients expressing suicidal ideation"

Norris & Clark (2021) The Suicidal Patient: Evaluation and Management. *American Family Physician.*

Pharmacotherapy

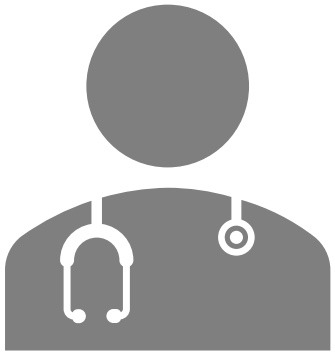
Maximally treat underlying disorder

Utilize evidence based prescribing practices

Consider pharmacotherapy support such as the Waco Guide to Psychopharmacology in primary Care

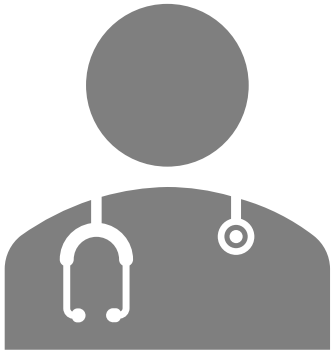
Pharmacotherapy

- Continue to evaluate for and treat underlying psychiatric disorders
- Autopsy data of individuals who had died by suicide:
  - 8-17% had any circulating psychotropic medication
  - Of those with depression- only 6-14% adequately treated



Pharmacotherapy- post psychiatric hospitalization

- Risk of suicide highest during weeks after inpatient psychiatric hospitalization
- See them early and often
  - Suicide risk decreases if seen for follow up within 7 days
  - High risk for nonadherence



Pharmacotherapy: Lithium

- Lithium can reduce risk of suicide in patients with both unipolar depression and bipolar disorder
  - Unipolar depression: augmentation
  - Bipolar disorder: primary pharmacotherapy or augmentation

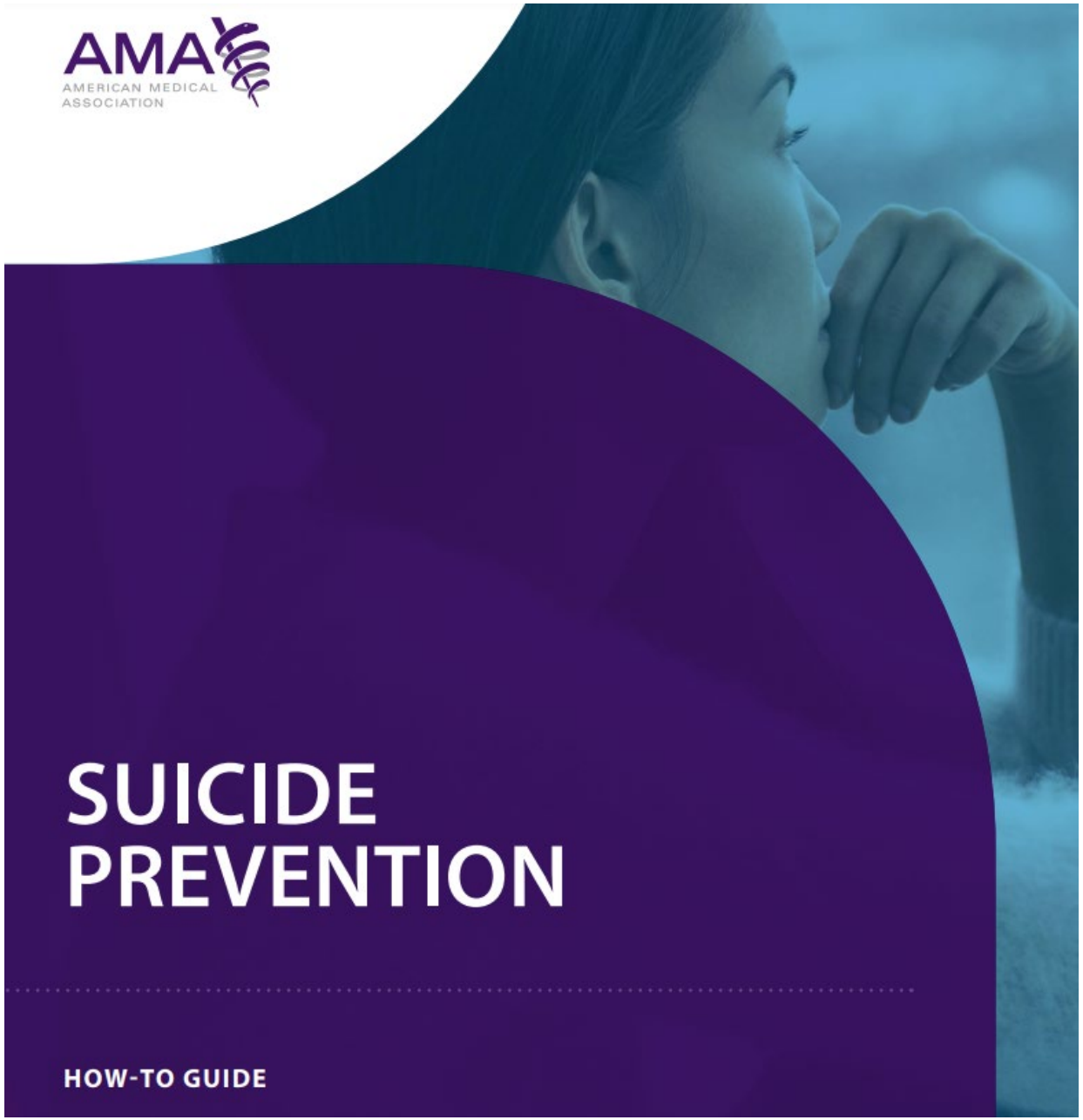
Lancet Psychiatry 2016

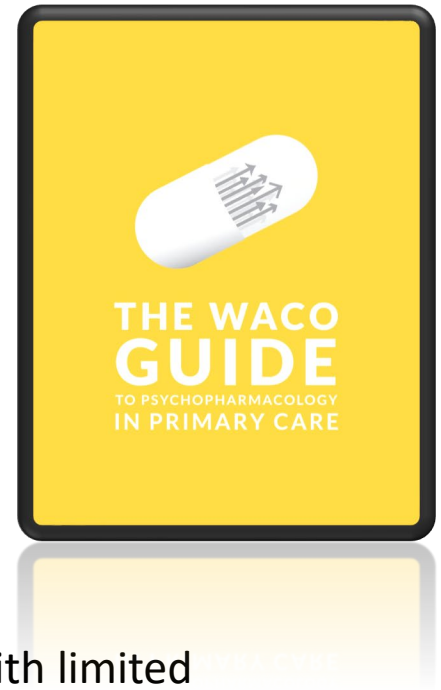
Pharmacotherapy: others

- Not routinely prescribed in primary care
  - Clozapine
  - Ketamine/Esketamine

Pharmacotherapy- SSRIs and Suicidality

- 2007 FDA warning for increased suicidality ages 18-24 years:
- Recommends informing patients of risk
  - Close monitoring
  - Warning acknowledges untreated depression as a significant risk for suicidality
  - Does not recommend against use of SSRIs in this population
- Further studies have not supported this black box warning
- Pediatric/Adolescent studies: thoughts of suicide increased from 2% to 4%, but no increase in completed suicide
- **Conclusion: While black box warning exists, majority of recommending bodies endorse use of pharmacotherapy**





“For primary care clinicians with limited experience prescribing and dosing for this behavioral health condition, the American Medical Association Psychopharmacology How-to Guide and **The Waco Guide**, an evidence based clinical decision resource, may increase clinician competency and confidence when prescribing treatment is deemed appropriate. “

988 | SUICIDE & CRISIS LIFELINE

988 — A Resource for Behavioral Health Crises

Skilled, Caring Support 24/7: 988 counselors are trained to provide emotional and mental health support and crisis intervention.

Minimal Law Enforcement Intervention: Most crises are managed without involving law enforcement, reducing the likelihood of escalated responses.

Connection to Local Resources: People are referred to local mental health and/or substance use treatment services for follow-up care, ensuring continuity of support.

911 — A Response System for Medical, Fire, or Police Emergencies

Immediate Intervention for Physical Danger: 911 dispatches police, fire, or EMS to address urgent threats to life or safety.

Law Enforcement Involvement: Law enforcement officers are typically dispatched in crises involving potential violence or criminal activity.

Additional Provider Resources

- New York State Office of Mental Health and Columbia University Online Course – Offers instruction on when and how to use safety planning interventions, with step-by-step guidance on implementation.
- SPRC Quick Guide for Clinicians – Offers a concise reference to reinforce best practices during safety planning. Designed to be used with safety plan templates.
- Safety Plan Template (Brown & Stanley) – Offers a downloadable, fillable worksheet for developing plans collaboratively with patients.
- Counseling on Access to Lethal Means (CALM) – Offers a free self-paced online course that helps providers feel more confident and competent in discussing means of safety with patients and their families. A train-the-trainer version is also available.

Key Takeaways

Ask and Listen	Promote Connection	Limit Access to Lethal Means
Treat Mental Disorders	Safety Plan	988

References

- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Accessed March 10, 2022. https://www.cdc.gov/suicide/facts/index.html
- Lay San Too, Matthew J. Spittal, Lyndal Bugeja, Lennart Reifels, Peter Butterworth, Jane Pirkis. The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies. Journal of Affective Disorders, Volume 259, 2019, Pages 302-313, ISSN 0165-0327, https://doi.org/10.1016/j.jad.2019.08.054.
- Yeh HH, Westphal J, Hu Y, Peterson EL, Williams LK, Prabhakar D, Frank C, Autio K, Elsiss F, Simon GE, Beck A, Lynch FL, Rossom RC, Lu CY, Owen-Smith AA, Waitzfelder BE, Ahmedani BK. Diagnosed Mental Health Conditions and Risk of Suicide Mortality. Psychiatr Serv. 2019 Sep 1;70(9):750-757.
- ClLuoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159:909–91
- Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. *J Gen Intern Med.* 2014;29:870–877.
- Caroline A. Blades, Werner G.K. Stritzke, Andrew C. Page, Julia D. Brown,The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide-related content. Clinical Psychology Review, Volume 64, 2018, p. 1-12
- Mathias, C. W., Michael Furr, R., Sheftall, A. H., Hill-Kapturczak, N., Crum, P., & Dougherty, D. M. (2012). What's the harm in asking about suicidal ideation?. *Suicide & life-threatening behavior*, *42*(3), 341–351. https://doi.org/10.1111/j.1943-278X.2012.0095.x

References (2)

- Christine Polihronis, Paula Cloutier, Jaskiran Kaur, Robin Skinner & Mario Cappelli (2020) What's the harm in asking? A systematic review and meta-analysis on the risks of asking about suicide-related behaviors and self-harm with quality appraisal, Archives of Suicide Research
- Sall J, Brenner L, Millikan Bell AM, et al. Assessment and management of patients at risk for suicide: synopsis of the 2019 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guide- lines. *Ann Intern Med*. 2019;171(5):343-353.
- Large MM, Ryan CJ, Carter G, et al. Can we usefully stratify patients according to suicide risk? *BMJ*. 2017;359:j4627.
- Morriss R, Kapur N, Byng R. Assessing risk of suicide or self harm in adults. *BMJ*. 2013;347:f4572.
- Kessler, R. C., Bossarte, R. M., Luedtke, A., Zaslavsky, A. M., & Zubizarreta, J. R. (2020). Suicide prediction models: a critical review of recent research with recommendations for the way forward. *Molecular psychiatry*, *25*(1), 168–179. https://doi.org/10.1038/s41380-019-0531-0
- Norris DR, Clark MS. The Suicidal Patient: Evaluation and Management. Am Fam Physician. 2021 Apr 1;103(7):417-421.

References (3)

- American Association of Suicidology. https://suicidology.org/resources/warning-signs/ Accessed: March 15, 2022
- Norris DR, Clark MS. The Suicidal Patient: Evaluation and Management. Am Fam Physician. 2021 Apr 1;103(7):417-421.
- Probert-Lindström S, Berge J, Westrin Å*, et al* Long-term risk factors for suicide in suicide attempters examined at a medical emergency in patient unit: results from a 32-year follow-up study *BMJ Open* 2020.
- Nock MK, Borges G, Bromet EJ, Alonso J, Angermeyer M, Beautrais A, Bruffaerts R, Chiu WT, de Girolamo G, Gluzman S, de Graaf R, Gureje O, Haro JM, Huang Y, Karam E, Kessler RC, Lepine JP, Levinson D, Medina-Mora ME, Ono Y, Posada-Villa J, Williams D. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Br J Psychiatry. 2008 Feb;192(2):98-105
- Suicide Prevention Resource Center. https://www.sprc.org/about-suicide/risk-protective-factors. Accessed March 14, 2022
- American Psychiatric Association. https://www.psychiatry.org/patients-families/suicide-prevention. Accessed March 15, 2022

References (4)

- VA/DOD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. 2019.
- Suicide Prevention in Primary Care A Toolkit for Primary Care Clinicians and Leaders. https://zerosuicide.edc.org/sites/default/files/suicidesafercareguideforprimarycareproviders.pdf. Accessed March 15, 2022
- SPRC, 2021. https://sprc.org/resources-programs/stanley-brown-safety-plan. Accessed March 15, 2022
- Psychological Health Center of Excellence (2020) https://www.healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf. Accessed March 15, 2022
- The Waco Guide to Psychopharmacology in Primary Care. www.wacoguide.com.

Additional Warning Signs

American Association of Suicidology
https://suicidology.org/resources/warning-signs/
Accessed: March 15, 2022

- Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- **Anxiety**, agitation, unable to sleep or sleeping all of the time
- Feeling **trapped** – like there's no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking
- Dramatic **mood changes**
- Giving away prized possessions or seeking long-term care for pets