The Joint Commission

Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01, revised November 2018

SELECTION OF RESOURCES

Purpose

The purpose of this document is to help organizations comply with the revised NPSG 15.01.01. The document provides accredited organizations with a compendium of instruments and resources that may be used to meet the requirements of the standard. Joint Commission staff and suicide prevention experts have verified that the instruments and resources meet the requirements of the standard and elements of performance with which they are associated. The resources were compiled from key stakeholders including national organizations, federal and state agencies, professional associations, relevant academic institutions, peer reviewed publications and private entities.

Note: The instruments and resources identified in this document are intended to provide organizations with a range of options that may be used to meet the requirements of the NPSG. Specific instruments and/ or resources, however, may not be appropriate for all organizations. The list of instruments and resources is also not intended to be exclusive (i.e., other validated instruments that are not found on this list may also be used to meet the NPSG requirements). Ultimately, there is no single screening or assessment instrument that is appropriate for all patient populations in all settings. Organizational leaders are encouraged to review multiple options and to select validated/ evidence-based tools and resources that meet the needs of their specific organization or systems.

How to use this resource list

Resources are organized into five sections, first four sections according to specific Elements of Performance in NPSG 15.01.01. EP1 Environmental Risk Assessment; EP2 Validated Screening Tools; EP3,4 Evidence- Based Suicide Risk Assessment Tools; EP6 Evidence-Based Resources for Safety Planning and Follow Up Care upon Discharge. The last section includes general suicide reduction tools that may cover a combination of elements of performance of the NPSG 15.01.01.

A brief description of the resources, the organizations that supported development of materials as well as web links, are included. For easy access to the resources, this document should be viewed in electronic format, rather than printed in hard copy, because the website URLs are hyperlinked.

When indicated by the relevant websites, information related to authorship, applicable settings, applicable patient populations and resource availability are also provided. In addition, references of peer reviewed published evidence or a brief description of the development process of the resources are provided as applicable.

Joint Commission project staff: suicide prevention workgroup

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Disclaimer: This compendium of resources is not intended to be a comprehensive source of all relevant information relating to suicide prevention. Resources that are evidence-based and/ or have been widely and effectively used for the prevention of suicide in healthcare settings were selected based on their relevance to the revised NPSG15.01.01. The inclusion of a product name, vendor, or service should not be construed as an endorsement of such product, vendor, or service, nor is failure to include the name of a resource, product, vendor, or service be construed as disapproval. Because the information contained herein is derived from many sources, the Joint Commission cannot guarantee that the information is completely accurate or error free. The Joint Commission is not responsible for any claims or losses arising from the use of, or from any errors or omissions in, this compendium of resources.

The Joint Commission Mission

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. For more information about The Joint Commission, please visit https://www.jointcommission.org.

Questions

Please direct questions or comments about this compendium of resources to:

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Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP1 – Environmental Risk Assessment	
Tools	**Brief Description**
ASHE Patient Safety and Ligature Identification Checklist **ASHE On Demand: A Safe Health Care Environment: Suicide, Self-Harm, and Ligature Risk Assessments** **ASHE Virtual Rounding Tools** • **Virtual Rounding Tool: General Acute Care Patient Room** • **Virtual Rounding Tool: General Acute Patient Care Bathroom** **ASHE Three-step ligature risk guidance for general acute care or emergency departments** **Settings:** Hospital, other **Availability:** Free to ASHE members	**The American Society for Health Care Engineering of the American Hospital Association** (ASHE) developed multiple tools and resources on ligature risks in the physical environment to help hospitals and other health care facilities understand and implement CMS guidance and Joint Commission recommendations related to establishing a policy to perform an environmental-risk assessment when an at-risk patient is present. The tools are available free of charge to ASHE members. Information about the tools can be found on the ASHE News and Resources web page: http://www.ashe.org/resources/preventing-self-harm-and-ligature-risks.shtml • The ASHE Patient Safety and Ligature Identification Checklist can be used to create ligature-resistant environments when 1:1 continuous observation is not practical. While it is not meant to be exhaustive, it is intended to help understand the possible patient and staff safety risks, potential ligature points and other self-harm concerns for behavioral health areas. It is categorized by room type and contains items that are known to pose specific ligature or self-harm risks. • The ASHE On Demand: A Safe Health Care Environment: Suicide, Self-Harm, and Ligature Risk Assessments is a recording that focuses on the process of risk assessment and mitigation of behavioral health patient safety physical risks. • The ASHE Three-step ligature risk guidance for general acute care or emergency departments provides a three-step approach (**Identify; Observe; Remove**) to managing ligature risks and preventing patient self-harm in general acute care or emergency departments. These steps do not apply for psychiatric units. **Recommending Organizations:** 1. The American Society for Health Care Engineering of the American Hospital Association
The Mental Health Environment of Care Checklist (MHEOCC) (05/24/2018, XLS)	The US Department of Veteran Affairs (VA) developed the Mental Health Environment of Care Checklist (MHEOCC) for VA Hospitals to review inpatient mental health units for environmental hazards. The purpose is to identify and abate environmental hazards that could increase the chance of patient suicide or self-harm. The checklist has been used in all VA mental health units since October 2007. Contact Peter.Mills@va.gov for more information.

The Mental Health Guide **Author:** US Department of Veteran Affairs VA **Settings:** Hospitals **Availability:** Free **https://www.patientsafety.va.gov/docs/joe/eps_mental_health_guide.pdf**	The Mental Health Guide was developed by a multidisciplinary team comprising of members from the VA National Center for Patient Safety, Nursing, Safety, Environmental Management, and Interior Design to provide guidance and education to the field in relation to determining products suitable for the locked Inpatient Mental Health Environment. The Guide offers recommended products and solutions, is accessed electronically and was designed to be a "living" document updated as new products are identified and verified. It contains the following resources: • Products and ideas for use in Inpatient Mental Health areas, including both positive and cautionary attributes to consider before purchase. • Products developed by industry with feedback from Integrated Product Team members. • Background to educate staff to evaluate products at the facility level. • Training module and sample checklists for non-clinical staff who may access a locked inpatient mental health unit for routine maintenance and inspection. The products and manufacturers represented in the guide do not represent an endorsement by the VA for any manufacturer or vendor. **Recommending Organizations:** 1. The VA US Department of Veterans Affairs **Evidence/ Development:** The Mental Health Guide was developed as a result of research by a multidisciplinary workgroup from VAs across the country and collaboration with product manufacturers.
Behavioral Health Design Guide Edition 7.3 **© 2018 Behavioral Health Facility Consulting, LLC** **Authors:** James M. Hunt, AIA David M. Sine, DrBE, CSP, ARM, CPHRM **Settings:** BHC units **Availability:** Free **http://www.bhfcllc.com/download-the-design-guide/**	The **Behavioral Health Design Guide** is intended to address the built environment of the general adult inpatient behavioral health care unit. The document details practical means of protecting patients and staff. It is intended to represent best current practices, in the opinion of the authors. It is intended to represent best current practices, in the opinion of the authors. The Guide is updated frequently, and the date of each edition is indicated on the cover and at the bottom of each page of the document. Readers are urged to check: www.bhfcllc.com whenever referring to this Guide to assure the latest information is being accessed. **Recommending Organizations:** 1. Behavioral Health Facility Consulting, LLC **Evidence/ Development:** Authorship by national experts

Patient Safety Standards, Materials and Systems Guidelines Recommended by the New York State Office of Mental Health 14th Edition| July 31, 2015 **Author:** NYS-OMH **Settings:** Inpatient psychiatric units **Availability:** Free **https://www.omh.ny.gov/omhweb/patient_safety_standards/guide.pdf**	The purpose of the New York office of mental health environmental guide is to provide a selection of materials, fixtures, and hardware that the NYS-OMH has reviewed and supports for use within inpatient psychiatric units throughout New York State. While installation of these products will not eliminate all risks, the items selected represent styles and properties of products that help lower patient risk while on an inpatient psychiatric unit. Many of the items in this document represent the current state of the art and it is anticipated that additional or more effective products will continue to be developed. The NYS-OMH intends to periodically update these guidelines to keep current with these changes but notes that hospitals also have an obligation to continue to review products that will assist in this goal. Utilization of any of these products is not mandatory. This document is not intended to provide guidance for outpatient psychiatric facilities. **Recommending Organizations:** 1. New York State Office of Mental Health **Evidence/ Development:** Review and evaluation by NY-OMH

Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP2 - Validated/ Evidence-Based Screening Tools	
Tools	**Brief Description**
Ask Suicide-Screening Questions (ASQ) Toolkit by National Institute of Mental Health **Authors:** NIMH **Settings:** Emergency Departments, Medical/surgical unit, outpatient primary care, specialty clinics **Population:** youth age 10-24 **Availability:** Free **www.nimh.nih.gov/asq**	**Ask Suicide-Screening Questions (ASQ) National Institute of Mental Health** The ASQ toolkit was developed and validated by a team from the National Institute for Mental Health (NIMH) following a 2008, multisite study. ASQ is a four-item suicide-screening tool designed to be used for people ages 10–24 in emergency departments, inpatient units, and primary care facilities. A Brief Suicide Safety Assessment is available to be used when patients screen positive for suicide risk on the ASQ. The toolkit is organized by the medical setting in which it will be used: emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics. The ASQ is free of charge and available in multiple languages. All toolkit materials are available on the NIMH website at www.nimh.nih.gov/asq **Recommending Organizations:** 1. National Institute for Mental Health (NIMH). 2. National Action Alliance for Suicide Prevention (Action Alliance): Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc. 3. Zero Suicide Initiative http://zerosuicide.sprc.org/ **Evidence/ Development:** 1. Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ)A Brief Instrument for the Pediatric Emergency Department. *Arch Pediatr Adolesc Med.* 2012;166(12):1170–1176. doi:10.1001/archpediatrics.2012.1276
Columbia-Suicide Severity Rating Scale (C-SSRS) Triage version **Authors:** Columbia University, the University of Pennsylvania, and the University of Pittsburgh — supported by the National Institute of Mental Health (NIMH)	The **Columbia-Suicide Severity Rating Scale (C-SSRS)** evidence-supported screening tool was developed by Columbia University, the University of Pennsylvania, and the University of Pittsburgh supported by the National Institute of Mental Health (NIMH). The C-SSRS Triage version features questions that help determine whether an individual is at risk for suicide. There are brief versions of the C-SSRS often used as a screening tool (first two questions) that, based on patient response, can lead to the administration of the additional questions to triage patients. The protocol and the training on how to use it are available free of charge. http://www.cssrs.columbia.edu/.

Settings: General, Healthcare **Population:** All ages **Availability:** Free **http://www.cssrs.columbia.edu/.**	This triage guide shows how some different types of programs are using the worrisome answers to guide clinical decision making (e.g.. does the patient require 1:1 observation or a psychiatrist to consult?) The triage model embeds the Columbia Protocol into the Electronic Health Record (EHR) and provides alerts for high risk answers. To demonstrate how this works the C-SSRS website further provides an example from NYOMH. There is no cost or license required for health/behavioral health care providers, to put the Columbia Protocol tools into EHR/EMR. **Recommending Organizations:** 1. National Institute of Health NIH 2. Substance Abuse and Mental Health Service Administration SAMHSA 3. National Action Alliance for Suicide Prevention (Action Alliance) 4. Department of Defense 5. CDC National Center for Injury Prevention and Control 6. United States Food and Drug Administration FDA 7. Zero Suicide Initiative http://zerosuicide.sprc.org/ **Evidence/ Development:** The Columbia Lighthouse Project/Center for Suicide Risk Assessment. The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence Last Revised 2-7-2018 http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/evidence/ Posner et al. The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults Am J Psychiatry 2011;168: 126 6 –1277)
Patient Health Questionnaire-9 (PHQ-9) Depression Scale **Authors:** Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. **Settings:** Primary Care, BHC **Population:** adults, age 12+ **Availability:** Free **https://www.phqscreeners.com/select-screener**	The **Patient Health Questionnaire-9 (PHQ-9) Depression Scale** is a validated widely used nine-item tool used to diagnose and monitor the severity of depression. Question 9 screens for the presence and duration of suicide ideation. It is available in Spanish and other languages and has also been modified for the adolescent population. All screening tools and instruction manuals are available at no cost. https://www.phqscreeners.com/select-screener **Recommending Organizations:** 1. AIMS Center University of Washington 2. Substance Abuse and Mental Health Service Administration SAMHSA 3. National Action Alliance for Suicide Prevention (Action Alliance): Transforming Health Systems Initiative Work Group. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe.* Washington, DC: Education Development Center, Inc.

(All PHQ, GAD-7 screeners and translations are downloadable from this website and no permission is required to reproduce, translate, display or distribute them).	4. Zero Suicide Initiative http://zerosuicide.sprc.org/ **Evidence:** Gregory E. S et al. Does Response on the PHQ-9 Depression Questionnaire Predict Subsequent Suicide Attempt or Suicide Death? Psychiatric Services 64:1195–1202, 2013; doi: 10.1176/appi.ps.201200587) Rossom RC, Coleman KJ, Ahmedani BK, et al. Suicidal Ideation Reported on the PHQ9 and Risk of Suicidal Behavior across Age Groups. *Journal of affective disorders*. 2017;215: 77-84. doi: 10.1016/j.jad.2017.03.037. Does Suicidal Ideation as measured by the PHQ-9 Predict Suicide Among VA Patients? Samantha A. Louzon, Robert Bossarte, John F. McCarthy, and Ira R. Katz Psychiatric Services 2016 67:5, 517-522
Suicide Behavior Questionnaire-Revised (SBQ-R, Osman et al., 2001) **Population:** ages 13-18 **Availability:** Free **https://www.integration.samhsa.gov/images/res/SBQ.pdf**	**Suicide Behavior Questionnaire-Revised (SBQ-R)** The SBQ-R is a 4 item self-report questionnaire that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones, and includes a question about lifetime suicidal ideation, plans to commit suicide, and actual attempts. https://www.integration.samhsa.gov/images/res/SBQ.pdf Item 1 evaluates lifetime ideation and attempt, Item 2 assesses frequency of ideation in the past 12 months, Item 3 explores suicide threats, and Item 4 evaluates the likelihood of future suicidal behavior. **Recommending Organizations:** 1. National Action Alliance for Suicide Prevention (Action Alliance): Transforming Health Systems Initiative Work Group. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe*. Washington, DC: Education Development Center, Inc. **Evidence:** Brown, G. (2003). *A review of suicide assessment measures for intervention research with adults and older adults*. Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Brown2003 Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors QuestionnaireRevised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454. https://www.ncbi.nlm.nih.gov/pubmed/11785588 Kreuze E and Lamis D 2017 A Review of Psychometrically Tested Instruments Assessing Suicide Risk in Adults OMEGA—Journal of Death and Dying 2018, Vol. 77(1) 36–90

Suicide risk screening in pediatric hospitals: Clinical pathways to address a global health crisis Brahmbhatt, Khyati et al. *Psychosomatics* (2018) https://www.psychosomaticsjournal.com/article/S0033-3182(18)30429-8/abstract	This paper details the first interdisciplinary and international effort to generate Clinical Pathways (CPs) for pediatric suicide risk screening in general hospital settings. The Clinical Pathway was created as a guide for hospitals worldwide to improve youth suicide risk screening and implementation of appropriate next steps. The Pathway includes the use of the Ask Suicide-Screening Questions (ASQ) (brief primary screener) and the Columbia Suicide Severity Rating Scale (C-SSRS) or the ASQ Brief Suicide Safety Assessment (secondary screeners) for screening and risk stratification of suicidality in children and adolescents in medical settings (14-17). The publication includes 4 appendices: • The introductory document (Appendix A) is intended to help orient providers, managers, and administrators in a variety of disciplines and specialties to the pathway. • The flow diagrams (Appendix B: 1-3) visually depict the steps in the clinical pathways for suicide risk screening in the ED (Appendix B.1) and in the pediatric inpatient medical/surgical setting (Appendix B.2). Both pathways describe a similar 3-tiered screening process. Further, a brief suicide risk screening for the C-SSRS was created for hospitals that may already be using this scale (Appendix B.3). • The text document (Appendix C) contains a narrative description of the pathway that is to be used side-by-side with the flow diagrams by individuals or institutions implementing a pediatric suicide risk screening process within their institution. • Sample scripts for conducting and ASQ screen, the Brief Suicide Safety Assessment and steps taken after are provided in Appendix D.
Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc. **Author:** National Action Alliance for Suicide Prevention (Action Alliance): Transforming Health Systems Initiative Work Group. (2018).	The **Recommended standard care for people with suicide risk: Making health care suicide safe** report provides recommendations on suicide-related standard health care for primary care, behavioral health, and emergency department settings. It was produced by health care and suicide prevention experts working with the National Action Alliance for Suicide Prevention (Action Alliance). The information is intended to guide health care organizations that wish to better identify and support people who are at increased risk of suicide and for advocates who will work with hospitals and clinics to make them safer. The report describes why improving suicide care is urgently needed; identifies gaps in health care that contribute to suicide deaths; summarizes the evidence-based solutions that should

Settings: Primary Care, Behavioral Health, Emergency Departments **Availability:** Free **https://theactionalliance.org/resource/recommended-standard-care**	be adopted; and, provides information on resources that are available to make care safer and better.
ED-SAFE Study Materials **The Patient Safety Screener (PSS-3): A Brief Tool to Detect Suicide Risk in Acute Care Settings** **Author:** Emergency Medicine Network (EMR) **Settings:** Emergency Departments **Availability:** Free **http://www.sprc.org/micro-learnings/patientsafetyscreener**	ED-SAFE is an NIMH-funded, 8-site suicide prevention project. The major goals are to examine: the impact of screening ED patients for suicide risk, the effect of an ED-initiated intervention on suicidal behavior, and the economic impacts of treatment as usual, screening, and the intervention. The ED-SAFE resource collection includes **provider guidance and training tools**, the **Patient Safety Screener** to be administered by ED nursing staff and **Patient Safety Secondary Screener** to assess if referral to mental health treatment is warranted. Resources also include **patient handouts** in English and Spanish for self-care, how to stay safe and a personal safety plan.

Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP3,4 - Validated/ Evidence-Based Suicide Risk Assessment Tools	
Tools	**Brief Description**
Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment version **SAFE-T with C-SSRS** **Author:** Columbia University, the University of Pennsylvania, and the University of Pittsburgh — supported by the National Institute of Mental Health (NIMH) **Settings:** All **Population:** all ages and special populations in different settings **Availability:** Free	The C-SSRS Risk Assessment version can be used as a suicide assessment tool following the use of one of the screening tools. See http://cssrs.columbia.edu/documents/risk-assessment-page/. The risk assessment version provides a checklist of protective and risk factors for suicide, used along with the C-SSRS. The Columbia Protocol questions have also been incorporated into the SAMHSA SAFE-T model with recommended triage categories. See document **SAFE-T Protocol with C-SSRS – Recent.** Note that the C-SSRS Full version, without the risk assessment, is not sufficient to qualify as an evidence-based suicide risk assessment process. Assessment of the risk and protective factors, in a structured or unstructured way, is required in addition to the suicide inquiry. **Recommending Organizations:** 1. National Institute of Health NIH 2. Substance Abuse and Mental Health Service Administration SAMHSA 3. National Action Alliance for Suicide Prevention (Action Alliance) 4. Department of Defense 5. CDC National Center for Injury Prevention and Control 6. United States Food and Drug Administration FDA **Evidence:** The Columbia Lighthouse Project/Center for Suicide Risk Assessment. The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence Last Revised 2-7-2018 http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/evidence/ Posner et al. The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults Am J Psychiatry 2011;168: 126 6 –1277)
Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997) **Settings:** In-patient and out-patient settings	The 19-item **Scale for Suicide Ideation – Worst** (SSI-W; Beck et al., 1997) is an interviewer-administered rating scale that measures the intensity of patients' specific attitudes, behaviors, and plans to commit suicide during the time period that they were the most suicidal. The instrument was developed to obtain a more accurate estimate of suicide risk. As with the SSI, each SSI-W item consists of three options graded according to the suicidal intensity on a 3-point scale ranging from 0

	to 2. The ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The SSI-W takes approximately 10 minutes to administer. (extract from Brown 2003, pg 7). Although the SSI-W has been used less frequently than the SSI, the reliability and validity of this measure have been established. **Evidence:** Brown, G. (2003). *A review of suicide assessment measures for intervention research with adults and older adults*. Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Brown2003 Beck, A. T., Brown, G. K., & Steer, R. A. (January 01, 1997). Psychometric characteristics of the Scale for Suicide Ideation with psychiatric outpatients. Behavior Research and Therapy, 35, 11, 1039-1046.
Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991) **Settings:** In-patient and out-patient settings	The **Beck Scale for Suicide Ideation** (BSI; Beck & Steer, 1991) is a 21-item self-report instrument for detecting and measuring the current intensity of the patients' specific attitudes, behaviors, and plans to commit suicide during the past week. The BSI was developed as a self-report version of the interviewer-administered Scale for Suicide Ideation. The first 19 items consist of three options graded according to the intensity of the suicidality and rated on a 3-point scale ranging from 0 to 2. These ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The last two items assess the number of previous suicide attempts and the seriousness of the intent to die associated with the last attempt. As with the SSI, the BSI consists of five screening items. If the respondent reports any active or passive desire to commit suicide, then an additional 14 items are administered. The BSI takes approximately 10 minutes to administer. Although the BSI is less widely used than the SSI, the BSI may be a viable alternative for measuring suicide ideation using a self-report format. (extract from Brown 2003: 8-9).

	Evidence: Brown, G. (2003). *A review of suicide assessment measures for intervention research with adults and older adults*. Bethesda, MD: National Institute of Mental Health. https://go.edc.org/Brown2003 Kreuze E and Lamis D 2017 A Review of Psychometrically Tested Instruments Assessing Suicide Risk in Adults OMEGA—Journal of Death and Dying 2018, Vol. 77(1) 36–90

Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP6 - Evidence-based resources for safety planning, and follow up care upon discharge	
Tools	**Brief Description**
Safety Planning Intervention (SPI) **Authors:** Barbara Stanley and Gregory K. Brown **Settings:** ED, trauma centers, crisis hot lines, psychiatric inpatient units, and other acute care settings. **Availability:** Free **http://suicidesafetyplan.com/About_Safety_Planning.html**	The **Safety Planning Intervention (SPI)** is an innovative and brief treatment, for suicidal patients evaluated in the ED, trauma centers, crisis hot lines, psychiatric inpatient units, and other acute care settings. The SPI is a collaborative effort between a treatment provider and a patient and takes about 30 minutes to complete. The basic steps include (a) recognizing the warning signs of an impending suicidal crisis; (b) using your own coping strategies; (c) contacting others in order to distract from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the availability of means to complete suicide. (Stanley & Brown, 2011) This intervention can be used in the context of ongoing outpatient treatment or during inpatient care of suicidal patients. SPI has been determined to be a best practice by the Suicide Prevention Resource Center. (www.sprc.org). In this paper, the SPI is described in detail and a case example is provided to illustrate how the safety plan may be implemented: Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk Cognitive and Behavioral Practice, Volume 19, Issue 2, May 2012, Pages 256-264 http://suicidesafetyplan.com/About_Safety_Planning.html http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog_Beh_Practice.pdf A recent large-scale cohort comparison study (Stanley B, et al. 2018) found that SPI+ was associated with a reduction in suicidal behavior and increased treatment engagement among suicidal patients following ED discharge and may be a valuable clinical tool in health care settings. Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776 https://www.ncbi.nlm.nih.gov/pubmed/29998307

Safety Planning Guide: A Quick Guide for Clinicians ©2008 Barbara Stanley and Gregory K. Brown **Settings:** Behavioral Health Care, Outpatient Mental Health **Availability:** Free **http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians** or **Safety Planning website**	This quick guide for clinicians may be used to develop a safety plan—a prioritized written list of coping strategies and sources of support to be used by patients who have been deemed to be at high risk for suicide. The authors strongly recommend that the guide be used after reviewing the Safety plan treatment manual to reduce suicide risk. You can learn more about safety planning through the authors' Safety Planning website.
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version By Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. **Populations:** Military Service Members and Veterans **Settings:** All VA settings **Availability:** Free **http://www.sprc.org/resources-programs/safety-plan-treatment-manual-reduce-suicide-risk-veteran-version**	The **Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version** was developed by Stanley & Brown, 2008 and is intended to be used by VA mental health clinicians, including suicide prevention coordinators, as well as other VA clinicians who evaluate, treat, or have contact with patients at risk for suicide in any VA setting. The manual provides a detailed description of how VA clinicians and patients may collaboratively develop and use safety plans as an intervention strategy to lower the risk of suicidal behavior. The manual identifies 6 steps for **Developing a Safety Plan** and outlines the rationale, instructions and examples of each step. Step 1: Recognizing Warning Signs Step 2: Using Internal Coping Strategies Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis Step 5: Contacting Professionals and Agencies Step 6: Reducing the Potential for Use of Lethal Means The manual further describes key activities for **Implementation of the Safety Plan:** • Assess for likelihood that the plan will be used and problem solving if there are obstacles: • Evaluate if the proposed safety plan format is appropriate to the veterans' capacity and circumstances • Review plan periodically The manual underscores the safety plan as one component of comprehensive care of the suicidal individual that is used in conjunction with other important components which include risk

	assessment, appropriate psychopharmacologic treatment, psychotherapy and hospitalization. https://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf **Evidence:** Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776 Rationale and study protocol for a two-part intervention: Safety planning and structured follow-up among veterans at risk for suicide and discharged from the emergency department Currier, Glenn W. et al. Contemporary Clinical Trials, Volume 43, 179 – 184 Barbara Stanley, Gregory K. Brown, Glenn W. Currier, ChelseaLyons, Megan Chesin, Kerry L. Knox, "Brief Intervention and Follow-Up for Suicidal Patients with Repeat Emergency Department Visits Enhances Treatment Engagement", *American Journal of Public Health* 105, no. 8 (August 1, 2015): pp. 1570-1572.
Patient Safety Plan Template By Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. **Settings:** Primary Care, Outpatient Mental Health **Availability:** Free **http://www.sprc.org/resources-programs/patient-safety-plan-template**	The **Patient Safety Plan Template** is a fill-in-the-blank template for developing a safety plan with a patient who is at increased risk for a suicide attempt**.** **Populations:** Adults, Young Adults Ages 18 to 25 Years, Military Service Members and Veterans http://www.sprc.org/sites/default/files/resource-program/Brown_StanleySafetyPlanTemplate.pdf
Safety Planning Intervention for Suicide Prevention online education course From, New York State Office of Mental Health and Columbia University	The **Safety Planning Intervention for Suicide Prevention** is a free, online course from the New York State Office of Mental Health and Columbia University designed for education and training of behavioral health care practitioners the courses focus is on strategies of effective care/treatment and safety planning. The course describes the Safety Planning Intervention tool and how it can help individuals, explains when to work with individuals to create a safety plan, and describes the steps in creating a safety plan. http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm

	Recommending Organizations: 1. New York State Office of Mental Health 2. Suicide Prevention Resource Center http://www.sprc.org/strategic-planning/finding-programs-practices 3. Zero Suicide initiativehttp://zerosuicide.sprc.org/toolkit
Caring for Adults with Suicide Risk – A Consensus Guide for Emergency Departments (the ED Guide) **Populations:** Adults **Settings:** Emergency Departments **Author:** Suicide Prevention Resource Center (SPRC) **Availability:** Free **http://www.sprc.org/ed-guide**	The **ED Guide** is designed to assist emergency department (ED) providers with decisions about the care and discharge of patients with suicide risk to improve patient outcomes after discharge. The guide includes: • A Decision Support Tool • Brief ED-based Interventions • A Discharge Planning Checklist • Patient-centered Care Guidelines It can help answer the following questions: • Can this patient be discharged or is further evaluation needed? • How can I intervene while this patient is in the ED? • What will make this patient safer after leaving the ED? The guide also includes references to a comprehensive set of external resources which can be accessed via hyperlinks in the guide. A **Quick Guide** version of **the ED Guide** is in Appendix A. The authors recommend providers read the complete version before using the Quick Guide. **http://www.sprc.org/sites/default/files/EDGuide_full.pdf** **http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf** **Recommending Organizations:** 1. Suicide Prevention Resource Center 2. SAMHSA **Evidence/ Development:** The **ED Guide** was developed with extensive input from a consensus panel of experts from emergency medicine and suicide prevention organizations. Recommendations in the ED Guide were developed using an iterative process that included both reviews of the literature and expert panel consensus.

Counseling on Access to Lethal Means (CALM) **Populations:** Adults, Youth **Settings:** All **Author:** Online version - Suicide Prevention Resource Center (SPRC) **Availability:** Online - Free **https://training.sprc.org/enrol/index.php?id=3**	**Counseling on Access to Lethal Means (CALM)** is a free, online course from the Suicide Prevention Resource Center about how to reduce access to the methods people use to kill themselves. It covers who needs lethal means counseling and how to work with people at risk of suicide—and their families—to reduce access. While this course is primarily designed for mental health professionals, others who work with people at risk for suicide, such as health care providers and social service professionals, may also benefit. This online course was developed in collaboration with Catherine Barber, director of the Means Matter Campaign at the Harvard Injury Control Research Center, and Elaine Frank, a co-developer of the original in-person CALM workshop. **Recommending Organizations:** 1. Suicide Prevention Resource Center 2. SAMHSA 3. Zero Suicide Initiative http://zerosuicide.sprc.org/toolkit/engage#quicktabs-engage=1 4. Harvard Injury Control Research Center, Means Matter **Evidence:** Johnson, R.M., Frank, E.M., Ciocca, M., & Barber, C.W. (2011). Training mental health care providers to reduce at-risk patients' access to lethal means of suicide: Evaluation of CALM Project. Archives of Suicide Research, 15(3), 259-264. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21827315 Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., . . . Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, *3*, 646–659. Stone, D. M., Holland, K. M., Bartholow, B., Crosby, A. E., Davis, S., & Wilkins, N. (2017). *Preventing suicide: A technical package of policies, programs, and practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Zero Suicide Institute (2018). Engage: Reducing Access to Lethal Means. Retrieved from http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ENGAGE%20LETHAL.pdf

Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports. **Authors:** Riblet N, Shiner B, Watts, BV, Mills P, Rusch B, Hempbill RR J Nerv Ment Dis. 2017 Jun;205(6):436-442. **Setting:** Inpatient mental health unit **Availability:** PUBMED https://www.ncbi.nlm.nih.gov/pubmed/28511191	To examine the high risk for death by suicide after discharge from an inpatient mental health unit, this 2017 publication presents a review of root cause analysis reports of suicide within 7 days of discharge from across all Veterans Health Administration inpatient mental health units between 2002 and 2015. Findings: There were 141 reports of suicide within 7 days of discharge, and a large proportion (43.3%, n = 61) followed an unplanned discharge. Root causes fell into three major themes including challenges for clinicians and patients after the established process of care, awareness and communication of suicide risk, and flaws in the established process of care. The authors conclude that flaws in the design and execution of processes of care as well as deficits in communication may contribute to post discharge suicide. Furthermore, while policies mandate mental health follow-up within 7 days of discharge, the risk for suicide in the week after discharge may be the greatest in the first few days after discharge. Inpatient teams should also be aware of the potentially heightened risk for suicide among patients with unplanned discharges. Need for additional research to better understand the drivers of unplanned discharge and whether they may have a role in suicide risk is indicated.

General suicide reduction tools	
Tool	**Brief Description**
The Zero Suicide Toolkit **Availability:** Free **http://zerosuicide.sprc.org/toolkit**	Zero Suicide is a key concept of the **2012 National Strategy for Suicide Prevention**, a priority of the **National Action Alliance for Suicide Prevention** (Action Alliance), a project of Education Development Center's **Suicide Prevention Resource Center** (SPRC), and supported by the **Substance Abuse and Mental Health Services Administration** (SAMHSA). After researching successful approaches to suicide reduction, the Action Alliance's Clinical Care and Intervention Task Force identified seven essential elements of suicide care for health and behavioral health care systems to adopt: 1. **Lead** – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles. 2. **Train** – Develop a competent, confident, and caring workforce. 3. **Identify** – Systematically identify and assess suicide risk among people receiving care. 4. **Engage** – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means. 5. **Treat** – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors. 6. **Transition** – Provide continuous contact and support, especially after acute care. 7. **Improve** – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. The Zero Suicide Toolkit presents multiple sets of tools organized according to the seven essential elements of Zero Suicide implementation. For each essential element, the toolkit provides a comprehensive list of readings and implementation resources for health and behavioral health care systems. In addition to the toolkit, the Zero Suicide website http://zerosuicide.sprc.org/ includes information about how to get technical assistance in adopting and implementing the Zero Suicide approach.