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Abbreviations

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<th>Zero Suicide</th>
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<tr>
<td>CPEP</td>
<td>Comprehensive Psychiatric Emergency Room</td>
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<tr>
<td>BH</td>
<td>Behavioral Health</td>
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<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>AIM</td>
<td>Assess, Intervene, Monitor</td>
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<tr>
<td>C-SSRS</td>
<td>Columbia Suicide Severity Rating Scale</td>
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<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>SPI</td>
<td>Safety Planning Intervention</td>
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<tr>
<td>SFU</td>
<td>Structured Follow Up</td>
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<tr>
<td>CPI</td>
<td>Center for Practice Innovations</td>
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<tr>
<td>LMS</td>
<td>Learning Management System</td>
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<tr>
<td>HOPE Pathway</td>
<td>High-risk Out-Patient Engagement Pathway</td>
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<tr>
<td>CTL</td>
<td>Crisis Text Line</td>
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<tr>
<td>SPISA</td>
<td>Safety Planning Intervention Scoring Algorithm</td>
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Acknowledgments

This guide was developed by New York State Office of Mental Health's Suicide Prevention Center of New York (SPCNY), the lead entity in suicide prevention in the state. SPCNY provides technical assistance that advances the New York State Suicide Prevention Plan. Our mission is to promote, coordinate, and strategically advance suicide prevention across the state with the goal of reducing suicide attempts and deaths among New Yorkers. While there is no single solution to preventing suicide, SPCNY combines both clinical and public health approaches in its work.

The content of this guide could not have been developed without the partnership of the following health systems in Syracuse, NY as grant partners of the New York State Garrett Lee Smith (GLS) State & Tribal Suicide Prevention Grant (2019-2024): Contact Community Services, Inc., Helio Health, Liberty Resources, Inc., St. Joseph’s Health, and SUNY Upstate University Medical Center.

Introduction

New York State has received national recognition for its work integrating suicide prevention into health and behavioral health systems. As called for in the 2016-2017 NYS Suicide Prevention Plan, the New York State Office of Mental Health's Suicide Prevention Center of New York (SPCNY) set out to systematically support health systems in reducing suicide deaths among those receiving care—beginning with settings that care for those most at-risk. Our evolving approach, refined over the course of implementing several large, federal suicide prevention grants, is called AIM for Zero Suicides. It draws heavily on the national Zero Suicide model and incorporates the helpful clinical framework developed by New York experts called the AIM model (Assess, Intervene, Monitor).

The AIM model provides a clinical framework for reducing suicide risk. Developed by Dr. Barbara Stanley, Director of the Suicide Prevention, Training, Implementation and Evaluation (SP-TIE) program at Columbia University and the New York State Psychiatric Institute, the model highlights three domains of clinical practice essential to reducing suicide risk:

- **Assess** all individuals for suicide risk using evidence-based screening tools
- **Intervene** with at-risk individuals, using suicide-specific interventions
- **Monitor** at-risk individuals with increased follow-up contact and regular screening

What is the purpose of this guide?

As part of the federally funded Garrett Lee Smith (GLS) State & Tribal Suicide Prevention Grant (2019-2024), one goal has been to develop, implement, and refine a New York State-specific AIM model for youth in health and behavioral health systems. The model is designed to improve suicide-specific care for people in need, as well as reduce the burden of suicide attempts and deaths for these systems of care. The AIM model is grounded in the Zero Suicide framework and emphasizes systematic screening, identification, intervention, and monitoring to increase access to and engagement in services for individuals at risk for suicide.

With lessons learned and refinements made throughout the past four years, this guide intends to provide a sustainable model of Zero Suicide, known as the AIM for Zero Suicide model. In this guide, you will learn how to adapt the AIM for Zero model in specific settings, including: Outpatient Behavioral Health, Inpatient Behavioral Health, Substance Use Disorder settings, Comprehensive Psychiatric Emergency Programs (CPEP), Emergency Departments (ED), and Primary Care settings.
Overview of the Zero Suicide Model

The Zero Suicide Model is the country’s leading model for suicide prevention in healthcare. It is both an aspirational concept and a practical set of tools based on empirical evidence:

- The majority of suicide deaths occur among individuals with recent contact in the healthcare system, often within the last 30 days.
- To truly have impact requires a systemic approach; relying on the heroic acts of individual clinicians and crisis workers is wholly inadequate.
- Treating underlying behavioral health conditions, such as depression or alcohol use disorder, among those at increased risk for suicide is necessary but not sufficient.
- Effective interventions must directly target suicide risk.

Implementation of the Zero Suicide model starts with a commitment from health system leadership to reduce suicide deaths among all those receiving care.

New York State’s GLS project is grounded in the Zero Suicide model and utilizes several of the tools provided in the Zero Suicide toolkit, publicly available at http://zerosuicide.sprc.org/toolkit. This guide is generated through the experience of this pilot project and reflects New York specific examples and experiences that are state specific and generalizable. We suggest utilizing the national toolkit, as linked above, as well as this New York State Implementation Guide for the most comprehensive tools and recommendations.
Steps for Implementation of the AIM for Zero Model

A. **Prepare** to implement the Zero Suicide model
   1. Get buy-in from leadership and identify champions
   2. Create Zero Suicide Implementation Team
   3. Administer Organizational Self-Study and Workforce Survey

B. Implement **Suicide Safer Care Best Practices** using the *Assess, Intervene, Monitor (A-I-M) for Zero Model*, which includes:
   1. Universal Precautions for all patients, regardless of risk
   2. Universal screening using the C-SSRS
   3. Comprehensive suicide risk assessment for those who screen positive
   4. Evidence-based interventions for individuals at elevated suicide risk
   5. Structured follow-up after discharge from acute care
   6. Non-demand caring contacts

C. All **non-clinical staff** complete basic training on suicide prevention

D. **Clinical staff** complete clinical training curriculum and deliver suicide-safer care to individuals who present for services using the setting-specific protocol. Clinical supervisors should also complete clinical trainings in order to provide appropriate supervision and support.

E. **Monitor Implementation Annually**
   - Utilize Workplan to assess implementation progress and set goals for a specific time period (e.g. annually)

F. **Continuous Quality Improvement (CQI) and Data Collection Metrics**
   - Collect data monthly on delivery of suicide safer-care elements
   - Regularly conduct fidelity checks on quality of services delivered (e.g. audit risk assessments and safety plans)
Implementation of the Zero Suicide Framework in New York

Engaging Leadership

- Implementation of the New York State-specific Zero Suicide model begins with a visible commitment from the health system leadership to reduce suicide attempts and deaths among those receiving care. (Example available [here](#))
- Leadership buy-in is essential in both developing and sustaining a safety-oriented culture where suicides are preventable through strategic investments in workforce training, implementation of the latest suicide care clinical protocols, and continuous quality improvement.
- Establishing your AIM for Zero Suicides implementation team is critical, as this team will be responsible for building and providing the foundation for your organization's Zero Suicide work. This will be a multidisciplinary team that includes key personnel representing different aspects of the organization. It needs to include personnel empowered and authorized to make changes to policies and procedures within key areas of the organization, as well as representation from a person receiving services. Survivors of suicide attempts and survivors of suicide loss are critical stakeholders in the planning, implementation, and evaluation of your change efforts.
- The **Zero Suicide Organizational Self-Study** is designed to help you to assess what core elements of suicide-safer care your organization have in place. It can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan.
- Within the Zero Suicide framework, implementation teams from each participating service line within the health system complete an annual **workplan** to assess the current status of implementation of the seven elements of Zero Suicide and to set goals for the coming year.
- It is important to build a no-blame culture after a suicide death by developing policies and implementing Postvention supports and procedures. OMH SPCNY has developed a Postvention Guide, "The Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors." Also available, is "Developing a Postvention Plan: Getting Started Tips" and "Clinicians As Loss Survivors" Brochure.

Training

- Workforce development is critical when implementing the Zero Suicide Framework.
- Suicide-specific competencies must be developed around core elements in suicide care at different levels of the organization.
- All staff need to be trained to the level that is most appropriate to the care they provide. Some trainings will be for general (non-clinical) employees within the agency to learn the basics about suicide prevention. Clinicians and clinical supervisors will be trained in evidence-based screening, assessment, safety planning, structured follow-up and monitoring practices and interventions.
- For New York State OMH and OASAS-affiliated clinicians, trainings can be accessed online through the Center for Practice Innovations (CPI) Learning Management System (LMS) [here](#). If you are not OMH/OASAS affiliated clinicians and are located in New York and would like access to these trainings, please email cpihelp@nyspi.columbia.edu for more information.
<table>
<thead>
<tr>
<th>Training Title</th>
<th>Mode</th>
<th>Discipline</th>
<th>Training Description</th>
<th>Length</th>
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<tbody>
<tr>
<td>Telehealth with Suicidal Individuals</td>
<td>Online Module</td>
<td>Clinical staff</td>
<td>This module will provide clinicians guidance on evidence-based practices for screening, assessing, and managing suicide risk via telehealth. Topics to be addressed include basic guidelines for initiating remote contact when a client might be suicidal including requesting their physical location, developing a contact plan, and planning how to arrange for emergency care while staying on the phone with the client.</td>
<td>60 min</td>
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<tr>
<td>Engaging Families and Social Support in Working with Suicidal Individuals</td>
<td>Online Module</td>
<td>Clinical staff</td>
<td>This module aids practitioners working with suicidal patients to consider and understand the value of family support. The course discusses ways in which clinicians can collaborate with suicidal individuals in involving family members and friends when possible.</td>
<td>60 min</td>
</tr>
<tr>
<td>Suicide Prevention for Healthcare Workers</td>
<td>Online Module</td>
<td>Non-clinical staff</td>
<td>This brief training module illustrates how you or anyone, even with no formal mental health care training, can learn how to recognize and engage effectively with individuals at risk for suicide, and to help connect them with professional help or additional support.</td>
<td>20 min</td>
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<tr>
<td><strong>ASSESS</strong></td>
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<tr>
<td>The Columbia Suicide Severity Rating Scale (C-SSRS): A Tool to Detect and Assess Suicidal Risk (Brief training also available as a refresher)</td>
<td>Online Module</td>
<td>Clinical staff conducting screening</td>
<td>This module demonstrating how to utilize the C-SSRS: a standardized suicide screening and risk-assessment tool. Employing video vignettes, animation, interactive activities, and instruction, this module illustrates how to use both the C-SSRS screener and full-version and reviews the rationale behind using evidence-based practices and forms when gauging a client’s suicide risk level.</td>
<td>75 min</td>
</tr>
<tr>
<td>Comprehensive Suicide Risk Assessment</td>
<td>Online Module</td>
<td>Clinical staff conducting risk assessments</td>
<td>The Suicide Risk Assessment Training provides guidance and a framework for mental health providers to conduct a comprehensive assessment of suicidal risk that informs triage decisions and recommendations for effective prevention and intervention.</td>
<td>30 min</td>
</tr>
<tr>
<td>Suicide Screening and Risk Assessment with Youth</td>
<td>Online Module</td>
<td>Clinical staff conducting screening &amp; risk assessments</td>
<td>This module will aid practitioners to use “best practices” in screening and risk assessment for young people experiencing suicidal ideation and/or behavior. In this course, we will describe how to utilize evidence-based screening tools, explain the components of a comprehensive suicide risk assessment, and make developmental adaptations to screening and risk assessment procedures when working with young clients experiencing suicidal ideation and/or behavior, as well as their families.</td>
<td>60 min</td>
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<td><strong>INTERVENE</strong></td>
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<tr>
<td>Safety Planning Intervention for Suicide Prevention Updated in 2023</td>
<td>Online Module</td>
<td>Clinical staff delivering intervention</td>
<td>This module explains the safety plan intervention through clinical vignettes with an at-risk client and through didactic instruction.</td>
<td>45 min</td>
</tr>
<tr>
<td>Means Reduction Counseling for Suicidal Individuals</td>
<td>Online Module</td>
<td>Clinical staff engaged in Safety Planning</td>
<td>This module demonstrates the importance of and shows clinicians techniques for collaborating with their suicidal client to reduce their access to the methods they are likely to use in a suicide attempt.</td>
<td>60 min</td>
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<td><strong>MONITOR</strong></td>
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<tr>
<td>Structured Follow-Up and Monitoring</td>
<td>Online Module</td>
<td>Clinical staff delivering Structured Phone Follow-Up</td>
<td>This training module demonstrates how to provide structured follow-up and monitoring for individuals after a crisis and how to maintain telephone contact with suicidal individuals during the time of transition from an emergency or inpatient visit to outpatient treatment.</td>
<td>30 min</td>
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Evaluation & Quality Improvement

- Monthly data collection on service delivery is valuable; this practice of continuous data collection gives the evaluation team information to assess whether the project protocol is being delivered as intended as well as to detect any implementation gaps.

- Data can be provided in de-identified form via email to the Quality Improvement Officer, or others identified to evaluate the data, such as an academic or research partner. For ease of collection, it is recommended that measures be integrated into the electronic medical records (EMRs).

Fidelity Checks

- Monitor the delivery of specific interventions and practices to ensure they are implemented with fidelity.

- Utilize available tools to rate/assess quality of completed interventions; for example, Safety Planning Intervention Scoring Algorithm (SPISA) is a rating scale that assesses the quality and completeness of each step of the Stanley Brown safety plan.

- Periodic chart reviews can be used to ensure that services are delivered with fidelity. This can include review of suicide risk assessments, safety plans, treatment plans, progress notes and discharge summaries.

Identify, Engage, Treat & Transition: Clinical Components of the AIM for Zero Model

The four clinical elements of Zero Suicide are embedded in the AIM model. A-I-M stands for Assess, Intervene, and Monitor, a three- part model where “Assess” refers to the use of systematic screening and comprehensive risk assessment to identify at-risk patients. “Intervene” consists of conducting suicide-specific evidence-based interventions. “Monitor” provides strategies for ongoing monitoring and increased contact during known high-risk periods, such as care transitions. The common elements (shown below) are for all individuals under care and include universal screening and a risk-level based Suicide Care Management Plan (SCMP).
AIM Model of Suicide-Safer Care for Youth – OVERALL

All procedures should be adapted to the youth’s developmental stage and involve family engagement throughout the episode of care. Procedures denoted with a ★ must be completed with both the youth and their family/collaterals.

Note: Items in BLUE represent procedures for all patients, and items in YELLOW for those assessed to be at higher risk.

**UNIVERSAL SCREENING WITH THE C-SSRS ★**
All patients screened with the C-SSRS SCREEN version

**COMPREHENSIVE SUICIDE RISK ASSESSMENT ★**
including Risk & Protective Factors and Access to Lethal Means

**Suicide Care Management Plan**

**UNIVERSAL PRECAUTIONS ★**
Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

**TREATMENT PLAN ★**
with goals and objectives that specifically target suicide

**Stanley-Brown SAFETY PLAN ★**
with lethal means reduction counseling

**STRUCTURED PHONE FOLLOW-UP ★**
1st call within 24-72 hours of discharge, 2nd call after 1st outpatient appt

**OUTPATIENT APPOINTMENT**
Scheduled within 5 days of discharge

**WARM HAND-OFF OF RECORDS**
prior to first outpatient visit

**NON-DEMAND CARING CONTACTS ★**
Postcards, texts, or e-mails at 2 and 12 weeks post-discharge
A - Elements of Assess

Universal screening and comprehensive suicide risk assessment

1. **Universal Screening**
   All patients ages 12 and older in a healthcare setting should be screened for suicide risk using an evidenced-based tool. Patients ages 8-11 should be screened if they are presenting with a behavioral health concern, if the patient or accompanying adult raises a concern, or if there is any history of suicidal ideation or behavior. There are no screening tools that have been validated for children under age 8; however if a youth exhibits warnings signs or there is a report of self-harm or suicidal behavior, providers should complete a suicide risk assessment.
   
   a. **In Behavioral Health settings**, it is recommended youth be screened using the Columbia Suicide Severity Rating Scale (C-SSRS), a validated, standardized screening tool consisting of seven questions that ask about the presence and severity of lifetime and current suicidal ideation, including passive and active ideation and behaviors, methods, plan, and intent.
   
   b. **In Primary Care settings**, it is recommended youth be screened using a validated screener, such as the ASQ or PHQ-A, completed annually, such as in a well visit, and reviewed by the PCP. If “Yes” to any of ASQ Questions 1-4, or to Question 9 on PHQ-A, or based on collateral information or clinical judgment, administer C-SSRS w/ Triage Points for Primary Care.
   
   c. **In medical ED (non-behavioral health) settings**, it is recommended youth be screened using a validated screener, such as the ASQ or PHQ-A. If “Yes” to any of ASQ Questions 1-4, or to Question 9 on PHQ-A, or based on collateral information or clinical judgment, administer C-SSRS w/ Triage Points for Emergency Departments.

2. **Administering C-SSRS & Comprehensive Suicide Risk Assessment**
   
   a. **In Behavioral Health settings**, patients who respond “Yes” to any question on the C-SSRS, or by clinical judgment, should receive a comprehensive suicide risk assessment that identifies risk and protective factors, assesses access to lethal means, and informs the rationale for triage and clinical interventions. Be sure to include the accompanying adults in this process.
   
   b. **In Primary Care settings,**
      
      I. **If initial screen (ASQ, PHQ-A, or C-SSRS) is negative,** continue annual screening with PHQ-A or ASQ and refer to outpatient behavioral health, if determined to be clinically necessary
      
      II. **If individual screens positive on the C-SSRS w/ Triage Points for Primary Care (yes to questions 3, 4, 5, 6) or by clinical judgment,** be sure to:
          1. Add suicide to problem list
          2. Make referral to internal or external behavioral health provider to complete a Comprehensive Suicide Risk Assessment.
   
   c. **In ED (non-behavioral health) settings,**
      
      I. **If individual screens positive on the C-SSRS Emergency Department Screen Version with Triage Points (yes to questions 3, 4, 5, 6) or by clinical judgment,** be sure to:
          1. Ensure patient receives Comprehensive Suicide Risk Assessment by trained staff, either embedded in emergency department or from psychiatry (consult).

3. **Assess Level of Suicide Risk**
   
   o **Low:** YES to C-SSRS Q1 or Q2 in the past 3mo and NO to all other questions
   
   o **Moderate:** YES to Q3 in the past 3mo or Q6/Q7 Lifetime –OR– clinical judgment
   
   o **High:** YES to ANY of Q4, 5, 6, or 7 in the past 3mo –OR– clinical judgment
   
   o **If suicide risk is IMMINENT, ensure immediate safety & refer to CPEP/ED**
      1. When making referrals to inpatient, be sure to provide warm handoff of records
      2. If not at imminent risk, continue to Intervene
   
   o See also Level of Care Determination
I - Elements of Intervene

Intervene and Monitor form the basis of the Suicide Care Management Plan (SCMP) which includes best practices and evidence-based interventions based on suicide risk level.

A. Low Risk SCMP – Provide Universal Precautions
   1. In Behavioral Health settings, provide verbal psychoeducation about the fluctuating nature of suicide risk and warning signs should be provided to all youth and their families.
      ▪ See also Universal Precautions Sample Script
      ▪ Provide additional resources such as “A Guide to Staying Safe” brochure
   2. In all settings, provide 988 Suicide & Crisis Lifeline and Crisis Text Line.

B. Moderate Risk SCMP
   1. Universal Precautions
   2. Stanley-Brown Safety Planning Intervention (SPI) - a collaborative intervention to develop a prioritized list of warning signs, coping strategies, and resources for youth to use during a suicidal crisis
      ▪ See also Safety Planning Checklist, Stanley-Brown Safety Plan Template, and the What I Should Know About My Safety Plan patient handout
      ▪ For Behavioral Health settings, complete with youth and their parent/guardian as soon as risk is identified
      ▪ For Primary Care, complete with youth and their parent/guardian if there are trained behavioral health staff onsite; otherwise ensure warm handoff to behavioral health provider
      ▪ For ED, complete if the youth is being discharged (not referred to CPEP or admitted to inpatient psychiatric care)
   3. Lethal Means Reduction Counseling – A critical part of the Safety Plan is Step 6: Making the Environment Safe, which is to identify the youth’s access to specific methods of attempting suicide. Means Reduction Counseling is collaboratively working with the youth and their families to reduce or restrict access to potential methods and following up to ensure that concrete actions to do so are completed.
      ▪ For Behavioral Health settings, complete with youth and their parent/guardian as soon as risk is identified.
      ▪ For Primary Care, complete with youth and their parent/guardian if there are trained behavioral health staff onsite; otherwise ensure warm handoff to behavioral health provider
      ▪ For ED, complete if the youth is being discharged (not referred to CPEP or admitted to inpatient psychiatric care)
      ▪ For all settings, provide Make Your Home Suicide-Safer brochure to families
   4. Suicide-specific Treatment Planning - For youth at-risk of suicide it is not sufficient to target a behavioral health diagnosis; treatment goals, objectives, and interventions should directly address suicidal thoughts and behaviors, reduce modifiable risk factors, and enhance modifiable protective factors; helps the youth and their family to improve coping skills around risk factors that are not modifiable. This includes direct engagement with family members and supportive adults
      ▪ See Clinician Guide: Engaging Families and Supportive Others
      ▪ Provide families with resources, including When A Loved One Struggles Brochure
      ▪ For Primary Care and ED settings, make a Behavioral Health Referral (either internally or externally)
        o Consider if a higher level of care is indicated
        o Warm Hand-Off to BH Provider. Use the Warm Handoff Clinician Checklist to ensure all appropriate documents are being transferred.
C. High Risk SCMP – in Behavioral Health settings, youth should be placed on a **High-Risk Pathway** if, *in the past three months*, they endorse **Suicidal ideation with intent and/or plan** (YES response to Q4 or 5 on the C-SSRS) – **OR** – **Suicidal behavior** (not just NSSI; YES response to Q6/7 on the C-SSRS) – **OR** – based on **clinical judgment** from comprehensive suicide risk assessment.

**Individuals who are placed on the high-risk pathway should receive:**

1. Universal Precautions
2. Stanley-Brown Safety Planning Intervention (SPI)
3. Lethal Means Reduction Counseling
4. Suicide-specific Treatment Planning
   - For Primary Care and ED settings, a Behavioral Health Referral
     - Consider if a higher level of care is indicated
     - Warm Hand-Off to BH Provider
5. Suicide-specific evidence-based treatment (referrals if not an Outpatient Behavioral Health setting)
   - Primary treatment models
     - **Dialectical Behavior Therapy (DBT)**
     - **Cognitive Behavioral Therapy for Suicide (CBT-SP)**
     - **Collaborative Assessment and Management of Suicidality (CAMS)**
   - Adjunctive/short-term treatment
     - **Attempted Suicide Short Intervention Program (ASSIP) - ages 18+ only**
     - **Youth-nominated Support Team (YST)**

### HOPE PATHWAY for High-Risk Individuals

The high-risk pathway interventions are presented to the youth and their families as the **HOPE Pathway (High-risk Out-Patient Engagement Pathway)**. The HOPE Pathway is a way to explain to high-risk clients and their families the importance of providing extra care and attention.

See [The HOPE Pathway Clinician Guide](#), [Adding the HOPE Pathway Client Handout](#), and [Adding the HOPE Pathway Parent Handout](#) to assist in explain what the HOPE Pathway is and what it entails.

### M - Elements of Monitor

**Ongoing follow-up (especially during high-risk periods) and re-screening at regular intervals**

1. **Increase clinical contact** for those at Moderate and High Risk
   - Inpatient/CPEP/ED settings – Higher level of supervision
   - Outpatient BH settings – Weekly sessions and **same day follow-up** if individual misses a scheduled outpatient appointment

2. **Monitor everyone with regular screening**
   - Inpatient/CPEP/ED settings – screen at admission and discharge, or as clinically indicated
   - Outpatient Behavioral Health settings – screen at initial visit, after a care transition (e.g., after return from inpatient admission or ED/CPEP visit), or if a change in clinical status
     - For **Low risk** - screen at every treatment plan review, or as clinically indicated
     - For **Moderate and High-risk** - screen at every clinical contact with **C-SSRS Since Last Contact**
   - Primary Care Settings
     - For **low risk**, screen with ASQ or PHQ-9 at Annual Well Visit, major life transitions, major medical illness, and/or as clinically indicated
     - For **moderate and high-risk**, screen at every appointment with the **C-SSRS Primary Care: Since Last Visit** version and also ask these questions:
       - Are you still receiving mental health care/treatment? When is your next appointment?
       - Do you still have your Safety Plan? Does it need to be revised?
     - For **IMMINENT RISK**, secure immediate warm handoff to emergency or mobile crisis services, then schedule follow-up ent within **7 days**
3. Care Transitions

A. Post-discharge care transition from Crisis ED/CPEP/Inpatient to Outpatient setting for youth at Moderate or High-Risk:
   1. **Warm handoff** of records to outpatient provider before the first appointment, which includes:
      i. Initial Suicide Risk Assessment
      ii. Stanley Brown Safety Plan with lethal means reduction information
      iii. Discharge Summary, including updated suicide risk assessment and treatment recommendations for outpatient care, specifically addressing suicide risk and identifying biggest barriers to reducing risk
   2. **Structured follow-up, e.g. phone call, mobile crisis visit**
      i. 1st call made to youth ages 12 and older within 24-72 hours of discharge from inpatient and CPEP settings
      ii. 2nd call should then be made within 72 hours after first outpatient appointment
      iii. Calls can also be made to parent/guardian instead or in addition to youth (if under 18)
   3. **Non-Demand Caring Contacts** - All youth ages 12 and older at moderate and high-risk discharged from inpatient and CPEP settings should receive a caring text, e-mail, or postcard within 2 weeks of discharge and another one within 12 weeks of discharge
      i. See [Example Caring Contact](#)

B. From Primary Care setting to Behavioral Health care for youth at Moderate or High-Risk:
   1. **Warm Hand-Off** of records to external BH provider before the first appointment, including: *PHQ-A or ASQ, C-SSRS, and Stanley Brown Safety Plan*
   2. **Phone Follow-Up** within 7 days of referral
      • Did you have an appointment? When?
      • Do you still have your Safety Plan? Does it need to be revised?
      • Continue weekly follow-up until they have attended 1st appointment
AIM Model of Suicide-Safer Care for Youth – CPEP

All procedures should be adapted to the youth’s developmental stage and involve family engagement throughout the episode of care. Procedures denoted with a ★ must be completed with both the youth and their family/collaterals.

### UNIVERSAL SCREENING WITH THE C-SSRS ★

### COMPREHENSIVE SUICIDE RISK ASSESSMENT ★
including Risk & Protective Factors and Access to Lethal Means

### RISK LEVEL DETERMINATION

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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#### Universal Precautions ★
Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

#### Treatment Plan ★
with goals and objectives that target suicide

#### Stanley-Brown Safety Plan ★
with means reduction counseling prior to discharge

### While in CPEP

#### INCREASE CLINICAL CONTACT
(line of sight or 1-to-1) until discharge or transfer to inpatient

### Post-Discharge Transition

#### Outpatient Appointment
Scheduled within 5 days of discharge

#### Warm Hand-Off of Records
prior to first outpatient visit

#### Structured Phone Follow-Up ★
1st call within 24-72 hours of discharge; 2nd call after 1st outpatient appt

#### Caring Contacts ★
Postcards, texts, or e-mails at 2 and 12 weeks post-discharge

#### Likely Inpatient Admission

---

**Assess**

**Intervene**

**Monitor**
All procedures should be adapted to the youth’s developmental stage and involve family engagement throughout the episode of care. Procedures denoted with a ★ must be completed with both the youth and their family/collaterals.

**UNIVERSAL SCREENING WITH THE ASQ, PHQ-A or C-SSRS ★**
- Negative for suicide risk: Care as Usual
- Positive for suicide risk: COMPREHENSIVE SUICIDE RISK ASSESSMENT ★ including Risk & Protective Factors and Access to Lethal Means

**RISK LEVEL DETERMINATION**
- LOW RISK
- MODERATE RISK
- HIGH RISK

**UNIVERSAL PRECAUTIONS ★**
Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

**Stanley-Brown SAFETY PLAN ★**
with lethal means reduction counseling prior to discharge

**WHILE IN ED**
INCREASE CLINICAL CONTACT
(line of sight or 1-to-1) until discharge or transfer to inpatient

**POST-DISCHARGE TRANSITION**
BEHAVIORAL HEALTH OUTPATIENT APPOINTMENT ★
Scheduled within 5 days of discharge

**WARM HAND-OFF OF RECORDS**
prior to first outpatient visit

**STRUCTURED PHONE FOLLOW-UP ★**
1st call within 24-72 hours of discharge; 2nd call after 1st outpatient appt

**LIKELY INPATIENT ADMISSION**
AIM Model of Suicide-Safer Care for Youth – INPATIENT

All procedures should be adapted to the youth’s developmental stage and involve family engagement throughout the episode of care. Procedures denoted with a ★ must be completed with both the youth and their family/collaterals.

**UNIVERSAL SCREENING WITH THE C-SSRS ★**

**COMPREHENSIVE SUICIDE RISK ASSESSMENT ★**
including Risk & Protective Factors and Access to Lethal Means

**RISK LEVEL DETERMINATION**

- **LOW RISK**
- **MODERATE RISK**
- **HIGH RISK**

**UNIVERSAL PRECAUTIONS ★**
Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

**TREATMENT PLAN ★**
with goals and objectives that specifically target suicide

**Stanley-Brown SAFETY PLAN ★**
with means reduction counseling

**SUICIDE-SPECIFIC EVIDENCE-BASED TREATMENT**
DBT, CT-SP, CAMS

**WHILE ON UNIT**

**INCREASE CLINICAL CONTACT & SUPERVISION**

**RE-SCREENING PRIOR TO DISCHARGE**

**POST-DISCHARGE TRANSITION**

**WARM HAND-OFF OF RECORDS**
prior to first outpatient visit

**STRUCTURED PHONE FOLLOW-UP ★**
1\textsuperscript{st} call within 24-72 hours of discharge; 2\textsuperscript{nd} call after 1\textsuperscript{st} outpatient appt

**CARING CONTACTS★**
Postcards, texts, or e-mails at 2 and 12 weeks post-discharge

---

**Assess**

**Intervene**

**Monitor**

**RE-SCREENING PRIOR TO DISCHARGE**
**High Risk**
Entry: Suicidal ideation with intent or plan or suicidal behavior in the past 90 days (Yes to C-SSRS Q4, 5, 6, or 7) – OR – clinical judgement
Exit: No suicidal ideation with intent or plan, suicidal behavior, or psychiatric hospitalizations for at least 90 days – OR – clinical judgement

---

**UNIVERSAL SCREENING WITH THE C-SSRS ★**

**COMPREHENSIVE SUICIDE RISK ASSESSMENT ★**
including Risk & Protective Factors and Access to Lethal Means

---

**RISK LEVEL DETERMINATION**

- **LOW RISK**
  - Appropriate for outpatient care

- **MODERATE RISK**
  - Consider whether a higher level of care is indicated

---

**LEVEL OF CARE DETERMINATION**

- **LOW RISK**
  - Appropriate for outpatient care
- **MODERATE RISK**
  - Consider whether a higher level of care is indicated
- **HIGH RISK**
  - Non-imminent risk or post ED/CPEP/INPATIENT discharge
  - If risk is imminent

---

**UNIVERSAL PRECAUTIONS ★**
Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

**Stanley-Brown SAFETY PLAN ★**
with means reduction counseling

**TREATMENT PLAN ★**
with goals and objectives that specifically target suicide

**WEEKLY APPOINTMENTS**

**SCREEN EVERY SESSION**

**SAME-DAY PHONE CONTACT ★**
after missed appointments

**SAME-DAY PHONE CONTACT ★**
after missed appointments

**PRIORITIZE AFTER CARE TRANSITION**

---

**RE-SCREENING AT LEAST QUARTERLY ★**
at treatment plan review or as clinically indicated

**SCREEN EVERY SESSION**

**SUICIDE SPECIFIC EVIDENCE-BASED TREATMENT**
DBT, CT-SP, CAMS

---

**Ensure safety**

**Refer to CPEP/ED**

---

****High Risk Care Management Plan is Referred to as “HOPE Pathway” in the manual and when presented to clients.**
All procedures should be adapted to the youth’s developmental stage and directly involve family throughout the episode of care.

**UNIVERSAL SCREENING WITH THE PHQ-A or ASQ**

- **Negative for suicide risk**
  - NO to Q9 on PHQ-A, or NO for all ASQ

- **Positive for suicide risk**
  - (YES to Q9 on PHQ-A, or YES to Q1, 2, 3, or 4 on ASQ, or clinical judgement)

**ADMINISTER C-SSRS SCREEN with Triage Points for Primary Care**

- **Positive for suicide risk - YES to any question OR clinical judgement**

- **Non-imminent risk**
  - or post-ED/CPEP/Inpatient discharge

- **If BH staff not available during visit**

  - Internal referral for Comprehensive Suicide Risk Assessment

  - See Outpatient & School-based Mental Health protocol

**INITIAL RISK LEVEL DETERMINATION (based on C-SSRS)**

- **LOW RISK**
- **MODERATE RISK**
- **HIGH RISK**

**ADD SUICIDE TO PROBLEM LIST**

**UNIVERSAL PRECAUTIONS**

Psychoeducation regarding the fluidity of suicide risk; Provide 988 National Suicide & Crisis Line and GOT5 Crisis Text Line number

**Stanley-Brown SAFETY PLAN**

With lethal means reduction counseling

**FACILITATE PATIENT-CENTERED CARE**

- Warm handoff to suicide-specific, evidence-based treatment (DBT, CAMS, CBT-SP)
- Refer to other specialty care (e.g., SUD, FEP, etc.)
- Enroll in Collaborative Care if available

**If risk is imminent, patient will not engage in interventions, or safety at home is not guaranteed:**

- Ensure immediate safety
- Warm Handoff to Crisis Services, CPEP or ED

**Continue to Page 2**
MONITOR

LOW RISK

PHQ-A or ASQ
Re-screening at
Annual Well Visit

– OR DURING –

• Transitions (e.g., foster care)
• Change in medical status
• If trauma reported
– OR –

Clinically indicated

MODERATE RISK

AT EVERY FOLLOW-UP APPT
For those with suicide on Problem List

• Screen every appointment with the C-SSRS – Primary Care: Since Last Visit version
• Are you still receiving BH care/treatment? If yes, when is your next appointment? If no, what is getting in the way?
• Do you still have your safety plan? Does it need to be revised?

HIGH RISK

SAME-DAY CONTACT FOR MISSED APPOINTMENT
Phone call at time of missed appointment or make contact within school day

• Check if in school
• Call cell phone or emergency contact

AFTER CPEP/ED REFERRAL

SCHEDULE FOLLOW-UP APPOINTMENT within 14 days of discharge
# Appendices – Guidance Documents

## Screening and Comprehensive Suicide Risk Assessment

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The words you use matter. You can better reach youth, break down negative stereotypes and give teens hope by choosing words that are more relatable and promote understanding.

This simple but caring approach may help youth feel more comfortable and willing to talk openly about mental health and to reach out for support early.

Your presentation will resonate more effectively and honestly by choosing the best words for your audience. Included here are suggested words and phrases to help teens be more open and receptive to your message.

It only takes one person to make a difference. Lead by example. Be that person.

A person is not their mental health condition. You wouldn’t say someone “is cancer,” so we wouldn’t say someone “is bipolar.” Use words like “has,” “lives with” or “experiences” instead. Talk about mental health in a way that encourages hope and empowers youth. Words like “brain disorder/disease,” “mentally ill” and “suffers from” can be intimidating to teens and give the illness the power.

When talking about suicide, consider other meanings your words may have. For example, “committed suicide” implies that suicide is a crime. You can help eliminate the misunderstanding and stigma that prevent people from speaking up and getting support by choosing words that are more clear and neutral.
Suicide screening with youth

Before You Screen:
Before screening for suicide, you should inform the youth about limits to confidentiality, alongside what information will be shared with their guardians. Minors cannot legally provide consent for treatment or disclosure to their families, and you may have a legal obligation to break confidentiality to guardians if a youth is at risk. To obtain honest, accurate information about suicide risk, you should:

- Discuss the limits of confidentiality and their rationale before screening
- Establish rapport and build an honest, collaborative relationship with the client
- Gain their permission (assent) if possible to disclose to family members. If there is resistance, explore their concerns, validate, and problem-solve together
- Involve youth clients in the decision-making process of how to disclose (e.g., you tell guardians, the client and you tell guardians together with your support, etc.)

REMEMBER: Ultimately, you do not need the youth’s permission to disclose suicidality to their guardians, but it will be advantageous to rapport if you can help them understand why disclosure is important and get them on board. Being collaborative and focusing on safety can help.

When to Screen:
Suicidal youth often do not ask for help. For this reason, clinicians should:

- Provide universal screening to all youth at intake to behavioral settings
- Use a validated suicide screening tool, such as the ASQ or C-SSRS
- Screen at regular intervals after intake, including before discharge in inpatient/CPEP settings
- Screen at least quarterly in outpatient or school-based mental health settings

How to Screen:
It can be helpful to:

- Screen youth clients privately without family members present
- Get collateral information from important others, such as family or teachers, if possible (with parent or guardian permission)
- Use the youth’s own words when referring to suicidal thoughts and behaviors
- Be familiar with screening questions and what constructs they aim to assess so that you can ask conversationally or explain what you’re asking if a youth doesn’t understand
- You may need to break questions into smaller parts or rephrase questions using simpler language for clarity, especially with younger children or those with cognitive impairments.

REMEMBER:

- Asking youth directly about suicidal thoughts is the best way to identify those at risk.
- Preparing youth and their families that you will be asking screening questions and why they are important can help make the process go more smoothly.
- Asking regularly is important - just because a youth is not suicidal today does not mean they won’t be suicidal tomorrow. Many are just one acute stressor away from suicidal thoughts.
- Asking about suicide won’t put the idea in a youth’s head. Most youth thinking of suicide are relieved when they’re asked, and it normalizes the experience of talking about suicidal thoughts and behaviors.
Adapting the Columbia Suicide Severity Rating Scale (C-SSRS) for youth

The C-SSRS is a guide, not a script to be read verbatim off the page. For this reason, it can be helpful to use the youth’s own words when referring to suicidal thoughts and behaviors or to rephrase questions using simpler language for clarity. Some examples of alternate phrasings to the original C-SSRS questions are:

Ideation:

- **Q1:** Have you ever wished you were dead or wished you could go to sleep and not wake up?
  Have you thought about being dead or what it would be like to be dead? Have you felt that you or your family would be better off if you were dead? Have you ever wished you weren’t alive anymore?

- **Q2:** Have you actually had any thoughts of killing yourself?
  Have you thought about doing something to end your life? Have you thought about doing something to make yourself not alive anymore?

- **Q3:** Have you been thinking about how you might do this?
  Have you thought about how you would kill yourself? Have you thought about how you would make yourself not alive anymore? What did you think about?

- **Q4:** Have you had these thoughts and had some intention of acting upon them?
  When you have these thoughts of killing yourself, do you intend to act on them or do something to make it happen? When you thought about making yourself not alive anymore or killing yourself, did you think that this was something you might actually do?

- **Q5:** Have you started to work out or work on the details of how to kill yourself?
  Have you ever thought about how or when you would kill yourself? Have you ever planned out how you would do it, like where or when?

Behavior:

**Actual Attempt:** Have you made a suicide attempt?
Did you ever do anything to try to kill yourself or make yourself not alive anymore? Did you ever hurt yourself on purpose? Why did you do that? Did you ____ as a way to end your life? Did you want to die (even a little) when you ____?

**Aborted/Interrupted Attempt:** Has there been a time when you started to do something to end your life but something or someone stopped you before you actually did anything?
Was there ever a time when you started to do something to end your life but someone or something stopped you? Has there been a time when you started to do something to make yourself not alive anymore, but you stopped yourself?

**Preparatory Behavior:** Have you taken any steps towards preparing to kill yourself?
Have you done anything to get ready to kill yourself or make yourself not alive anymore? Like giving things away, writing a goodbye note, or getting things you need to kill yourself?

REMEMBER:

- Sometimes youth engage in non-suicidal self-injury (NSSI) such as cutting, scratching, burning, or banging the body or punching walls, but this not the same as a suicide attempt. The difference is intent.
  - NSSI has no intent to die; its purpose is to regulate emotions, feel something when numb, or communicate distress. Often NSSI functions as a coping skill, albeit a maladaptive one.
  - Any behavior with at least some intent to die should be considered suicidal. The intent to die does not need to be 100%. Sometimes intent can be inferred from the severity or lethality of a behavior, such as taking a very large number of pills, using a firearm, or jumping from a high place.

- Although NSSI is not a suicide attempt, it should still be taken seriously. NSSI is #1 predictor of suicide attempts in youth, so it’s very important for a clinician to know about! To assess NSSI, you can ask: Have you ever done anything to hurt yourself on purpose without intending to die?
Developing a collaborative team-based approach

- Involving the youth’s parents/guardians in assessment is critical, although other important family members or figures from school or community settings can also be included. Help guide the family to explore options of who to include and in what capacity.
- Clinicians, youth, and their families may not always see eye-to-eye about the goals of treatment or even whether treatment is needed. Clinicians can help to align goals, getting everyone on the same team where safety is the top priority. Clinicians should help youth and their family to understand each other’s perspectives without “taking sides.”
- Many youth and their families have misconceptions about mental health and suicide risk. Psychoeducation about warning signs and how suicide risk fluctuates over time can help.

Conducting a comprehensive suicide risk assessment (CSRA) with youth

Even if a youth does not screen positive when asked directly about suicidal thoughts and behaviors, adolescents and young adults may be experiencing other things in their life that put them at increased risk. Additionally, because youth frequently do not come to treatment of their own accord, they may not be willing to share suicidal symptoms.

For these reasons, a CSRA should be conducted with all youth:
- Upon intake to any behavioral health setting
- After any positive screen
- As your clinical judgment dictates

REMEMBER: Even if a youth denies suicidal ideation, that does not necessarily mean they are not at-risk. A comprehensive suicide risk assessment is vital to developing a clear conceptualization of their risk.
- Many youth do not come to treatment of their own accord and may be reticent to disclose suicidal ideation out of mistrust, fears of hospitalization or their family’s reactions, or a desire to avoid rescue. A comprehensive suicide risk assessment can identify situations and risk factors that may put youth at elevated risk without relying on their self-report.
- Even if a youth is not suicidal today does not mean they won’t be suicidal tomorrow. Many are just one acute stressor away from suicidal thoughts. A comprehensive suicide risk assessment can identify potential stressors proactively.
- Youth have less developed coping and problem-solving skills than adults, so what seems like a temporary problem to an adult may seem insurmountable to a child. Young people may act more impulsively in reaction to stressors and their suicide risk may fluctuate more rapidly, making it especially important to anticipate and plan for a crisis.

A comprehensive risk assessment with youth assesses all categories of an individual’s risk and protective factors (not just suicidal ideation and behavior), including:
- Chronic/distal and acute/proximal risk factors, both modifiable and non-modifiable
- Individualized warning signs
- Protective factors

Although the categories of risk and protective factors to assess are the same, clinicians must be aware of developmental differences when working with youth, particularly which risk factors are most important at different developmental stages and how risk factors may present differently at different developmental stages. Clinicians should also always obtain collateral information from family and important others.

When conducting a CSRA with youth, keep the following considerations in mind:

Suicide specific characteristics:
- Intent to act on suicidal urges fluctuates more rapidly in young people, especially those with a history of impulsive behavior or mood lability; thus, any suicidal ideation reported should be taken seriously.
- Youth at greatest risk tend to have a higher ability to enact potentially-lethal self-injury as a result of high pain tolerance or fearlessness about death. They might also have experienced a gradual “wearing down” of aversion to fear and pain through non-suicidal self-injury, multiple attempts, or reckless behavior where they did not care if they could get hurt.
Conducting a comprehensive suicide risk assessment (CSRA) with youth (cont.)

Access to lethal means:
- Since family often has greater control over the environment, carefully consider the ability and willingness of the family to reduce access and provide adequate supervision.
- Older adolescents are more independent and may be able to purchase or otherwise obtain means from outside the home. Assess frequently if access to means has changed.
- Assess for access to means across all environments, not just the home. Always ask about firearms.

Demographic, ethnic, and cultural characteristics:
- Female youth are twice as likely to make a suicide attempt as male youth, but male youth are three times more likely to die by suicide.
- African-American, Hispanic/Latino/a, and multi-racial youth now report higher rates of suicide attempt than their White counterparts, although White youth still die more frequently by suicide.
- LGBT+ youth are at particularly high risk for suicide, especially transgender and non-binary youth.
- Other cultural factors such as religion, immigrant status, acculturation, and family attitudes towards help-seeking and mental health stigma also impact client risk.

Medical and psychiatric diagnoses:
- Youth recently diagnosed with a serious mental health or medical condition, particularly one that could change their plans for the future, are at increased risk.
- A number of mental health conditions, including depression, anxiety, disordered eating, sleep disturbance, and substance misuse put youth at increased risk for suicide. Youth who “act out” or engage in oppositional, delinquent, impulsive, or high-risk behavior are at particularly high-risk.
- Clinicians should closely monitor any abrupt changes in mood or behavior.
- Youth who have had negative treatment experiences, are non-adherent, are not actively engaged, or have substantial barriers to treatment may be at greater risk.

Interpersonal and environmental risk factors:
- Conflict with family, friends, or a significant other often precede suicidal ideation and attempts, as do traumatic experiences, abuse, victimization, and bullying, especially chronic bullying leading to school refusal or feeling unsafe, covert bullying like social exclusion or cyber-bullying, and bullying over aspects of the youth’s identity.
- Other important risk factors include: academic trouble or disciplinary problems; feeling trapped or hopeless about the future; real, perceived, or anticipated loss of an important relationship, such as break-up with a significant other or death of a loved one; or loss of status/sense of failure regarding something important to one’s identity, like not making a sports team or getting cast in the school play, getting a poor grade, or not getting into a preferred college.
- Exposure to suicide in their peer group or family can also lead to normalization and social contagion.
- Social isolation or exclusion increases risk, particularly during the adolescent years.

Protective Factors:
- Some protective factors for youth might include not wanting to hurt family or friends, a sense of responsibility to younger siblings or pets, or looking forward to future events.
- Religious or spiritual prohibitions can also be potent protective factors for youth who identify strongly with faith traditions that reject suicide.
- Sometimes even just “surviving” until things get better, when they can move out and be more independent, can be a protective factor.
- Just like risk factors, protective factors fluctuate over time, and the loss of a protective factor can become a risk factor. As such, risk assessment should be ongoing to capture fluctuations.

REMEMBER:
- Symptoms present differently at varying developmental stages (i.e., depression in a teen may look like that of an adult, but depression in a child may present as “acting out,” frequent complaints of boredom [anhedonia], or social withdrawal). Behaviors must be considered in the context of what’s appropriate for a youth of that age (e.g., being afraid of the dark is more problematic for a 16 year old than a 6 year old).
- Consider whether certain behaviors represent a large departure from the youth’s typical behavior, as well as what’s developmentally appropriate for same-age peers.
Assigning a risk level with youth

After conducting a risk assessment, you must use the information gathered to assign a risk level. Be sure to document the assigned risk level in the youth’s medical record and provide specific evidence to justify your risk level determination and provide a rationale for the treatment selected. The following considerations are guidelines for establishing a suicide risk-level, but you can also use your clinical judgement when appropriate:

- **Youth at low risk for suicide**: Have no current or recent active ideation with intent or plan (though sometimes low-level or fleeting suicidal ideation without intent may be present); Mostly distal risk factors. If there are proximal risk factors or warning signs, they are usually few in number; No access to means; Strong, numerous protective factors outweigh their risk factors.

- **Youth at moderate risk**: Have at least one or two notable proximal risk factors or warning signs present or the possibility of an activating event in the future; May have a history of non-suicidal self-injury or suicidal behavior but no immediate suicidal intent; You may worry that their intent may fluctuate rapidly or they may have a history of acting impulsively; Protective factors are present, but less prominent; May have access to lethal means, but the youth and their family are willing and able to safety plan, reduce access to means, and devise a plan for appropriate supervision.

- **Youth at high risk for suicide**: Have numerous acute, proximal risk factors and warning signs that outweigh protective factors; Report active suicidal ideation with intent or plan, or you have reason to believe they may be withholding this information or are likely to act impulsively with little planning; May have recently engaged in non-suicidal self-injury or suicidal behavior; Have access to means; youth or family are not able or willing to safety plan, reduce access to means, and provide increased supervision.

**REMEMBER:**

- Risk assessment is nuanced – there is no easy algorithm or checklist for determining risk. You must use your clinical judgment. This is an excellent time to engage in supervision or peer consultation.
- Just because a youth client denies suicidal behaviors and thoughts does not mean they are not at risk. Perhaps they are unwilling or unable to disclose. Ultimately, the risk-level that you assign depends on that client’s and their family’s individual characteristics, circumstances, and your clinical judgment.
- When assigning a risk level or making a level of care determination, you should consider the family’s ability and willingness to safety plan, reduce access to lethal means, and provide adequate supervision. A youth whose family is unable or unwilling may need a higher level of care.

Making a level of care determination with youth

Sometimes a youth client will need a higher level of care, such as inpatient hospitalization, evaluation at the emergency department, intensive outpatient, or residential treatment. However, most times, youth clients can be maintained safely at a lower level of care, such as outpatient treatment or school-based mental health, as long as there are strong support systems in the youth’s natural environment, including:

- Family support for safety planning, means reduction, and supervision
- The ability and willingness to monitor the youth in the home
- The family’s ability and willingness to facilitate access to ongoing treatment

Of course, clinicians can only do so much, and so they must also carefully consider the family’s willingness and ability to provide a safety net across environments. Ultimately, clinicians should strive to treat suicidal youth in the least restrictive setting where their safety can be maintained:

- **A higher level of care** may be indicated if: The clinician cannot determine the youth and family’s ability to maintain safety; There are warning signs of imminent risk; The youth has active suicidal ideation with some intent to act in the near future; or the youth or the family are unwilling or unable to safety plan, reduce access to means, and provide additional supervision. If a youth is at imminent risk do not leave them alone, especially during transfers, to reduce flight risk and maintain safety.

- **A lower level of care**, such as outpatient and school-based mental health settings, is appropriate for youth clients at low risk, and may be appropriate moderate-to-high risk youth if they receive specialized, more intensive interventions.

Contact SP-TIEInfo@nyspi.columbia.edu for more information.
Sample Suicide Risk Assessment Checklist
Based on CPI's Comprehensive Suicide Risk Assessment Module

1. Suicidal Ideation and Behavior - C-SSRS Screening Questions
   - Q1 – Wish to die: Have you ever wished you were dead or wished you could go to sleep and not wake up?
   - Q2 – Active suicidal ideation: Have you actually had any thoughts of killing yourself?
   - Q3 – Suicidal ideation with method: Have you been thinking about how you might do this?
   - Q4 – Suicidal ideation with intent: Have you had these thoughts and had some intention of acting on them?
   - Q5 – Suicidal ideation with intent and plan: Have you started to work or worked out the details of how to kill yourself? Do you intend to carry out this plan?
   - Q6 – Suicidal behavior: Have you done anything, started to do anything, or prepared to do anything to end your life?
     - Suicide attempt: A self-injurious act performed with at least some intent to die, regardless of whether actual injury occurred
     - Interrupted or aborted attempt: When individuals take steps to end their life but someone or something stops them before they actually do anything, or the individuals stop themselves
     - Preparatory behaviors: Actions to prepare for taking one’s life, such as collecting/buying pills, purchasing a gun, saying goodbye, or writing a will or suicide note.
   - Q7 – Suicide attempt: Have you made a suicide attempt? How many attempts have you ever made? How long ago was your most recent attempt?

2. Risk & Protective Factors
   - Distal Risk Factors: longstanding background factors that elevate chronic risk of suicide
     - Non-Modifiable:
       - Adolescent/Young adult
       - Male
       - Veteran or Active Military
     - Modifiable:
       - Gender and/or Sexual Minority (LGBTQ+)
       - Previous suicide attempt(s)
       - Family history of suicide

   - Proximal Risk Factors: current, acute factors that elevate imminent risk
     - Current psychiatric symptoms: aggressive or impulsive behaviors and negative mood states
     - Substance misuse
     - Recent medical diagnosis
     - Bullying, victimization, or trauma
     - Interpersonal, job, or financial loss
     - Negative life circumstances
     - Access to means

   - Warning Signs: might indicate increasing suicide risk
     - Spike in suicidal thoughts
     - Planning for a suicide attempt
     - Preparatory behaviors
     - Communicating the possibility of not being around
     - Sleep Disturbance
     - Increase isolation
     - Agitation
     - Hopelessness
     - Substance Use

   - Protective Factors: may help buffer an individual from suicide risk
     - Reasons for Living
       - Responsibility to family
       - Children & pets
       - Looking forward to events in the future
     - Deterrents
       - Fear of death
       - Spiritual values
       - Worries about severe injury
       - Fear of consequences
     - Coping Skills
**Weighing Risk & Protective Factors:** The strongest risk factors are those that are most acute/proximal

- Current presentation of suicidal ideation or recent suicidal behavior
- Access to lethal means
- Current mood state—agitation, mania, psychosis, aggression, mixed mood state
- Recent high-risk precipitants or changes in status

### 3. Risk Formulation -
*Assign a risk level based on the results of the screening, risk assessment, chart or collateral review (if possible), and your clinical judgement.*

**HIGH RISK**
- Suicidal ideation with intent and plan, especially if the plan is imminent or lethal
- Recent suicidal behavior (attempt, interrupted/aborted attempt, preparatory behavior)
- Persistent ideation that feels uncontrollable, strong, or intensely fluctuating intent or suicide rehearsal
- History of prior attempt with lethal method or impulsive attempt with little planning, especially if the circumstances around the prior attempt resemble current or anticipated triggers
- Has access or could easily obtain access to lethal means
- Many acute/proximal risk factors and warning signs outweigh protective factors
- Psychiatric disorders with severe symptoms
- Recent or anticipated acute precipitating event (such as trauma or loss)
- Distressing change in situation or treatment
- Few or no protective factors—particularly a sense of being a burden on others or extreme isolation with little support

**MODERATE RISK**
- Suicidal ideation with plan but no intent
- No recent suicidal behavior
- Multiple risk factors, but more distal/chronic than proximal/acute (suicide attempt in distant past, psychiatric diagnoses, trauma history)
- Can anticipate a possible precipitant in the near future but none imminent
- No immediate access to means, but may be able to obtain them
- Few or weak protective factors
- More intact problem solving or coping skills
- Has social supports that may be able to assist in maintaining safety

**LOW RISK**
- May have thoughts of death or even active suicidal thoughts but with no plan or intent
- No recent history of suicidal behavior
- Risk factors are modifiable or mostly distal/chronic
- None or minimal acute/proximal risk factors or warning signs
- Strong protective factors, including reason for living
- Good social supports

**Next Steps:**

- **Plan to Mitigate Risk Factors**
- **Plan to Strengthen Protective Factors**
- **Level of Care Determination**
  - Consider level of intent/planning, plan’s imminence (plan to act in the near future) AND access to lethal means.
  - Some suicidal individuals act with little to no planning - assessment of all risk and protective factors is necessary to help anticipate crises.
  - Consider protective factors, like willingness and/or ability to utilize support and engage in actions to remain safe (engage in safety planning, safeguard the home environment) are.
  - Strive for the least restrictive level of care that keeps the patient safe.
Weighing Risk & Protective Factors

The strongest risk factors are those that are most acute/proximal:
- Current presentation of suicidal ideation or recent suicidal behavior
- Current mood state—agitation, mania, psychosis, aggression, mixed mood state
- Recent high-risk precipitants or changes in status
- Access to lethal means

Determine Risk Level

- Determining level of care and appropriate interventions is based on risk level.
- A clinician’s risk formulation weighs population-based risk factors and the individual presentation to ascribe a level of risk.
- Level of risk will increase or decrease depending on number and extent of risk and protective factors.
- Assign a risk level based on the results of the screening, risk assessment, chart or collateral review (if possible), and your clinical judgement.
- Document determination and rationale based on the level of risk. Be specific in presence/absence, severity, recency/duration of ideation, method, plan, intent, and behavior. Include consideration of risk and protective factors.
- USE RISK FORMULATION TO DRIVE INTERVENTION, NOT PREDICTION

LOW RISK
- May have thoughts of death or even active suicidal thoughts but with no plan or intent
- No recent history of suicidal behavior
- Risk factors are modifiable or mostly distal/chronic
- None or minimal acute/proximal risk factors or warning signs
- Strong protective factors, including reason for living
- Good social supports

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- Suicidal ideation with plan but no intent
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- Few or weak protective factors
- More intact problem solving or coping skills
- Has social supports that may be able to assist in maintaining safety

HIGH RISK
- Suicidal ideation with intent and plan, especially if the plan is imminent or lethal
- Recent suicidal behavior (attempt, interrupted/aborted attempt, preparatory behavior)
- Persistent ideation that feels uncontrollable, strong, or intensely fluctuating intent or suicide rehearsal
- History of prior attempt with lethal method or impulsive attempt with little planning, especially if the circumstances round the prior attempt resemble current or anticipated triggers
- Has access or could easily obtain access to lethal means
- Many acute/proximal risk factors and warning signs outweigh protective factors
- Psychiatric disorders with severe symptoms
- Recent or anticipated acute precipitating event (such as trauma or loss); distressing change in situation or treatment
- Few or no protective factors—particularly a sense of being a burden on others or extreme isolation with little support
When making a level of care determination, take into account the individual's:

- Level of intent/planning
- Probability or likelihood of acting on the plan in near future
- Access to lethal means
- Protective factors, including
  - family/supports
  - willingness and/or ability to utilize support and engage in actions to remain safe (i.e. engage in safety planning, safeguard the home environment)
  - availability of adults to supervise the person

**Questions to Consider**

**Outpatient & SUD Settings**

- Does the person in care need to be immediately referred to the emergency department or an inpatient unit to maintain safety?
- Do the person in care's symptoms warrant a more intensive program (such as an intensive outpatient or residential treatment program)?
- If appropriate to be maintained in the outpatient setting, do they have an updated, more intensive Suicide Care Management Plan to maintain safety between sessions?
- What additional monitoring and supports will be needed to maintain safety in the home, school, and community?

**Inpatient & Emergency/CPEP Settings**

- What precautions are needed to maintain safety while in the CPEP or on the unit?
- What additional monitoring and supports will be needed to maintain safety in the home, school, and community upon discharge?
- What resources will be needed for ongoing treatment upon discharge?

**Determining if a Higher Level of Care is Needed**

- The person in care has active suicidal ideation with some intent to act and potential access to means, and they or their supports cannot or will not provide what is needed to keep the patient safe
- You cannot determine the person's (or their support's) ability to maintain safety or utilize supports
- You suspect imminent risk given active warning signs despite no endorsement of suicidal ideation

**Outpatient & SUD Settings**

- Many individuals can be maintained in outpatient treatment with a specialized, more intensive High-Risk Outpatient Engagement (HOPE) Plan (if the proper supports and monitoring are in place)
- If possible, review pros and cons of different courses of action and decide collaboratively. If working with youth, be sure to engage with their family/caregiver

**If the individual needs a higher level of care:**

- Know protocols and procedures for referrals to CPEP, Crisis ED, and Inpatient
- Consult with supervisor(s)
- Do not leave the person in care alone and assess potential for flight risk
- Let the individual (and their supports) know that you want to help and emphasize safety
- Document determination and rationale based on risk level
- Follow-up with individual (and supports if possible) to assist with care transition!

**If the individual is appropriate for the current level of care:**

- Assign a risk level based on screening, assessment, and clinical judgement
- Document determination and rationale based on level of risk
- Remember, you are not liable for poor prediction; you are only liable for negligence (i.e. not asking, documenting or taking preventative actions)

**Transitions from one level of care to another are particularly high-risk time periods for suicidal behavior**

Some suicidal individuals act with little to no planning, so a thorough assessment of all risk and protective factors is necessary to help anticipate crises.

Not all suicidal individuals need to be hospitalized. Strive for the LEAST RESTRICTIVE level of care that keeps the person safe.
COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
NYASSC Screening Version

Qs 1-5 ask about suicidal ideation; Qs 6-7 assess suicidal behavior (with Q 7 assessing past suicide attempt specifically)

<table>
<thead>
<tr>
<th>Question</th>
<th>Past 3 months</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Wish to die: Have you ever wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2- Active suicidal ideation: Have you actually had any thoughts of killing yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3- Suicidal ideation with method: Have you been thinking about how you might do this?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4- Suicidal ideation with intent: Have you had these thoughts and had some intention of acting on them?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5- Suicidal ideation with intent and plan: Have you started to work or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6 – Suicidal behavior: Have you done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7 – Suicide attempt: Have you made a suicide attempt (took an action to end your life)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

How many attempts have you ever made? #_________

How long ago was your most recent attempt?

□ Past 3m □ 4-12m □ 1-5 yrs. □ 5 yrs.+

Suggested Risk Level:

Low  Moderate  High

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu
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### COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
#### Emergency Department Screening Version

### SUICIDE IDEATION DEFINITIONS AND PROMPTS:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past month</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ask questions that are in bold and underlined.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1) Wish to be Dead:</strong> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2) Suicidal Thoughts:</strong> General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you had any actual thoughts of killing yourself?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</strong> Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. ”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.”</td>
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<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might do this?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4) Suicidal Intent (without Specific Plan):</strong> Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5) Suicide Intent with Specific Plan:</strong> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6) Suicide Behavior Question</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</em></td>
<td>Lifetime</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Past 3 Months</td>
<td></td>
</tr>
<tr>
<td><strong>If YES, ask:</strong> <em>Was this within the past 3 months?</em></td>
<td></td>
<td></td>
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</tbody>
</table>

**Response Protocol to C-SSRS Screening** (Linked to last item marked “YES”)

- **Item 1** Behavioral Health Referral at Discharge
- **Item 2** Behavioral Health Referral at Discharge
- **Item 3** Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- **Item 4** Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
- **Item 5** Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
- **Item 6** Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- **Item 6** 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

**Disposition:**
- Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
- Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Behavioral Health Referral at Discharge
### COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for Primary Care*

#### Ask questions that are in bold and underlined.

<table>
<thead>
<tr>
<th>Ask Questions 1 and 2</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>2) Have you actually had any thoughts of killing yourself?</strong></td>
<td></td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

<table>
<thead>
<tr>
<th>3) Have you been thinking about how you might do this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. &quot;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.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Have you had these thoughts and had some intention of acting on them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.</td>
</tr>
</tbody>
</table>

If YES, ask: **Was this within the past 3 months?**

#### Possible Response Protocol to C-SSRS Screening

- Item 1 Behavioral Health Referral
- Item 2 Behavioral Health Referral
- Item 3 Behavioral Health Referral
- Item 4 Behavioral Health Consultation and Patient Safety Precautions
- Item 5 Behavioral Health Consultation and Patient Safety Precautions
- Item 6 Behavioral Health Referral
- Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
**PHQ-9 modified for Adolescents (PHQ-A)**

Name: ___________________________  Clinician: ___________________________  Date: __________

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>(0) Not at all</th>
<th>(1) Several days</th>
<th>(2) More than half the days</th>
<th>(3) Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Little interest or pleasure in doing things?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
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<tr>
<td>4. Poor appetite, weight loss, or overeating?</td>
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<td></td>
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<tr>
<td>5. Feeling tired, or having little energy?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
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<td></td>
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</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

- □ Yes  □ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

- □ Not difficult at all  □ Somewhat difficult  □ Very difficult  □ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

- □ Yes  □ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

- □ Yes  □ No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.**

**Office use only:**

**Severity score:** __________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)
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 & Crisis Lifeline: 988
- 24/7 Crisis Text Line: Text “Got5” to 741-741
What are universal precautions?

Universal Precautions are measures taken to prevent suicide attempts with all patients seeking behavioral health treatment, regardless of whether they have come in for concerns specifically relating to suicide.

Universal precautions primarily include providing all patients with suicide-specific:

- Screening
- Psychoeducation
- Crisis resources

Why are universal precautions important?

Half of those who die by suicide visited a healthcare setting in the month prior to their death, highlighting the need to implement precautions for everyone entering a healthcare setting, particularly populations seeking treatment for mental health concerns.

90% of those who die by suicide have a diagnosable mental health disorder, further highlighting the need to screen and provide psychoeducation and resources specific to suicide to all clients during intake. Because suicide risk can ebb and spike over time, it’s also important to implement universal precautions for patients routinely.

Implementing universal precautions also provides an easy transfer into safety planning and means reduction counseling for those who are identified as at-risk of suicide, because this begins the process of identifying specific warning signs and resources to call if a crisis emerges.

Where are universal precautions needed?

Each type of behavioral health site will have a specific application of the suicide-safer care model with site-specific protocols for patients. However, it is crucial to instate universal precautions across all behavioral health settings including CPEP, outpatient, inpatient, school-based, and substance use disorder treatment settings.

For those in a CPEP setting, universal precautions are particularly important as they may present the only opportunity to make a targeted suicide prevention intervention.
The components of universal precautions include:

**Universal screening**
All behavioral health clients should receive screening using the Columbia Suicide Severity Rating Scale and a comprehensive suicide risk assessment. Screening should be conducted:
- Upon admission/intake to a behavioral health setting
- After care transitions
- Whenever a client shows an abrupt change in behavior, a lack of improvement, or worsening
- In anticipation of or when an experience of loss or stressor occurs
- Whenever suicidal communication is made or implied
- As clinical judgement dictates

For low risk clients, screening should occur at least quarterly on an outpatient basis. For moderate to high risk clients, screening is recommended for every visit.

**REMEMBER:** Asking about suicide won’t put the idea in a client’s head. In fact, opening the conversation to talk about suicide normalizes the experience of talking about suicidal thoughts and behaviors and may provide relief. It can even potentially save someone’s life.

**Psychoeducation**
Remind clients that it’s not uncommon for people suffering with a mental illness to have suicidal thoughts in their lifetime.

Provide the client with psychoeducation about the fluctuating nature of suicide risk – i.e., how risk can come and go, but also increases or decreases in intensity over time.

Both the client and clinician should be aware that just because an individual has no current or recent ideation, doesn’t meant that they will never experience ideation in the future.

Provide the client with suicide-specific psychoeducation regarding common warning signs (thoughts, feelings, and behaviors) that precede suicide risk, such as: feeling increasingly hopeless, isolating oneself or withdrawing from social interactions, and/or abusing drugs and/or alcohol. The FACTS acronym is useful here – certain Feelings, Actions, Changes, Talking, and Situations can be warning signs.

After explaining that warning signs often precipitate suicide risk, ask the client if any of the warning signs you listed as an example sound familiar to them. If the client can identify possible warning signs, encourage them to reach out if they notice these signs in the future, even if the client has no history of suicidal thoughts or behaviors.

**Crisis resources**
- Provide all clients with useful contacts that can be reached during a suicidal crisis such as the National Suicide Prevention & Crisis Lifeline (988) or Crisis Text Line (text “Got 5” to 741741).
- Suggest that clients put these emergency resources into their phone while you are with them, so that they have easy access to 24/7 free, confidential support if a suicidal crisis arose. It is also a good idea to have pre-printed resources to give to your client as a back-up.
- If your client would prefer to speak to a resource that has interventions tailored to specific identities (i.e., lifelines for LGBTQIA, youth, or veterans), be familiar with and able to provide these resources.
Adaptations for Working with Youth:

Suicide screening

Before You Screen:
Before screening for suicide, you should inform the youth about limits to confidentiality, alongside what information will be shared with their guardians. Minors cannot legally provide consent for treatment or disclosure to their families, and you may have a legal obligation to break confidentiality to guardians if a youth is at risk. To obtain honest, accurate information about suicide risk, you should:

- Discuss the limits of confidentiality and their rationale before screening
- Establish rapport and build an honest, collaborative relationship with the client
- Gain their permission (assent) if possible to disclose to family members. If there is resistance, explore their concerns, validate, and problem-solve together
- Involve youth clients in the decision-making process of how to disclose (e.g., you tell guardians, the client and you tell guardians together with your support, etc.)

REMEMBER: Ultimately, you do not need the youth’s permission to disclose suicidality to their guardians, but it will be advantageous to rapport if you can help them understand why disclosure is important and get them on board. Being collaborative and focusing on safety can help.

When to Screen:
Suicidal youth often do not ask for help. For this reason, clinicians should:

- Provide universal screening to all youth at intake to behavioral settings
- Use a validated suicide screening tool, such as the ASQ or C-SSRS
- Screen at regular intervals after intake, including before discharge in inpatient/CPEP settings
- Screen at least quarterly in outpatient or school-based mental health settings

How to Screen:
Standardized screeners, such as the ASQ or C-SSRS, are guides, not a script to be read verbatim. It can be helpful to:

- Screen youth clients privately without family members present
- Get collateral information from important others, such as family or teachers, if possible
- Use the youth’s own words when referring to suicidal thoughts and behaviors
- Be familiar with screening questions and what constructs they aim to assess so that you can ask conversationally or explain what you’re asking if a youth doesn’t understand
- You may need to break questions into smaller parts or rephrase questions using simpler language for clarity, especially with younger children or those with cognitive impairments.

REMEMBER:
- Asking youth directly about suicidal thoughts is the best way to identify those at risk.
- Asking regularly is important - just because a youth is not suicidal today does not mean they won’t be suicidal tomorrow. Many are just one acute stressor away from suicidal thoughts.
- Young people may act more impulsively and their suicide risk may fluctuate more rapidly, making it especially important to anticipate and plan for a crisis.
- Asking about suicide won’t put the idea in a youth’s head. Most youth thinking of suicide are relieved when they’re asked, and it normalizes the experience of talking about suicidal thoughts and behaviors.
- Preparing youth and their families that you will be asking screening questions and why they are important can help make the process go more smoothly.
Adaptations for Working with Youth:

Psychoeducation for youth and their families

All youth clients and their families, regardless of their risk status, should be provided accurate psychoeducation about suicide risk:

- Remind youth and their families that it’s not uncommon for youth with mental health concerns to have suicidal thoughts in their lifetime, so discussing and planning for the possibility with all clients is important.
- How you provide psychoeducation may differ between youth clients who have and have not experienced suicidal thoughts.
  - For those who have never experienced suicidal thoughts, discussion should focus on how these kinds of thoughts are relatively common for this age range, what the most common warning signs are, and how to respond if they occur.
  - For youth who have experienced suicidal thoughts, these points can be tailored to focus on their specific experiences of fluctuating risk and personalized warning signs.
- Families have different levels of mental health literacy and different cultural beliefs about mental health and treatment. Be sensitive and provide psychoeducation in a manner that is respectful of these differences while still providing accurate recommendations.
- Psychoeducation about the fluctuating risk nature of suicide risk and potential warning signs should be provided to both the client and their family. When discussing the FACTS acronym (Feelings, Actions, Changes, Talking, and Situations), be sure to use developmentally-appropriate examples of warning signs.
- After explaining that warning signs often precipitate suicide risk, ask both the youth client and their family if any of the warning signs you listed as an example sound familiar. Encourage them to reach out if they identify possible warning signs in the future, even if the client has no history of suicidal thoughts or behavior.

Crisis resources

Provide all youth clients and their family with useful 24-hour contacts for a crisis:

- Contacts should include the name and location of a local emergency department or CPEP, as well as national services such as the National Suicide Prevention & Crisis Lifeline (988) or Crisis Text Line (text “Got 5” to 741741).
- If youth are reluctant to reach out to a hotline, calling or texting together can be a good way to demystify the process.
- If your community has youth-specific crisis resources, such as mobile crisis, drop-in centers, or respite care, share these resources with your client’s family as appropriate.
- Encourage youth clients to put emergency resources into their phone while you are with them. Some youth may prefer to use texting or phone apps as opposed to phone or paper resources.
- Even if youth save information in their phone, also provide families with pre-printed resources.
- Be familiar with hotlines tailored to specific identities (i.e., LGBTQIA, BIPOC, etc.).

Contact SP-TIEInfo@nyspi.columbia.edu for more information.
Suicidal feelings can be overwhelming and incredibly painful in the moment, but if you make it through somehow, they often pass. It’s hard to remember that these feelings will pass when you’re really upset though…

We know it can be hard to think clearly when you’re upset, so we want to figure out what to do ahead of time. Suicidal thoughts come and go and eventually pass with time, and the risk of acting on these thoughts decreases over time.

I’d like to share with you two resources for people in crisis that we share with all patients before leaving the hospital…So if you (or even a friend or family member) need help, you have options.

The first is the number for the National Suicide and Crisis Lifeline: 988. You can call 988 at any time to be connected to a live person trained to help.

If you prefer texting with a crisis counselor rather than speaking to a person over the phone, there is the Crisis Text Line. You can reach the Crisis Text Line 24/7 by texting GOT5 to 741-741.

If you were in crisis, which do you think you would be more likely to use, a hotline or text line?

Ok. Can you enter the [PREFERRED NUMBER] into your phone now? [IF CRISIS TEXT LINE, HAVE THEM TEXT “GOT5” TO 741-741 AND THAT WILL BRING THEM TO THE TERMS OF USE AGREEMENT. THEY CAN STOP THERE BEFORE BEING CONNECTED TO A COUNSELOR.]
"Everyone's journey is different. Don't compare your path to anyone else's."

AUTHOR UNKNOWN

If you're thinking about suicide or are worried about a friend or loved one, please reach out.

988 SUICIDE & CRISIS LIFELINE

A GUIDE TO Staying Safe

What to know about suicide

Need to talk?
WE'VE GOT TIME TO LISTEN
TEXT "GOT5" TO 741-741 TO START A CONVERSATION
FREE, 24/7, CONFIDENTIAL CRISIS SUPPORT BY TEXT

Veterans Crisis Line
DIAL 988 then PRESS 1

The Trevor Project
Text START to 678-678
Call us at 1-866-488-7386

Suicide prevention crisis lines are confidential & provide 24/7 emotional support when you need it.
**KNOW THE SIGNS**

Many people experience thoughts of suicide, particularly in times of stress or crisis. Because suicidal thoughts and feelings can change over time, it's helpful to know the warning signs:

- **TALKING ABOUT:**
  - Wanting to die
  - Intense guilt or shame
  - Being a burden to others

- **FEELING:**
  - Hopeless, trapped, or empty
  - That there is no reason to live
  - Unbearable pain, emotionally or physically
  - Extremely sad, anxious, or full of rage

- **CHANGES IN BEHAVIOR, SUCH AS:**
  - Increased use of alcohol or drugs
  - Reckless behavior
  - Withdrawal from others; isolation
  - Rage; thinking/talking about seeking revenge
  - Extreme mood swings
  - Looking for ways to kill oneself (searching online, stockpiling pills, buying a gun, etc.)
  - Visiting or calling people to say goodbye; giving away prized possessions

**RISK FACTORS**

There are certain things that may put you at risk for suicide. However, recognizing these factors in yourself or others does not automatically mean you are suicidal or that someone is considering suicide.

- **HISTORY OF:**
  - Mental health condition (depression, anxiety, bipolar, borderline personality, PTSD, etc.)
  - Trauma (physical, mental or emotional abuse)
  - Family members’ death by suicide
  - Previous suicide attempts
  - Substance abuse

- **CURRENTLY STRUGGLING WITH:**
  - Major physical illnesses/disability
  - Lack of social supports, relationship problems
  - Homelessness
  - Unemployment, financial struggles
  - Major loss, such as a death or break-up
  - High stress family and/or work environments
  - Risky behaviors (substance misuse, unsafe sex practices, etc.)
  - Bullying or victimization at home, work, or school

**USING YOUR SAFETY PLAN**

A Safety Plan is created to help you remain safe until the crisis passes and the risk of acting on these thoughts decreases. It can help you to know that there is something you can do to feel better.

1. When you recognize your own warning signs, this is when you should use your safety plan. What are some of yours?

2. What can you do, on your own, if you start to notice warning signs that could help yourself not to act on these thoughts or urges? Things that you can do to take your mind off of your problems could be mindfulness exercises, physical activity such as taking a walk, listening to music, etc.

3. If these internal coping strategies aren't working, who can you call or where can you go to help provide distraction? Calling your friend or a family member? Going to the gym or the coffee shop?

   Name________________________________ # ________________________
   Name________________________________ # ________________________

   Place _______________________________________________
   Place _______________________________________________

4. If these distraction aren't working for you, who can you contact for help during a crisis?

   Name ________________________________ # _______________________
   Name ________________________________ # _______________________

5. If there is no one you feel comfortable contacting, or you can't reach anyone, you can always reach out to a professional, your counselor, or call 911.

   Clinician Name____________________________________________
   Phone______________________________
   Clinician Name____________________________________________
   Phone______________________________

   You can also always reach out to your local suicide lifeline 24/7. These lines are confidential. The numbers are located on the back of this brochure.
A Guide for Clinicians:
Safety Planning Intervention for Suicide Prevention

What is a safety plan?
A Safety Plan is a prioritized, written list of coping tools and sources of support to use when a patient is feeling suicidal so that they do not act on their suicidal feelings. It is a personally tailored emergency plan.

Why should a client use the safety plan?
The Safety Plan helps prevent a suicidal crisis from escalating so that clients do not act on urges to self-harm. Acute suicidal crises, when people are most in danger of acting on suicidal feelings, often last only for a brief time. The safety plan helps give a client something to do to get through this time safely without engaging in suicidal behavior.

When should a client use the safety plan?
Clients should use their safety plan whenever they recognize any of the personal warning signs listed on the safety plan.

How should a client use the safety plan?
Once a client recognizes their warning signs, they should follow the specific instructions that are described on each step of their safety plan. If doing things on one step does not help to reduce the crisis, they should proceed to the next step until the crisis has lessened.

Where should a client keep the safety plan?
Clients should keep their safety plan in a place where they are able to easily find it and use it. Some people keep their safety plans at home and other people carry it with them in their purse, wallet, pocket, or cell phone.

Should a client share the safety plan with others?
Sometimes it is helpful for clients to share their safety plan with a family member or close friend who can help during a crisis.

What should a client do if they lose the safety plan?
A copy of each client’s safety plan is stored in their electronic health record. Clinicians may be able to retrieve a copy of their client’s safety plan. Many people make copies of their safety plan or keep a copy on their cell phone.

Does the safety plan work?
Recent research has been conducted that supports the effectiveness of safety planning. Individuals who received the safety plan intervention were less likely to report suicidal behaviors during follow-up than individuals who did not receive the intervention.
Safety Planning Intervention: 
Brief Checklist for Initial Safety Planning

DIRECTIONS: This checklist is a guide when conducting the initial Safety Planning Intervention; each section should be completed. Once the crisis narrative has been obtained:

1. **Introduce and provide rationale for safety planning** *(approximately 2-10 minutes)*
   - Let the client “tell the story” of their suicidal crisis *(crisis narrative)*, while you listen for warning signs, coping skills, supportive others, or means reduction opportunities to be listed on the safety plan.
   - **Provide psychoeducation** about how suicidal ideation may come and go over brief periods of time, using examples from their story.
   - Introduce the safety plan as a method for recognizing warning signs, taking action to actively cope with suicidal feelings, and reducing risk or keeping it from escalating.
   - Describe the safety plan as an *“emergency plan”* to prevent acting on suicidal feelings.
   - Describe how the safety plan consists of a sequence of steps. **If following one step is not helpful for reducing the suicidal crisis, then the client should proceed to the next step.**

2. **Complete each step of the safety plan** *(approximately 15-30 minutes)*
   - Describe the **rationale** for each step, then collaboratively brainstorm ideas.
   - **Be as specific as possible** and use the individual’s own words.
   - Assess feasibility of using each strategy and **trouble-shoot barriers to its use**.
   - After each step, remind individual that, if the suicidal crisis does not remit, they should go to the next step. *(Steps may be skipped, if needed.)*
   - For Step 5 on the safety plan *(Contacting Professionals & Agencies)*:
     - If there is no existing treatment, **describe the benefit of treatment** and local resources
     - Explain how to contact the National Suicide Prevention Lifeline or Crisis Text Line
   - For step 6 on the safety plan *(Making the Environment Safe)*:
     - Explain how making the environment safer will help lower risk of acting on suicidal feelings
     - **Always assess the availability or access to firearms.** If firearms are present, consider asking a family member or friend who would be authorized to possess a firearm to remove and secure it for a period of time, or lock the firearm and ammunition separately then give the key to a family member or friend.
     - Identify **other potential methods or plans** and collaboratively develop an action plan to make the environment safer for all dangerous means.
     - **If doubt is expressed about limiting access**, assess the pros and cons of having access to a given method, and brainstorm alternative ways of limiting access that are both safer and acceptable to the client.

3. **Review use of the safety plan** *(approximately 3 minutes)*
   - **Review** the steps of the safety plan with the individual and ask about the likelihood of using it
   - **Identify a location to keep the safety plan where it can be readily accessible**
   - Assess feasibility and **trouble-shoot obstacles** to using the safety plan intervention
   - Explain how the safety plan can be reviewed later to see how helpful it was for lowering risk and **how it can be revised to be more effective**
   - Provide individuals with the safety plan and explain that a **copy will be retained in their records**. Remind individuals that they can receive a copy should they want another one.
DIRECTIONS: This checklist is a guide when conducting follow-up after a safety plan has already been developed. The clinician should retrieve the last safety plan from the medical record.

Ask the client:

1. **Do you remember the safety plan you developed?**
2. **Have you actually used your safety plan?**
3. **Was the Safety Plan helpful for preventing you from acting on your suicidal urges? If not, why not (such as forgetting to use it, how to use it, or finding it)?**
4. **How can the Safety Plan be revised so that it would be more helpful to you? Are there specific steps that could be improved (see example questions below)?**

Steps of the safety plan to review:

- **Step 1 – WARNING SIGNS:** Can the warning signs be changed or revised to **be more specific** so that you will remember to use it? Can you review the Safety Plan on a regular basis so that you will remember to use it?

- **Step 2 – INTERNAL COPING STRATEGIES:** Are there new internal coping strategies that would be **more effective** or **more feasible** distractors? Are there any coping strategies listed on your safety plan that **should be removed because they were not helpful**?

- **Step 3 – PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISRACTION:** Are there new people or social settings that would be **more effective** or **feasible** distractors? Are there some people or social settings listed that **should be removed because they were not helpful**?

- **Step 4 – PEOPLE TO ASK FOR HELP IN A CRISIS:** Are there other family members or friends who should be **added**? Are there people listed on your safety plan who should be **removed because they were unhelpful or unavailable**?

- **Step 5 – PROFESSIONALS OR AGENCIES:** Are there other **professionals or agencies that should be added or removed**? Were there any problems you experienced when you tried to contact a professional or agency for help?

- **Step 6 – MAKING THE ENVIRONMENT SAFER:** Have you been able to make the environment safer by **removing or restricting access to means** that could be potentially harmful to you? Do you currently have access to a firearm? Is there anything else that could be done to make your environment safer?

- **USING THE SAFETY PLAN:** Was the location where you kept the Safety Plan helpful or convenient for you? **Is there a better place that you could keep it?** Can the Safety Plan **be placed somewhere so that it is more visible and serve as a reminder** to use it?
Adaptations for Working with Youth:

**Step 1 – Warning Signs:**
- Be sure that warning signs listed are specific predictors of suicidal crisis, not just risk factors.
- If youth are having trouble identifying their specific warning signs, ask them what was different about the day of their crisis (as opposed to chronic background states, like depression or anxiety, that may have been present for extended periods of time).
- If you are suggesting warning signs, it can be helpful to pull information from a youth’s crisis narrative. Be sure suggestions are understandable and developmentally-appropriate.

**Step 2 – Internal Coping Strategies:**
- Make sure that coping strategies selected are adaptive, good distractors that they are comfortable sharing with their family. Avoid substance use – Many substances are disinhibiting and exacerbate suicidal urges.
- Be specific, as vague descriptions of generic strategies may leave the youth vulnerable to upsetting content – “watch cute animal videos on YouTube (bookmarked)” is a better strategy than “go on the internet,” which could expose them to unhelpful people, trolls, or content that makes them more distressed.

**Step 3 – People and Social Settings That Provide Distraction:**
- Peers can be listed as social distraction (step 3) but should not be listed on step 4. Include contact information on the plan, and remember that contact can be in-person, phone, texting, gaming platforms, social media, apps, etc.
- Problem-solve with the youth that the people listed are good distractors (funny, engaging, enjoyable people; people unlikely to upset them further) and that places listed are available and accessible safely at different times of day.
- Make sure that any locations listed are places the youth has permission to go and are adaptive – a friend’s house may be helpful if adults are home, but not if peers will be using substances.
- Remind youth that, even if they do not feel like talking to others when they’re upset, sometimes just being around other people can increase safety.

**Step 4 – Trusted Adults I Can Ask for Help with a Crisis:**
- Peers should not be listed on step 4. Peers are more variable in their ability to respond appropriately, and may not have the power or resources to provide adequate help.
- You may need to be creative in identifying trusted adults to turn to in a crisis (especially if youth are not comfortable listing family and/or if family cannot provide an adaptive response). Good suggestions include parents, aunts/uncles, grandparents, adult siblings or cousins, a trusted teacher, coaches, mentors, school staff, or a friend’s parent.

**Step 5 – Professionals and Agencies I Can Contact During a Crisis:**
- Be sure to list local crisis resources, such as the name and location of a local emergency department or CPEP, as well as national services such as the National Suicide Prevention & Crisis Lifeline (988) or Crisis Text Line (text “Got 5” to 741741). Many youth prefer to use texting or chat apps rather than calling a hotline. If youth are reluctant to reach out to a hotline, calling or texting together can be a good way to demystify the process.
- Be familiar with hotlines tailored to specific identities (i.e., LGBTQIA, BIPOC, etc.).
- If your community has youth-specific crisis resources, such as mobile crisis, drop-in centers, or respite care, share these resources with your client’s family as appropriate.
- Encourage youth clients to put emergency resources into their phone while you are with them, but also put the information directly on the safety plan so everything is in one place.
Adaptations for Working with Youth (continued)

Step 6 – Making the Environment Safer

- Step 6 comes at the end of the safety plan because, by this point in the collaborative SPI process, hopefully you have built enough rapport to engage in effective lethal means reduction counseling and help the youth and their family to enact a means reduction plan. **Means reduction counseling is a collaborative negotiation.** Be open and non-adversarial.
- While removing means from the environment may be the safest plan, doing so is not always feasible. **Collaboratively identify options for reducing access to means that are feasible and acceptable to the youth and their family,** balancing the youth’s need for autonomy with the need for additional monitoring to maintain safety. Decide with the youth and family together on a plan that is feasible to maintain until risk drops and can be enacted right away.
- Do not rely on the youth to enact the means reduction plan. **Actively involve family** in the process, and **follow-up to make sure the plan was enacted** as agreed upon.
- A youth may need a higher level of care if their family is not able or willing to reduce access to means in the home/community and provide increased monitoring/supervision.
- See the Means Reduction Counseling with Youth Adaptations guide for more tips.

Involving Family

In all but the most unusual circumstances, guardians and/or family members should be actively involved in the safety planning process with youth. This can take different forms, including:

- Developing the safety plan collaboratively with the youth alone, then inviting the family in to review and problem-solve their roles
- Developing the safety plan together as a family (common for younger youth and those with cognitive impairments)
- Providing **psychoeducation** to family members about how safety planning works, how they can assist their child to successfully use the plan, and how to know when to seek help
- Involving family members in the enacting of the means reduction plan, such as helping to sanitize the environment, remove dangerous items, or provide additional supervision

Youth should be aware from the beginning of the safety planning process that plans will be shared with their guardians and/or family members, so everything listed should be “family-friendly.”

REMEMBER:

- Families have different levels of mental health literacy and different cultural beliefs about mental health and treatment. Be sensitive and respectful of these differences.
- Ultimately, you do not need the youth’s permission to share the safety plan with their guardians, but it will be advantageous to rapport if you can help them understand why having their family involved is important. Being collaborative, focusing on safety, and giving the youth options for how to involve family members can help.

Share a Copy of the Safety Plan

A copy should be placed in the medical record and a copy should be provided to the youth and their guardians or family members.

- Remember, youth may need multiple safety plans if their risk is different across different environments (e.g., home vs. school, mom’s versus dad’s house, etc.).
- Do not rely on the youth to share their plan with their family. Provide a copy directly to family members and discuss their roles with them if possible.
- Some youth may prefer to use a safety planning phone app or to take a picture of their safety plan on their phone rather than carrying a paper safety plan. This can increase the likelihood of them using the plan in a crisis. Be sure they have a paper copy, too, just in case.

Contact SP-TIEInfo@nyspi.columbia.edu for more information.
### 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: ___________________________

**STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):**
1. 
2. 

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SAFETY PLANNING CHECKLIST

A QUICK GUIDE

This checklist is a guide when conducting the SPI. Each section should be completed. The patient information document can be used to provide supplemental information about the Safety Plan.

Warning Signs
- Can the warning signs be revised to be more specific?

Coping Strategies
- Are there new internal coping strategies that would be more effective?
- Are there any coping strategies that should be removed because they weren't that helpful?

Social Contacts & Settings
- Are there new people or settings that would be more effective to add to your list?
- Are there some people/settings that should be removed?

Social Supports for Help in Crises
- Are there other family members or friends who should be added?
- Are there some people that should be removed?

Professionals & Agencies
- Are there other or new professionals who should be added?
- Were there any problems you experienced when you tried to contact a professional or agency for help?

Making the Environment Safe
- Have you been able to make the environment safer by removing or restricting access to anything that could be potentially harmful to you?
- Do you currently have access to a firearm?
- Is there anything that could be done to make your environment safer?

Using the Safety Plan
- Was the location where you kept the Safety Plan helpful and convenient for you?
- Is there a better place that you could keep it?

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1. Introduce Safety Planning (approx. 2 min)
☐ Introduce the safety plan as a method for helping to recognize warning signs and for taking action to reduce risk or keeping it from escalating
☐ Describe the safety plan as an “emergency plan” to prevent acting on suicidal feelings
☐ Describe how suicidal ideation may come and go over brief periods of time and that using the safety plan helps to actively cope with suicidal feelings
☐ Describe how the safety plan consists of a sequence of steps

If following one step is not helpful for reducing the suicidal crisis, then go to the next step

2. Complete each step of the Safety Plan (Approx. 15 min)
☐ Describe the rationale for each step
☐ Collaboratively brainstorm ideas for each step; be as specific as possible; use individual’s own words.
☐ Assess feasibility of using each strategy and trouble-shoot barriers to its use
☐ After each step, remind individual that if suicidal crisis does not subside, then go to the next step (steps may be skipped, if needed)

STEP 1: WARNING SIGNS
☐ Ask "How will you know when the safety plan should be used?"
☐ Ask "What do you experience when you start thinking about suicide or feel extremely depressed?"
☐ List warning signs, including thoughts, images, thinking processes, mood, and/or behaviors using the individual’s own words

STEP 2: COPING STRATEGIES
☐ Ask "What can you do, on your own, to help yourself not act on your thoughts and urges to kill yourself?"
☐ Assess how likely they would be able to do these things during a time of crisis
☐ If there is doubt around these strategies, ask "What might stand in the way of you doing these activities?"
☐ Collaborate and problem solve to address any potential roadblocks and identify other coping strategies

STEP 3: PEOPLE AND SOCIAL SETTINGS AS A DISTRACTION
☐ Ask "Who could help or where could you go to help you take your mind off things at least for a little while?" "Who helps you feel better when you are with them?"
☐ Assess how safe these places could be, and if they will be around others (i.e. coffee shops)
☐ Ask the individual to list several people and locations in case one is not available, especially at certain times of the day

STEP 4: FAMILY & FRIENDS WHO CAN HELP
☐ Instruct individual to use step 4 if step 3 does not work or lower risk
☐ Ask "Of your family and friends, who do you think you could contact for help during a crisis?" "Who can you talk to and support you when you are under stress?"
☐ List several people, in case one is not available
☐ Role play can be very useful in this step

STEP 5: CONTACTING PROFESSIONALS & AGENCIES
☐ Ask "Who are the mental health professionals that we should identify to be on your safety plan?"
☐ If there is no existing treatment, introduce and describe the benefit of treatment, describe local resources
☐ Explain how to contact the local 24-hour crisis line(s) or the 988 National Suicide Prevention & Crisis Lifeline

STEP 6: MAKING THE ENVIRONMENT SAFE
☐ Explain how making the environment safer will help to lower risk of acting on suicidal feelings
☐ Always assess the availability or access to firearms
☐ Identify any other potential methods or plans to kill oneself
☐ Collaboratively develop an action plan to make the environment safer
☐ For firearms, consider:
  (1) Asking a family member or friend, who would be authorized to possess a firearm, to remove it
  (2) Locking the firearm and ammunition, separately, and giving the keys to a family member or friend
☐ If doubt is expressed about limiting access:
  (1) assess pros and cons of having access to this method
  (2) Brainstorm alternative ways of limiting access so that it is safer

3. Review use of safety plan (Approx. 3 Min)
☐ Review the steps of the safety plan with the individual
☐ Provide a copy & Identify a location where it can be readily accessible including the use of the safety planning app
☐ Explain how the safety plan can be reviewed later and revised, if needed & that you will also keep a copy
What is it?
A list of coping tools and sources of support to use when you are having suicidal thoughts so that you do not act on those thoughts or impulses. It is an emergency plan just for you.

Why should I use it?
It helps prevent a suicidal crisis from getting worse so that you do not act on hurting yourself. Suicidal crises or when people are most in danger of acting on suicidal feelings, often last only for a short time. The Safety Plan helps you get through this time without making a suicide attempt.

When should I use it?
You should use your Safety Plan whenever you recognize any of your personal warning or danger signs that you might want to hurt yourself.

How do I use it?
Once you recognize your warning signs, follow the plan step by step described on your Safety Plan. If doing things on one step does not help, then go to the next step until you feel that the crisis has improved.

Where do I keep it?
In a place where you are able to easily find it and use it. Some people keep their Safety Plans at home and other people carry it with them in their bag, wallet, pocket, or cell phone.

Should I tell others about it?
Sometimes it is helpful to share your Safety Plan with a family member or close friend who can help you during a crisis, especially those that you have listed on your plan.

What do I do if I lose it?
A copy of your Safety Plan is stored in your electronic medical record. Your therapist may be able to retrieve a copy of your Safety Plan for you. Many people make copies of their Safety Plan, keep a copy on their cell phone, or use a Safety Plan app.

Adapted from "Safety Planning Information: For the Patient" Stanley & Brown, 2015
A Guide for Clinicians:  
Means Reduction Counseling for Suicide Prevention

What is Means Reduction?

Means reduction helps to prevent suicidal behaviors and self-harm by reducing or restricting access to the specific methods a suicidal individual is likely to use to attempt suicide. Means reduction specifically targets suicidal behaviors by focusing on **HOW**, not just **WHY**, people attempt suicide. It is the final and arguably most essential step of the suicide safety plan. Mean reduction is counseling and requires clinical skill to engage suicidal individuals who may be ambivalent about reducing access to their means.

Access to lethal means can be reduced by disposing of means, removing means from an individual’s home, limiting access to means, giving means to a trusted person in the individual’s life, or having a trusted person help limit a high-risk individual’s access to means (e.g., changing the combination on a safe containing a firearm or holding onto the key to a medicine cabinet).

Why does Means Reduction Work?

1. **Time Matters:** Most suicidal individuals have some ambivalence about killing themselves and suicidal states do not remain constant. The longer a high-risk individual’s access to means is delayed, the more likely a suicidal crisis will pass (e.g., quickly accessing pills from a medicine cabinet versus driving to a drug store to purchase pills to overdose). This is because the intensity and duration of suicidal urges varies greatly over time and many suicidal crises are short-lived.

2. **Means Substitution:** High-risk individuals often have a preference for the means they’d consider using as a part of their suicide plan. If the preferred means are not immediately accessible, alternative means are not necessarily sought. While mean substitution can occur in some cases, often it is with less lethal means than the original.

3. **Long Term Survival Rate:** Research shows that about 50% of people who attempt suicide die on their first attempt but 50% do not. Many people who make one attempt do not go on to make another one.

**REMEMBER:** Treating an underlying illness alone and hoping the suicidal thoughts or behaviors will diminish is not enough. It is important to directly target suicidal thoughts and behaviors while treating underlying psychiatric disorders.

Means Reduction Counseling

The goal of means reduction counselling is to educate patients about the importance of means reduction, and then collaboratively work with them to prevent/limit physical access to means. Means reduction counselling should be used in inpatient and outpatient mental health facilities as well as in emergency and primary care settings with individuals who:

- Have **current suicidal ideation** (with or without a plan)
- Have **engaged in suicidal behavior in the past six-months**
- Are, in your clinical judgment, at elevated risk of suicide
Steps to means reduction counseling include:

1. Ask directly about suicide
   - When individuals show warning signs of suicidal risk, e.g., talking about not being around anymore or the world being better off without them, ask if they have thought about or are thinking about taking their own life. If the answer is “yes,” conduct a thorough evaluation.
   - When assessing the nature of an individual’s suicidal thoughts and behaviors, give individuals time to respond.

2. Inquire about means
   - Ask individuals directly if they have thoughts about how they would attempt suicide and if they have access to any preferred method.
   - Ask about past attempts and any means used.
   - Focusing on details is key.

3. Educate the high-risk individual and reduce access to lethal means
   - After addressing preferred means ask: “What other ways might you consider to hurt yourself in your environment?” Try to limit access to these means as well.
   - When possible, include trusted people in the individual’s life to aid in reducing access. This is particularly important for adolescents and other particularly vulnerable populations.
   - Communicate with the individual’s other providers to gather and share information, if permission is granted. Consider providing prescriptions weekly instead of monthly.
   - Limit supplies of non-prescription medications and encourage disposal of any expired medications.
   - Remember not everything can be removed and one cannot eliminate all risk completely. If a high-risk individual’s preferred means is related to the environment (e.g., jumping off a bridge or in front of a train), engage the individual in ways to avoid potentially dangerous places or situations.
   - If the individual’s preferred method involves hanging, inquire as to whether there is a preferred object that can be removed (such as a rope or tie).
   - Alcohol reduces impulse control and increases the risk of suicide. Counsel about reducing access to alcohol and other substances.
   - Firearms are the most common method of suicide in the United States due to their high lethality rate. Be familiar with the laws regarding firearms in your specific jurisdiction, including who can legally hold them and how they can be removed in an emergency. Refer to http://nics.ny/safe-act.html for guidance.
   - Some depressed, anxious, or psychotic individuals may have cognitive distortions or irrational beliefs. Address the feelings and affect underlying such distortions or beliefs about means reduction.
   - Emphasize that any restrictions on access to means are not permanent.
   - Any means reduction is a major step to reduce suicide risk. This is not an all or nothing process. Negotiate a plan that is feasible and acceptable to the client.
   - Maintain a collaborative stance; make sure the discussion does not become adversarial. Work towards possible solutions and compromises using motivational strategies where appropriate.
   - Engage the suicidal individual in actively suggesting ways to improve safety.
   - Stress that the goal of means reduction counseling is to make the individual’s environment as safe as possible.

4. Follow up about the lethal means reduction plan
   - When possible, clinicians should follow up with high-risk individuals by continuing to assess the individual’s suicide risk and ensuring the means reduction plan is being followed and effective.
   - Timing and nature of follow-ups should be tailored to individuals’ circumstances and clinical status.
   - When possible, the time, date, and nature of the next follow-up should be agreed upon during the initial means reduction counselling session.
In all but the most unusual circumstances, guardians and/or family members should be actively involved in the means reduction process with youth.

REMEMBER: Effective means reduction counseling helps the youth and their family to identify options, develop, and enact a means reduction plan that is feasible and acceptable to all parties – youth, family, and clinician. Means reduction counseling is a collaborative negotiation.

- Be open, collaborative, and non-adversarial in your approach. Listen to all viewpoints and validate concerns, then help the youth and family problem-solve potential solutions.
- Families have different levels of mental health literacy and different cultural beliefs about mental health and treatment. Be sensitive and respectful of these differences.
- Provide psychoeducation to both the youth and their family members about how/why means reduction works, and how family members can reduce access and increase supervision to make the home environment safer.
- While removing means from the environment may be the safest plan, doing so is not always feasible – for example, it is unlikely that all cords or sharp objects can be removed from the home. Also, some families may feel strongly about the removal of certain means, such as necessary prescription medication or firearms. Collaboratively identify options for reducing access to means that are feasible and acceptable to the youth and their family. Decide with the youth and family together on a plan that is feasible to maintain until risk drops and can be enacted right away. REMEMBER: A less restrictive solution that is enacted NOW is still safer than a very restrictive solution that never actually happens.
- It can be challenging to balance a youth’s need for autonomy with the need for additional monitoring to maintain safety. A youth on “suicide watch” likely needs more supervision than a same-age peer who is not suicidal, and it may not be appropriate for them to spend long periods of time unsupervised in their room, walk to school unsupervised, or stay alone after school. Remind youth that increased supervision is not a punishment, but rather a temporary measure to increase safety.
- Be creative in recruiting family members, friends, and important others to aid the family with supervision. If your community has youth-specific resources, such as drop-in centers or respite care, share these resources with your client’s family as appropriate.
- Do not rely on the youth to enact the means reduction plan on their own. Actively involve family in the process of sanitizing the environment, removing dangerous items, and providing additional supervision. Follow-up to make sure the plan was enacted as agreed upon or use telehealth services to enact the plan with the family during clinical contact.
- Means reduction may be more challenging for older youth who are more independent and potentially able to obtain means on their own. Youth should be encouraged to think of solutions to prioritize their own safety, not just rely on others’ attempts to sanitize the environment. Means reduction plans should also be revisited often to make certain that new means have not been obtained or overlooked.
- A youth may need a higher level of care if their family is not able or willing to reduce access to means in the home/community and provide increased monitoring/supervision. Sometimes a family’s willingness and ability to engage in safety planning, means reduction, and monitoring can be more important than the youth’s, especially with younger children.

Contact SP-TIEInfo@nyspi.columbia.edu for more information.
Call 911 if:

- A suicide attempt is in progress or was just made
- A weapon is present during a suicide crisis
- The person’s safety or your safety is threatened

Recognize The Warning Signs

Take immediate action and call or text the 988 Suicide and Crisis Lifeline if someone:

- Makes a threat to kill themselves
- Looks for a way to carry out a suicide plan
- Talks about death or suicide in text messages, on social media, etc.
- Gives away their possessions

Call or text 988 if you are concerned about someone acting in unusual ways:

- Depressed or hopeless
- Withdraws from family or friends
- Rage or is seeking revenge
- Highly anxious or agitated
- Reckless or risky behavior
- Unusual or unexpected change in mood, behavior, or sleep
- Using more alcohol or drugs
- Saying there is no reason for living

MORE INFORMATION

988 Suicide and Crisis Lifeline
Call or text 988
Available 24 hours a day, 7 days a week
https://988lifeline.org/

Crisis Text Line
Text “Got5” to 741-741
Anonymous, text-based support, available 24 hours a day, 7 days a week
www.crisistextline.org

The Trevor Project Lifeline
Call 866-488-7386 or text START to 678-678
Information & support for LGBTQ young people, available 24 hours a day, 7 days a week
www.thetrevorproject.org

The Suicide Prevention Center of New York
www.preventsuicideny.org

American Foundation for Suicide Prevention
https://afsp.org/

Means Matter Campaign
https://www.hsph.harvard.edu/means-matter/

Poison Control
https://www.poison.org/

Make Your HOME Suicide-Safer

Prevent Suicide Through Lethal Means Safety
**Suicide-Safer Tips**

Lethal means safety in suicide is prevention by making a method less available. By putting space and time between a person with thoughts of suicide and the means to attempt suicide, the person is less likely to die by suicide.

**Firearms:**
- Consider options to safely store outside the home when someone is in crisis:
  - If legal, ask a trusted friend or family member to keep it temporarily:
  - If they can’t be removed from the home, lock the firearm and ammunition separately, or use a trigger lock. Ask a trusted friend or family member to keep the key.

**Medications:**
- Keep track of how many pills are in each prescription bottle and don’t keep a lethal amount at home.
- Know what is lethal – some over-the-counter medications can be fatal in large amounts.
- Get rid of old medicines safely.
- Keep both prescription and over-the-counter medications secured, such as in a locked cabinet.

**Alcohol & Drugs:**
- Talk about how substance use is a major risk factor for suicide.
- Limit the amount available in the home.

**Other Hazards:**
- Know what is lethal - lock up potentially harmful common household products and poisons.
- Identify and remove ropes, cords, and wires.
- Lock up or remove knives and other sharps.

**Provide Support:**
- Know the suicide warning signs.
- Create a safe, judgement-free environment when talking about tough issues.
- If you have concerns, ask the person directly if they are thinking about suicide.
- Seek help when needed.

**Is Your Home Suicide-Safer?**

Limiting a suicidal person’s access to fatal ways of attempting suicide can save their life.

**Firearms**

Lock or Remove. More than half of all suicide deaths result from a gunshot wound.

**Medications**

Lock and Limit. Most teens say prescription and other drugs are EASY to get from medicine cabinets. (drugfree.org)

**Alcohol**

Limit or Remove. Alcohol abuse is associated with a significantly increased risk of suicide.

**Other Hazards**

Identify and Remove ropes, cords, and wires. Lock up or remove knives and other sharps.

**Support**

Ask, Listen and Act. Ask directly if they are thinking about suicide. Listen closely and without judgment. Validate and support their feelings.

**Poisons**

Take Precautions. Know what is lethal – many common household products, such as cleaners and pesticides, are toxic and can be fatal if ingested.

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No method of means reduction is foolproof. If you are concerned about a loved one, seek help.

*Original version created by the Oakland County Youth Suicide Prevention Task Force.*
Clinician Guide to the
HOPE
High Risk Out-Patient Engagement Pathway

Suggested Introduction: Based on your appointment today, we would like to offer you extra care and attention. The HOPE Pathway was developed to support people who are learning to cope with suicidal thoughts and behaviors. We will provide you with more frequent therapy sessions to help cope.

The following is a list of interventions to be provided to your patient:

- **Universal Precautions:** Discussion of warning signs, the fluidity of suicide risk, and information about how to get help 24 hours a day, 7 days a week using the National Suicide Prevention & Crisis Lifeline 988 and Crisis Text Line: text GOT5 to 741-741

- **Suicide-Specific Screening and Risk Assessment:** Screen your patient at every session using the C-SSRS.
  - If there are changes in risk and protective factors, access to lethal means, or clinical status, update the comprehensive risk assessment.

- **Stanley-Brown Safety Plan:** Develop the Safety Plan collaboratively with the patient and family, if the person at risk is under 18; remember that safety planning is a clinical conversation with patients. Review Safety Plan regularly and revise as needed to ensure that it is useful for the patient.

- **Lethal Means Reduction Counseling:** As part of safety planning, develop a plan to get rid of the method the patient may use to hurt themselves. If the patient feels comfortable, ask their family members or a friend to help with this step. If the patient is under 18, family members will need to be involved in this step.

- **Plan for Two Foreseeable Changes:** Develop a plan to address at least two changes in the patient’s life that could lead to suicidal crisis.

- **Weekly Appointments:** Schedule appointments at least once a week while the patient is on the pathway. Same day follow up after every missed appointment to maintain care and safety: Request current phone number(s) and an address from the patient. Ask for permission to contact a family member or friend in case the patient cannot be reached, or if under 18, let the patient know that their family member will be contacted if the patient cannot be reached.

- **“Off ramp”**: The patient can exit the pathway with a negative C-SSRS (no to questions 4,5,6) for 90 days, no suicidal behavior for 90 days, and/or by clinical judgement.

- **Family/Collateral support in treatment:** We want to involve people close to them, with their permission, so everyone can better understand what is going on and learn how to help. If under 18, acknowledge that their family member(s) will be included in their treatment.
Adding a HOPE Pathway to your treatment

We care about your recovery and want to help you work through this difficult time. Based on your appointment today, we feel it is important to offer you extra care and attention.

To do so, we are giving you extra support for youth who have thoughts of suicide. We call it the HOPE Pathway. We believe therapy can help you understand your suicidal thoughts and feelings, and also help you make changes in your life. This Pathway is meant to help keep you safe while you work on these life changes.

Here is a list of supports and activities we want to help with and provide to you:

**Safety Plan.** Together we will come up with two things to help keep you safe:
1. A list of coping tools and sources of support to use when you are having suicidal thoughts so that you do not act on those thoughts or impulses.
2. A plan for you and your family to get rid of the things or methods you might use to hurt yourself.

**Regular check-ins.** We would like to see you weekly to make sure you are staying safe and getting the support you need.

**Appointments.** An appointment with one of our medical staff to discuss your current medications and if adding or changing medications could help you in your recovery.

If you miss an appointment, we will try to call you. If we cannot reach you immediately, we will continue to call you and your emergency contact to make sure you are safe.

**Resources.** Information about how to get help 24 hours a day, 7 days a week.

**Support.** We want to involve your family or people close to you, so they can understand better what is going on with you and learn how to help.

Most important, we want to help you see there is hope, you can feel better, and that suicide is not the answer.

Your therapist is: ______________________
Contact Number: _____________________

If you are in a crisis or need to talk, call 988 or text Got5 to 741-741

Need to talk?
WE'VE GOT TIME TO LISTEN
TEXT "GOT5" TO 741-741
to start a conversation
FREE, 24/7, CONFIDENTIAL CRISIS SUPPORT BY TEXT

988 SUICIDE & CRISIS LIFELINE
Adding a HOPE Pathway to your child's treatment

We care about your child’s recovery and want to help you and your family through this difficult time. Based on your child’s appointment today, we feel it is important to offer extra care and attention.

To do so, we are giving your child additional support designed for youth that are having thoughts of suicide. We call it the HOPE Pathway. We strongly believe therapy can help both you and your child understand their suicidal thoughts and to meaningful life changes. This Pathway is meant to help keep your child safe while working on these life changes.

The following is a list of supports or activities we want to provide for you and your child:

**Safety Plan.** We will develop a Safety Plan your child can use to identify warning signs of a possible suicidal crisis, as well as steps to manage them and get support.

**Secure Means.** A plan to get rid of or secure the means or methods your child might use to hurt themselves. We will need your help with this.

**Regular check-ins.** We would like to see your child weekly to make sure they are staying safe and getting the support they need.

**Appointments.** An appointment for your child with one of our medical staff to discuss current medications and if adding or changing medications could help in their recovery.

If your child misses an appointment, we will try to call them if they have their own phone. If we cannot reach your child immediately, we will contact you to make sure your child is safe.

**Resources.** Information about how you and your child can get help 24 hours a day, 7 days a week.

**Support.** We may want to involve other people close to your child, with your permission, so that they can understand better what is going on and learn how to help.

Most important, we want to help your child see there is hope, they can feel better, and that suicide is not the answer.

Your child’s therapist is: ______________________
Contact Number: ______________________

If you or your child are in a crisis or need to talk, call 988 or text Got5 to 741-741

Need to talk? WE’VE GOT TIME TO LISTEN
TEXT “GOTS” TO 741-741 TO START A CONVERSATION
FREE, 24/7, CONFIDENTIAL CRISIS SUPPORT BY TEXT
A Guide for Clinicians: Engaging Families and Supportive Others in Working with Suicidal Individuals

When appropriate, family members and other social supports from within a suicidal individual’s natural environment can be engaged in the patient’s treatment plan, enhancing patient safety by providing support to both the individual and treatment provider. Yet, family engagement guidelines are not a usual feature of clinical training, so it can also be a challenge for clinicians to know how to balance a patient’s treatment needs, safety concerns, and the needs of the family/supportive others as well.

Common Concerns

- Some suicidal individuals are unable to identify people who can support their recovery. Or patients may be experiencing family conflict. Clinicians may fear making the patient’s situation worse by involving the family.
- Patients are sometimes reluctant to give consent to involve loved ones, fearing that personal information may be revealed or they will become a burden to others.
- Some families are reluctant to attend sessions or can be defensive when they do attend.
- Clinicians may not feel sure about how to balance their focus on the patient’s safety with the needs and feelings of the patient’s social support network. They may be concerned that they would need to do family therapy if they bring the family in to support the patient’s treatment.
- Some families want to help but do not feel equipped to deal with the situation.

Inpatient Units

The three months after discharge is a particularly high-risk period for a suicidal individual. Families/supportive others should be engaged, when appropriate, throughout the course of the inpatient stay and especially in the discharge planning process. Clinicians should meet with the family/supportive others to plan for safety and follow up with outpatient treatment upon discharge.

Outpatient Settings

Families/supportive others can be engaged, when appropriate, to provide ongoing support, and enhance treatment outcomes and engagement. The clinician can facilitate working together to provide ongoing support, such as helping the patient attend appointments, serving as an emergency contact, monitoring warning signs, and/or occasionally attending sessions.

Emergency Departments

In the ED, decisions are made quickly and in a one-time interaction. Clinicians can try to engage the individual who came with the patient to the ED to provide support with next steps. This could include being part of the patient’s safety plan, and/or facilitating follow up on outpatient recommendations upon discharge from the ED or hospital.
The following best practice guidelines address these obstacles and concerns to facilitate family engagement:

1. **Engage patient and obtain consent**
   Help the patient identify people in their lives that may be willing to provide them with a safety net when they are suicidal by weighing the pros and cons of involving that individual in the treatment plan. If the patient refuses, it may be useful to explore their concerns. Consider the possibility of limited consent – sharing some but not all information with supportive others.

   **REMEMBER:** In times of imminent risk or life-threatening behavior, it is appropriate to override consent to ensure the patient’s safety.

2. **Address family concerns**
   Family members may feel scared, blamed, or even traumatized by their loved one’s suicidal thoughts or behaviors. It is important to approach family members without judgment. Understand that you may be seeing family members at their worst and they may find it hard to focus and take in information. Both parties will be experiencing fears related to suicide, so it is important to try to put everyone at ease and to help them through this difficult time.

3. **Providing psychoeducation better prepares loved ones to respond**
   Inform social supports about the fluctuating nature of suicidal risk: how it comes and goes rather than staying constant and stable.

   **Educate regarding the warning signs** for increased suicidal risk. The FACTS acronym helps – Certain Feelings, Actions, Changes, Talking, and Situations indicate increased risk.

   **Debunk myths about suicide.** Remind loved ones that:
   - Many suicidal individuals are ambivalent about dying
   - Talking about suicide is a risk factor for suicide attempt
   - Anyone can notice the signs of suicidal risk and encourage someone to get treatment
   - Restricting access to means provides a barrier between urges and actions

   **Provide resources regarding local emergency departments or 24-hour crisis hotlines:**
   National Suicide Prevention & Crisis Lifeline: 988 | Crisis Text: Text “Got5” to 741741

4. **Assess willingness and capacity of loved ones**
   Some loved ones may be too distraught to make plans for next steps. Explore whether it makes sense for the family to be involved, if they can help, or whether involving them would make the situation more difficult for both parties.

5. **If able and willing, families can help in a variety of ways**
   In addition to psychoeducation, consider involvement in treatment. This may include monitoring warning signs, checking in with the patient, reaching out at times of increased risk to the therapist, being listed as a contact on the patient’s safety plan, and/or being involved with a plan for reducing lethal means.

6. **Help the family reach a shared decision using evidence to inform their choice**
   Use the shared decision-making model to present and explore options for involvement and the pros/cons of each option. The goal here is to empower patients and families to make the best decision for everyone involved and encourage everyone to make an informed choice about how they might work together without imposing on the patient’s autonomy.
Adaptations for Working with Youth

Treating youth ALWAYS means treating a system. Underlying psychiatric issues are often influenced by the family environment and dynamics, and supervision and monitoring will be needed to keep the home environment safe. In all but the most unusual circumstances, parents or guardians should be actively involved in a youth’s assessment and treatment. Individual treatment of a youth alone is rarely effective. Typically, youth clinicians must also work with parents, but can also involve other important adults in the youth’s life (e.g., foster parents, grandparents, older siblings, other adults in the home).

Engaging families is critical for youth suicide prevention because adults in the youth’s environment need to learn how to best protect their child and act as both external informants and co-therapists. When appropriate, involving schools and broader social systems can also be important. The principles of involving family and important others in assessment and treatment are similar for both adults and youth, but clinicians do not need the youth’s permission to involve their parents/guardians.

When working with youth, families can:
- Engage in assessment to provide important collateral information
- Be actively involved in treatment planning, safety planning, and means reduction
- Understand clinical interventions and their rationale
- Orient their child to their safety plan and enact means reduction plans in the home
- Act as co-therapists to help de-escalate, coach, and problem-solve
- Provide increased supervision and monitoring to maintain safety during high-risk times
- Updating the outpatient provider between sessions on progress and changes

Some special considerations when working with youth include:
- Involving the youth’s parents/guardians in assessment and treatment is critical, although other important family members or figures from school or community settings can also be included so long as parents/guardians provide consent.
  - While youth permission is not required to involve outside parties, it can be advantageous to rapport to help the youth understand the rationale for their inclusion.
  - Help guide the youth and family to explore options of who to include and in what capacity. Remember there are degrees of disclosure, and the clinician should try to strike a balance that is comfortable to both the youth and family.
- As early as possible in your clinical interaction, inform the youth about limits to confidentiality, their rationale, and what information will be shared with their parents/guardians. Minors cannot legally provide consent for treatment or disclosure to their families, and clinicians may have a legal obligation to break confidentiality to guardians if a youth is at risk.
  - If possible, gain the youth’s permission (assent) to disclose to family members. If there is resistance, explore their concerns, validate, and problem-solve together.
  - Involve youth clients in the decision-making process of how to disclose (e.g., clinician tells guardians, the client and the clinician tell guardians together, etc.)
  - Remember that a clinician ultimately does not need the youth’s permission to disclose suicidality to their guardians, but it will be advantageous to rapport if you can help them understand why disclosure is important and get them on board. Be collaborative and focus on safety.
- Psychoeducation can help dispel the misconceptions about mental health and suicide risk that many youth and their families have.
  - Psychoeducation provides accurate information about mental illness and can help lead families to a place of understanding so they can assist their child.
  - Clinicians should sensitively assess family culture about mental health and may need to provide motivational enhancement or gently challenge some assumptions with the family or youth.
  - Try to normalize mental health concerns and treatment as much as possible (while not necessarily normalizing suicide as a viable option).
Adaptations for Working with Youth (continued)

- Try to create a collaborative environment that puts everyone on the same “team” with the joint goal of keeping the youth safe.
  - Clinicians, youth, and their families may not always see eye-to-eye about the goals of treatment or even whether treatment is needed. Clinicians can help to align goals, getting everyone on the same team, and focus on safety as the top priority.
  - Sometimes it can be useful to meet with the family separately to give them a space to process their feelings not directly in front of the youth. Validate family members for their feelings of being frightened, frustrated, or hostile.
  - Clinicians should help youth and their families to understand each other’s perspectives without “taking sides,” and assist them to communicate their experiences to each other more effectively. Clinicians should do their best to reframe anger or frustration to keep discussions civil. This is particularly important when family conflict is contributing to a youth’s symptoms.

- Help the family to discuss suicide and safety more openly and effectively
  - Remember that anger and frustration often come from a place of hurt or fear. If possible, clinicians should help family to communicate concern to the youth without blame, judgement, or belittling the youth’s problems. Clinicians can strengthen family members’ ability to communicate in a calm, non-accusatory manner and help them modulate strong emotions.
  - Clinicians can help the family to empathize with the youth’s wish to die even if they do not fully understand, express that they care, and convey that the youth is important.
  - Clinicians can help the family to negotiate about monitoring and supervision as a way to stay safe, not a punishment.
  - Clinicians should be collaborative and help the youth and their family to compromise on interventions such as safety planning, means reduction, and monitoring to enact a plan that is feasible and acceptable to the youth and family.

- Family (and sometimes teachers and schools) can be particularly helpful in identifying changes, monitoring the youth between sessions, and updating the clinician if there is a change in symptoms.
  - Discuss the difference between traditional supervision for a youth of a given age and what will be needed when on suicide watch. Depending on the level of risk, being alone after school or even shutting their bedroom door may not be appropriate.
  - Increased monitoring and means reduction needs to be balanced with the youth’s psychosocial needs – The goal is to keep the youth safe, not to punish them with “lockdown.”
  - Conflicts between safety and the youth’s privileges/freedom should be actively problem-solved but err on the side of caution.
  - Remind the youth and family that suicide risk waxes and wanes, so measures are temporary.
  - If possible, help the family to recruit other adults to help monitor the youth in the home, school, and community. Youth should also be taught to self-monitor, self-disclose, and engage in help-seeking.

- Share resources for family members
  - Be sure that family members have a copy of their child’s safety plan and know their role.
  - Discuss how to know when a youth may need help or a higher level of care and make families aware of what to do in cases of imminent crises. Share crisis information such as the address and phone number of a local ED and the National Suicide Prevention Lifeline.
  - Supporting a suicidal youth can be very stressful for families. Clinicians should be aware of resources provided both by their organization and in the community, such as respite care, support groups, or NAMI chapters, and always assess the family’s need for adjunctive therapy such as family therapy or multi-family groups. If appropriate, encourage family members to seek professional help for support.

Contact SP-TIEInfo@nyspi.columbia.edu for more information
If you are worried about a friend or loved one being at risk for suicide, please reach out

988 SUICIDE & CRISIS LIFELINE

Veterans Crisis Line
DIAL 988 then PRESS 1

Changing the Conversation

FALSE: People who talk about or attempt suicide are seeking attention
TRUE: Suicidal talk and behavior should always be taken seriously

FALSE: No one can stop a suicide if the person wants to die
TRUE: If people in crisis get the help they need, suicide is preventable

FALSE: Suicide should only be discussed with trained professionals
TRUE: Suicide prevention is everyone’s business; anyone can help prevent a suicide

Need to talk?
WE’VE GOT TIME TO LISTEN
TEXT “GOT5” TO 741-741 TO START A CONVERSATION
FREE, 24/7, CONFIDENTIAL CRISIS SUPPORT BY TEXT

988 CRISIS TEXT LINE

Text START to 678-678
Call us at 1-866-488-7386

Suicide Prevention Center of New York
https://www.preventsuicideny.org/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/find-support/nami-programs/nami-family-to-family

After an Attempt: Guide for Family Members

Additional Resources

Changing the Conversation

When a Loved One Struggles with Suicide

A Brief Guide for Caregivers
Hopelessness, excessive worry, burdensomeness, rejection, worthlessness

Impulsiveness, self-harm, increased drug or alcohol use, giving away possessions, looking for a way to die such as saving up pills, gaining access to a gun, or searching online

Particularly in the presence of other warning signs; changes in attitude, moods, behaviors, or social connection; sudden change in sleep or eating habits

Specific or vague statements or any expression of death or suicide; can be written, spoken, activity on social media, or non-verbal threats

Life changes that cause the person to be overwhelmed, unprepared, or triggered, such as personal loss, connection to death, bullying or abuse, failures, or getting in trouble

Look for the FACTS

Know the Warning Signs

F Feelings
Hopelessness, excessive worry, burdensomeness, rejection, worthlessness

A Actions
Impulsiveness, self-harm, increased drug or alcohol use, giving away possessions, looking for a way to die such as saving up pills, gaining access to a gun, or searching online

C Changes
Particularly in the presence of other warning signs; changes in attitude, moods, behaviors, or social connection; sudden change in sleep or eating habits

T Threats
Specific or vague statements or any expression of death or suicide; can be written, spoken, activity on social media, or non-verbal threats

Reducing Risk At Home

Limit access/create barriers to means that have been considered or used in previous attempt(s)
Lock, remove, or disable guns
Store guns away from ammunition
Limit availability of knives and sharp objects
Lock up prescribed and over-the-counter medications; get rid of old and unused ones

For more information, visit https://www.preventsuicideny.org/support-and-resources-for-individuals/

FACTS

Suicide Risk

Suicide risk fluctuates. For some people it may quickly increase, for others it may slowly increase over time.

Any warning sign of suicide is a reason to take action. However, it is important to note that suicide is rarely caused by a single circumstance or event.

To help individuals cope with suicidal urges, encourage them to use their safety plan. A safety plan is a list of coping strategies and social supports that people can use when they are in a suicidal crisis or very distressed. Visit mysafetyplan.org for more information.

Many suicide attempts are during a short-term crisis, so it is important to reduce access to lethal means during these periods of increased risk

How to Help

Ask directly about thoughts of suicide. Talking about suicide will NOT make it worse.

Actively listen. Allow them to vent and unload their feelings.

Be sympathetic and non-judgmental. Encourage them to talk about their feelings, even if it is hard to hear. However, avoid saying phrases like: “You have so much to live for”, “your suicide will hurt your family” or “snap out of it”.

Offer hope. Reassure them that help is available and suicidal feelings are temporary.

Encourage them to get treatment/support. Help them attend appointments and troubleshoot barriers, if possible.

Take them seriously. Ask if they are having thoughts of suicide. You are allowing them to share their pain, not giving them ideas.

Don’t promise confidentiality or secrecy. If someone is at risk for suicide, you may need to reach out for help from professionals to keep the person safe.
Initial Suicide Risk Assessment, including

- Initial C-SSRS screen
- Comprehensive suicide risk assessment, and
- Risk formulation

Suicide Care Management Plan, including

- What interventions were delivered, and
- If any planned interventions were not delivered

Safety Plan with Means Reduction, including

- Copy of safety plan that was given to patient

Discharge Summary, including

- Updated suicide risk assessment
- Treatment recommendations for outpatient care,
- Treatment specifically addressing suicide risk, and
- Identification of biggest barriers to reducing risk
Dear John,

It has been a short time since you were here with us at ECMC and we hope things are going well!

As always, we are here for you. Should you need anything, or if you have any questions or concerns, please contact us at 555-555-5555.

Sincerely,
Your Team at ECMC
A Guide for Clinicians:
Structured Follow-Up and Monitoring

What is structured follow-up and monitoring?
Structured follow-up and monitoring (SFUM) is a best practice intervention used by clinicians to proactively follow and monitor individuals at high risk for suicide. The intervention consists of four steps that guide clinicians regarding how and when to contact and continuously assess individuals who have recently been discharged from a hospital stay or Emergency Department visit due to suicide risk. The intervention provides support and a safety net as these individuals transition from crisis help to outpatient care during a high-risk period for suicide attempts.

Who should use structured follow-up and monitoring?
SFUM works best when the clinician who initially saw the individual conducts the intervention. This can include ED/urgent care clinicians or an inpatient clinician that was involved in the patient’s care during hospitalization. Otherwise, other staff members from the same treatment facility can conduct the intervention. SFUM should be conducted by trained professionals and paraprofessionals who can conduct risk assessments and clinically intervene.

When should structured follow-up and monitoring occur?
SFUM should be conducted with a suicidal individual after a suicidal crisis or with clients with recently increased suicidal ideation. The follow-up should preferably occur within 24-72 hours of discharge from an inpatient unit or emergency department.

The number and frequency of calls depends on the resources at your clinic, but two or more follow-ups are recommended, one within 24-72 hours of discharge and one following the first outpatient appointment. SFUM should continue until the individual is in treatment, rejects further treatment or follow-ups, or their risk of suicide diminishes sufficiently.

Why is structured follow-up and monitoring important?
When an individual is discharged from an ED visit or inpatient stay there is a break in continuity of care during an increased risk period for patients who have recently experienced a suicide crisis. A safety net is necessary in the period between discharge and commencing outpatient care in order to provide support for maintained safety and engagement in outpatient care. The SFUM intervention is designed to bridge this gap.

SFUM provides information about services or plans for aftercare, helps identify individuals of imminent risk and provide them with rescue, and provides support between a crisis visit and outpatient care including ongoing risk evaluations and safety assessments. As a result, SFUM enhances the continuity of care by facilitating engagement in treatment and decreasing isolation during elevated risk to help manage suicidality.
What are the steps of structured follow-up and monitoring?

Step 1: Mood check and risk assessment

The first step involves getting a general idea of how the individual is feeling (specifically with regards to suicidal ideation, depression, anxiety, agitation, substance use, and functioning). You can use the C-SSRS screen to directly assess suicidal ideation, intent, and behavior.

Additional useful questions to ask: How have you been feeling since we last spoke? Have you been seeing your therapist? Is there anything you’ve been struggling with lately?

If an individual is showing signs of imminent risk, the SFUM format should be halted – shift into crisis intervention and stay on the phone to help de-escalate.

Step 2: Review and revise the safety plan

Review the client’s safety plan together and make sure that it is both useful and being used. Assess and address what is and is not useful about the safety plan, then replace unhelpful items with more beneficial steps.

Ensure that both the clinician and the client have access to the new and revised copy of the safety plan and ensure that their access to means is reduced.

Step 3: Treatment engagement and motivation

Check that your client is aware of current options for treatment, review plans made for treatment in the past, and remind patients of upcoming treatment sessions. If clients reject treatment, help them to reconsider and try to identify and problem-solve any barriers or obstacles to treatment. During this process, praise the individual’s ability to identify barriers, validate their struggle with these barriers, and then attempt to resolve the issues. You can explore the pros and cons of treatment and ambivalence.

Some common barriers and obstacles to treatment include:

- **Logistical Barriers**: Any physical barriers to treatment such as financial issues, lack of insurance coverage, and lack of transportation to and from treatment sessions.

- **Motivational Barriers**: Internal barriers within the individual such as denying the severity of the mental health problem, believing that the problem can be handled without treatment, previous negative experiences with health professionals or a mistrust of treatment, and stigma regarding treatment. Some individuals might find it useful if a trusted person accompanies them to their first treatment session.

- **Structural Barriers**: Issues related to the health care system such as finding it hard to schedule appointments, having a lack of providers available, long waiting lists, and inconvenient services.

**REMEMBER**: Just because someone rejects clinical interventions does not mean they will also reject beneficial community support services such as social organizations, peer support, religious organizations, or support groups.

Step 4: Obtain consent and willingness for additional follow-up

Assess whether further calls are warranted. Ensure that you obtain consent and willingness for additional follow-ups before you hang up. If possible, set the time and date of the next follow-up before the end of the current contact. If the high-risk individual refuses to give consent for future follow-ups, make sure they understand they will not be receiving more intervention.
What is the nature of structured follow-up and monitoring?

- **REMEMBER:** You must obtain permission prior to reaching out to a client.
- SFUM phone calls should be **brief.** In fact, the average follow-up phone call lasts **15 minutes.**
- SFUM is **usually done by telephone but can also be conducted via email, text, or home visits** if your organization allows.
- **Be persistent even if the individual is hard to reach;** most high-risk individuals appreciate the effort you have made to check on them. **Organizations should decide in advance on a procedure regarding what to do if the individual is unreachable.**
- **Keep records** of all contacts and follow-ups you make with a high-risk individual and **develop a notification system** for your next contact. **Determine the length of follow-up period based on the individual’s circumstance and mental health status.**
- All calls should be **goal-directed and maintain focus on the agenda,** not open-ended. However, all calls should also be **supportive** of the patient and attentive to their needs, wishes, and values.
- The tone of the call should be **kind, professional, respectful, and friendly** – mirror and summarize statements said by the client without judgment.
- Some high-risk individuals may decide not to engage in outpatient treatment but may be willing to do telephone contacts; thus, **SFUM is important as it might be the only contact they get from a clinical professional.**

Adaptations for working with youth

Monitoring during high risk periods demonstrates that a clinician cares about their youth clients and their safety, allows clinicians to detect fluctuations in suicide risk, ensures safety between contacts, and enhances continuity of care. Follow up and monitoring provides a safety net during the high-risk period following discharge from an emergency department (ED), comprehensive psychiatric emergency program (CPEP), or inpatient unit. Further, suicidal youth often do not follow up on outpatient referrals or disengage from outpatient treatment prematurely, but follow up and monitoring enhances engagement in ongoing treatment, hopefully preventing the need for additional emergency care.

Phone follow-up should be provided to **both youth and their families within 24-72 hours of discharge from ED/CPEP/inpatient settings** and again after the first outpatient appointment. In outpatient or school-based settings, phone follow-up should be provided **within 8 hours of a missed appointment.**

When providing structured follow-up and monitoring to youth, clinicians should collaborate to decide on a follow-up plan with the youth and their family in advance. This includes:

- Providing psychoeducation about the purpose of follow-up
- Determining which family members should be contacted
- Letting the youth and family know (approximately) when the contact will occur and what will happen if the clinician cannot reach them
- Informing the youth that their family will be notified if they cannot be reached, if they miss an outpatient appointment, or if the clinician cannot determine their safety. It is preferable if the youth agrees to this policy, but permission is not required so long as their parents/guardians consent.
- For missed outpatient appointments, the clinician should call/text the youth first (in case they were just running late or a miscommunication about date/time occurred). However, if the youth cannot be reached or the clinician is concerned, they should notify the family.
- Know and clearly **communicate your organization’s policy about other forms of communication** (e.g., texting, email, social media) since youth clients may be more likely to utilize these services.

**Structured follow-up and monitoring is NOT just making contact or rescheduling the appointment.** Rather, it shows the youth and their family that their clinician is concerned and cares enough to check on them, and gives the clinician the opportunity to:

- Assess the youth’s current mood and level of risk
- Encourage re-engagement with treatment; and
- Provide interventions as needed (e.g., making sure means reduction plans were enacted, revising or problem-solving the use of the safety plan, teaching and refining skills in vivo, and involving family members or rescue in case of imminent risk)

Contact SP-TIEInfo@nyspi.columbia.edu for more information
COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Since Last Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bold and <strong>underlined</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) <em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td><strong>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</strong></td>
<td></td>
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</tbody>
</table>
| 3) **Have you been thinking about how you might 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." | YES | NO |
| 4) **Have you had these thoughts and had some intention of acting on them?**  
   As opposed to “I have the thoughts but I definitely will not do anything about them.” | YES | NO |
| 5) **Have you started to work out or worked out the details of how to kill yourself?**  
   **Did you intend to carry out this plan?** | YES | NO |
| 6) **Have you done anything, started to do anything, or prepared to do anything to end your life?**  
   Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. | YES | NO |

**Possible Response Protocol to C-SSRS Screening**

- Item 1 Behavioral Health Referral
- Item 2 Behavioral Health Referral
- Item 3 Behavioral Health Referral
- Item 4 Behavioral Health Consultation and Patient Safety Precautions
- Item 5 Behavioral Health Consultation and Patient Safety Precautions
- Item 6 Behavioral Health Consultation and Patient Safety Precautions
SELF CARE

Check in with your mental and physical state before symptoms of burnout/stress overload become overwhelming. Practice mindfulness and stress reduction to manage your vulnerabilities and mitigate the potential for burnout.

- Make adequate time for yourself & schedule breaks throughout the day
- Engage in activities you enjoy
- Take care of yourself physically and spiritually
- Take care of the relationships in your life
- Don’t isolate yourself
- Be aware of warning signs, such as violating boundaries, self-medicating, wishing patients would not show up, finding it difficult to focus on the task at hand, fatigue, and/or boredom
- Watch out for distress, burnout, and competence problems in your colleagues.
- Seek out personal psychotherapy
- Use colleague assistance programs and participate in peer support groups
- Accept that you’re human, in need of assistance, and a work in progress
- Don’t try to be perfect, to have it all, or to do it all. Know your limits and be realistic

PERSONALLY

- Feelings of shock, horror, fear, anxiety, deep sadness, regret, anger, hyper-vigilance, numbness, and/or disbelief
- Intrusive thoughts
- Can have physical, emotional, behavioral, and social components

PROFESSIONALLY

- Hyper-vigilance about suicide warning signs
- Overgeneralizing risk/seeing it everywhere
- Overworking oneself/taking on the most difficult cases
- Feeling overly responsible
- Acting overzealous
- Feeling numb to clinical data
- Minimizing or missing risk
- Calling out sick, neglecting clinical notes, missing supervision
- Distancing and minimizing impact of loss
- Intellectualizing loss
- Feeling burnt out

RESOURCES

OMH SPCNY Clinician Postvention Guide
Clinician Survivor Task Force
https://www.mirecc.va.gov/visn19/postvention/docs/Clinician_Survivors_TriFold.pdf
OMH’s Suicide Prevention Center of New York
https://www.preventsuicideny.org/
American Association of Suicidology
https://suicidology.org

This publication is based on the Overdose and Suicide Loss in the Behavioral Health Workplace Curriculum developed with SAMHSA funds by Dr. Vanessa McGann, Franklin Cook, NYS Office of Addiction Services and Support (OASAS), & NYS Office of Mental Health (OMH) Suicide Prevention Center

THE SUICIDE LOSS OF A CLIENT/PATIENT HAS A PROFOUND EFFECT ON CLINICIANS.
WHAT IS A CLINICIAN-SURVIVOR?

The term “Clinician-Survivor” was coined by the American Association of Suicidology to describe clinicians who have experienced the traumatic loss of a client.

FACTS

- Approximately 1 in 5 psychotherapists and 1 in 2 psychiatrists lose a patient to suicide over the course of their careers.
- Annually, approximately 15,000 clinicians lose a client to suicide for the first time.
- Sudden loss of a client can be traumatic to the professional and can be a contributing factor to professionals leaving the field.

MYTHS

- Clinician grief is a sign of enmeshment or counter-transference.
- Clinical training always provides the necessary tools to manage grief.
- A grieving clinician cannot help clients.
- Clinicians should always appear “strong” in front of other clients by not talking about the deceased.

HOW GRIEF IS TYPICALLY EXPERIENCED

- Helplessness
- Guilt and/or sense of responsibility for the death
- Diminished confidence
- Hyper-vigilance
- Mistrust of future clients
- Feelings of betrayal
- Periods of intense sadness in the early months that begin to abate over time
- Eventual return to enjoyable relationships and activities
- Eventual ability to remember the deceased with less pain and to reconcile and integrate the loss
- If feelings persist, please consider speaking with a professional.

FACTORS THAT MAY IMPACT A CLINICIAN’S GRIEF RESPONSE

- Legal & Regulatory Environment
- Level of Care (inpatient/outpatient)
- Duration and quality of the relationship with the client
- Agency reaction to patient loss (punitive vs. supportive)
- Intensity and demands on job (overtime/on-call hours)
- Fear of contagion effect
- Past or current experience with death and trauma
- Beliefs about role of clinicians in keeping patients alive
- Length of time in the field
- Educational or supervisory preparation for death and loss
- Hindsight bias, or when something seems more predictable after it already happened.

WHAT IS A CLINICIAN-SURVIVOR? (cont.)

Annually, approximately 15,000 clinicians lose a client to suicide for the first time. Sudden loss of a client can be traumatic to the professional and can be a contributing factor to professionals leaving the field.

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- Hindsight bias, or when something seems more predictable after it already happened.
Developing a Postvention Plan: Getting Started Tips

Postvention is a term used to describe an organized response in the aftermath of a suicide for the purpose of facilitating the healing from the grief and distress of suicide loss, mitigating negative effects of exposure to suicide, and preventing suicide among people who are at high risk after exposure to suicide. Behavioral health postvention plans typically include procedures that mitigate the impact a client suicide can have on the professional identity of professional caregivers, as well as on the relationship with colleagues and their clinical work. Community postvention programs usually include guidelines for safe reporting to the media as well as guidelines for appropriate memorial services.

Optimal organizational postvention practices balance the need to support staff, clients and the family of the deceased with the tasks of conducting root cause analyses, adhering to legal and regulatory considerations and respecting confidentiality. They include steps for dealing with the immediate aftermath of a suicide as well as a plan for short-term and long-term support.

1. Developing a postvention protocol starts with assembling a multi-disciplinary team representing a variety of programs, services, and departments to assure that the policy reflects the realities and the culture of the organization.

2. The multi-disciplinary team is charged with the task of developing the postvention protocol and is different from the postvention team, whose task is to coordinate and provide the postvention response.

3. While the multi-disciplinary team and the postvention teams are two separate entities, often some members of the postvention team are part of the multi-disciplinary team that is responsible for developing the plan.

4. When coordinating a postvention response, the postvention team will appoint a Suicide Response Coordinator who will be the central point of contact, monitor postvention activities, handle communications, and ensure that postvention guidelines are followed. Depending on organizational needs, the Suicide Response Coordinator might find it helpful to designate an assistant coordinator.

The table on pages 2-3 of this document provides a blueprint to assist organizations in establishing a postvention team and developing a postvention protocol. The first two rows of the table describe how to establish a multi-disciplinary team and a postvention team. The rest of the table provides important key points about developing a plan, including:

- debriefing and supporting staff
- supporting clients
- patient management and reporting duties
- contact with the deceased’s family
- considerations about participation in memorial services

Lastly, page 4 includes resources and training options that can be utilized to support the organization’s effort. These are by no means the only resources and your organization may choose to add others as they become available.
<table>
<thead>
<tr>
<th><strong>TEAMS</strong></th>
<th><strong>Who</strong></th>
<th><strong>What</strong></th>
<th><strong>When</strong></th>
<th><strong>Other Considerations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-disciplinary team</strong></td>
<td>Who will be developing a postvention plan for the organization? Does the team represent a variety of programs, services and departments?</td>
<td>Develop organizational postvention guidelines for dealing with immediate, short-term and long-term impact of the suicide. Identify postvention team that will implement plan and provide postvention response in the aftermath of a suicide.</td>
<td>How often will team meet? What’s the projected date of completion? How often will the team meet to ensure plan is current and up to date?</td>
<td>Does team expect to provide postvention support to external organizations (e.g. schools) or will it operate internally only? Do members of the team need resources/trainings to develop the postvention plan? Are there internal resources that can be deployed to support staff (e.g. EAP)? Are there external resources that can be deployed to support staff (e.g. sister facilities, other providers, coalitions)?</td>
</tr>
<tr>
<td><strong>Postvention team</strong></td>
<td>Who will be providing a postvention response in the aftermath of a suicide death? Who in the postvention team will also serve as a member of the multi-disciplinary team?</td>
<td>What tasks will be activated in the aftermath of the suicide death of a client or colleague? Coordinate response.</td>
<td>How often team will meet to stay current with plan and guidelines? How often team will meet with multi-disciplinary team?</td>
<td>Do members of the team need resources/trainings in order to implement the postvention plan? Are all members of the team familiar with the organization’s postvention protocol developed by the multi-disciplinary team? Will the postvention team meet to debrief after providing postvention support? Which other self-care resources are available to the postvention team, including ability for a member to opt out of an activation? Who will assume the role of Suicide Response Coordinator(s)?</td>
</tr>
<tr>
<td><strong>Staff debriefing</strong></td>
<td>Who will inform staff?</td>
<td>How long will the debriefing be? Is it there a private setting for the debriefing?</td>
<td>Debriefing should take place shortly after program is notified of the suicide.</td>
<td>Does the organization have a mechanism to identify staff who was most impacted by the loss (ex: ecological model)? A death by suicide can have an impact on all staff, including support staff. It is preferable to avoid large assemblies and to communicate first with those who worked closely with the deceased.</td>
</tr>
<tr>
<td>PLAN</td>
<td>Who</td>
<td>What</td>
<td>When</td>
<td>Other Considerations</td>
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<tr>
<td>Supporting staff</td>
<td>Who will provide short-term and long-term support to staff?</td>
<td>What are the internal resources available to staff?</td>
<td>How soon can resources be activated and for how long?</td>
<td>Staff members may be hesitant to openly discuss their feelings with supervisors. Professional caregivers may have to balance personal needs with providing support to clients, the deceased’s family, other staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are there external resources (ex: grief counseling)?</td>
<td></td>
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</tr>
<tr>
<td>Supporting clients</td>
<td>Who will address issues such as communications and identifying vulnerable clients?</td>
<td>Inform other service recipients as appropriate, utilizing safe messaging to minimize re-traumatization and speculation.</td>
<td>Depends on setting.</td>
<td>Does the organization have a mechanism in place to identify: 1) clients who might be at increased suicide risk as result of suicide loss/exposure, and 2) clients who meet criteria for complicated grief? How can organization encourage hope and help-seeking behavior?</td>
</tr>
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<td></td>
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<tr>
<td>Patient management/reporting tasks</td>
<td>Who is responsible for tasks associated with the death?</td>
<td>Where applicable: enter changes to EMR, discharge client, report to Justice Center and OMH, other.</td>
<td>Which tasks need to be completed right away, and which ones can wait?</td>
<td>Are there tasks that can be completed by someone other than impacted staff? Are there ways to mitigate fears about negative reactions from leadership, decrease self-blame, and increase support?</td>
</tr>
<tr>
<td>Contact with the deceased’s family</td>
<td>Who will manage contact with family, if appropriate?</td>
<td>What is the organization’s policy about contact with the family?</td>
<td>Consider confidentiality issues and whether there is a signed consent before contacting family.</td>
<td></td>
</tr>
<tr>
<td>Memorial service</td>
<td>Will staff and/or service recipients want to attend memorial services?</td>
<td>Develop guidelines about attending public memorial services as well as participating in agency-sponsored memorial activities.</td>
<td>Consider confidentiality and family’s wishes before attending funeral. Always follow recommended guidelines. Can staff take time off to attend funeral?</td>
<td></td>
</tr>
</tbody>
</table>
RESOURCES

Developing Postvention Plans and Policies

After a Suicide: Recommendations for Religious Services & Other Public Memorial Observances *(Suicide Prevention Resource Center)*

Memorials and Special Considerations *(National Association of School Psychologists)*

Centerstone Guidelines for Response After a Completed Suicide of a Client *(Zero Suicide Institute)*

Tips for Safe Messaging *(National Action Alliance for Suicide Prevention)*

For Managers & Supervisors

Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors *(NYS Office of Mental Health’s Suicide Prevention Center)*

A Manager's Guide to Suicide Postvention in the Workplace *(National Action Alliance for Suicide Prevention)*

For Clinicians & Staff

Clinician Guide After Losing a Patient to Suicide *(NYS Office of Mental Health’s Suicide Prevention Center)*

WEBINAR: How to Support Clinicians Who Experience Suicide Loss

Complicated Grief Assessment Tool

Inventory of Complicated Grief *(American Psychological Association)*

Coalition of Clinician Survivors

Uniting for Suicide Postvention - Providers *(US Department of Veterans Affairs)*

Support for Schools & Communities

A Guide for Communities and Organizations in NYS for Responding to a Death by Suicide *(NYS Office of Mental Health’s Suicide Prevention Center)*

After a Suicide: Toolkit for Schools *(American Foundation for Suicide Prevention, Suicide Prevention Resource Center, Education Development Center)*