Suicide Risk Management

September 2018

This Clinical Practice Model (CPM) recommends evidence-based guidelines to facilitate the screening and assessment for suicide risk:

- In adolescent and adult patients (age 12 and older)
- In child patients (ages 5 to 11) with a Behavior Health history and/or diagnosis or presents with warning signs of suicidal ideation
- Being seen in PMG ambulatory clinics, emergency department, and inpatient care settings

These recommendations emanate from collaboration among PHS work groups including Nursing, ED, and Primary care.

Why Focus on Suicide Risk?

In New Mexico as of 2016, suicide is the 2nd leading cause of death for people ages 15 to 44. New Mexico is ranked 4th in suicide death rate (22% vs. 13% national average). In 2010, the estimated cost of suicide in New Mexico was $506,888,000 of combined lifetime medical and work loss costs, or an average of $1,227,332 per suicide death.

Each time a patient visits a provider is an opportunity to screen for suicidal ideation. Nearly 50% of people who die by suicide see their primary care doctor in the month before their death. Researchers have found that about 25% of young adults have suicidal thoughts. Another study found that 25% of people who die by suicide are seen in the emergency room for nonpsychiatric reasons in the 12 months prior to their death.

A key factor in reducing suicides and suicidal behaviors may be the effective diagnosis and management of depression. When Providers recognize and treat depression, it increases prescription rates for antidepressants and, along with psychotherapy, may decrease suicidal ideation and completed suicides in their patients. Even though the USPSTF states that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care, screening all patients for suicidal thinking is an important part of suicide prevention and is recommended by The Joint Commission.

Studies show that a significant portion (6% to 14.9%) of children experience suicidal ideation and verbalize thoughts of suicide and death. One study found that over a 20-year period in the United States, 657 children ages 5 to 11 took their own lives. While there are no evidence-based treatments for suicidality in children under 12, there are guidelines for developmentally appropriate assessment.

With an evidence-based assessment tool – the Columbia-Suicide Severity Rating Scale (C-SSRS) – screening can be done consistently and efficiently. This type of regular screening may also help to optimize healthcare resources by pointing patients toward the appropriate level of care.

Clinical Leaders

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This CPM presents a model of care based on scientific evidence available at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative.

Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base.

If you have questions or concerns regarding this information, contact:

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This CPM is part of Presbyterian's Clinical Care Model, a broad, enterprise-wide body of documentation covering PHS' functions, programs, and care pathways, intended to build organizational acumen, facilitate cross-system collaboration, and accelerate our implementation of clinical initiatives.

Find all of PHS' Care Model at www.PHSCareModel.org.

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Suicide Screening, Assessment, and Response in Primary Care and Urgent Care Clinics

1. **Primary Care or Urgent Care visit**
   - *Patient Safety screening:* For depression and suicide risk

2. **Patient presents with warning signs**
   - *Suicidal ideation positive?*
     - **YES**
       - Make the patient feel at ease about answering suicide-related questions
     - **NO**
       - No further suicide risk screening at this visit

3. **Assess suicide risk:** *Suicide Severity Rating Scale Flowsheet*

4. **Evaluate risk level**
   - **Minimal**
     - Epic SSRS score: 1 to 3
     - *Response:*
       - Wishes to be dead or has suicidal thoughts
       - No consideration of method
       - No clear intent
       - No suicide plan
       - Has never acted on those thoughts
     - Document risk assessment
     - PCP monitors and re-assesses, as clinically indicated
     - Consider referral to BHC
     - BHC monitors and re-assesses, as clinically indicated
     - Address suicidal ideation in the treatment plan
     - Refer to specialty BH, as needed

   - **Moderate**
     - Epic SSRS score: 4 to 6
     - *Response:*
       - Wishes to be dead or has suicidal thoughts
       - Has considered the method
       - No clear intent
       - No suicide plan
       - May have acted on those thoughts in the past, longer than 3 months ago
     - Document risk assessment
     - Warm handoff to BHC or appointment scheduled with BHC within 1 week
     - Provide suicide prevention information
     - BHC conducts further assessment; completes a safety plan
     - Address suicidal ideation in the treatment plan
     - Consider referral to specialty BH

   - **High**
     - Epic SSRS score: 7 to 15
     - *Response:*
       - Wishes to be dead or has suicidal thoughts
       - Intends to act and/or has a plan for acting
     - Document risk assessment
     - Refer immediately to BHC
     - BHC conducts further assessment;
       - “Eyes on” patient monitoring; Safety check environment
     - If BHC is unavailable, transfer care to ED

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**Notes:** PMG patients are screened for both depression and suicide risk during the rooming process at every ambulatory visit.

1. Primary Support LPN or MA screens the patient initially using the Adult Patient Safety Questions in Epic, including the PHQ-2 and question #9 from the PHQ-9. If the patient replies positive to the “better off dead” question, a best practice advisory (BPA) will appear with instructions, including the full PHQ-9.

2. For more about **warning signs**, see p. 7.

3. During nurse triage phone calls, Primary Care Nurses may use alternative questions to assess suicide risk, as stated in the Barton Schmitt triage protocols.

   In Epic, the Primary Care Provider (PCP) is alerted by a BPA in the Plan activity to assess the patient for suicide risk using the Suicide Severity Rating Scale Flowsheet (hyperlink) and make the appropriate disposition.

4. Once a screening is completed, the results can be viewed in chart review in the Encounters tab: there is a hyperlink called “C-SSRS Screen.”

   Risk level appears as a numerical value in the C-SSRS Screen flowsheet. Recommended actions for different scores are included.

5. If risk gets higher, patient should seek help, visit the ED, call 911 or the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255).

6. Call C&L at Kaseman ED, (505) 291-2134, and transport via ambulance.

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Suicide Screening, Assessment, and Response in the ED

**Notes:** Suicide screening is completed on all patients age 12 and older who visit the ED or are hospitalized (inpatient status).

1. In Epic, the ED Nurse accesses the Suicide Risk tool in the Triage navigator.

2. For more about warning signs, see p. 7.

3. See questions, p. 5.

The Provider can review the Nurse’s assessment in the Review Visit activity and selecting Triage Summary under Suicide Screen. In the side-by-side view, the Provider can review by selecting Reports, ED tab, or Triage Summary.

Providers can re-assess (generate a new score) from the My Note activity. Within the navigator, select Scoring tools→Flowsheets→Suicide Screen.

4. Once a screening is completed, the results can be viewed in Summary activity, the Index report under Additional Reports section: choose “View-Only Flowsheet Data.” A new window opens. Select the link “Suicide/Homicide Screening.” It can also be viewed under Behavioral section: choose “RN Shift Assessment-Adult.”

Risk level appears as a numerical value in the Suicide/Homicide Screening flowsheet.

5. Epic navigator displays the “Safety Checklist - Room safety” within the navigators.
Suicide Screening, Assessment, and Response in Hospital

Notes: Suicide screening is completed on all patients age 12 and older who visit the ED or are hospitalized (inpatient status).

1 In Epic, the Inpatient Nurse accesses the Suicide/ Homicide Screening tool in the Admission navigator.

Similarly, the HOD Nurse accesses a smart form via a mini navigator in the More Activities tab.

2 For more about warning signs, see p. 7.

3 See questions, p. 5.

4 Once a screening is completed, the results can be viewed in Summary activity, the Index report under Additional Reports section: choose “View-Only Flowsheet Data.” A new window opens. Select the link “Suicide/Homicide Screening.” It can also be viewed under Behavioral section: choose “RN Shift Assessment-Adult.”

Risk level appears as a numerical value in the Suicide/Homicide Screening flowsheet.

5 Epic navigator displays the "Safety Checklist - Room safety" within the navigators.
Screening with Triage

C-SSRS
The Columbia-Suicide Severity Rating Scale (C-SSRS) is a widely accepted, evidence-based tool for assessing suicide risk that uses a series of simple, plain-language questions that anyone can ask. The results help users identify whether someone may be at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person may need. The C-SSRS asks: 1) Whether and when a person has thought about suicide (ideation); 2) What action(s) the person has taken to prepare for suicide; and 3) Whether and when the person attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition. The “screen with triage” version of the C-SSRS consists of five questions regarding suicidal ideation (of increasing severity) over the past month plus one question regarding lifetime suicidal behavior.

Suicide Assessment Tool: Comparing Questions for Adults vs. Children

<table>
<thead>
<tr>
<th>#</th>
<th>Adult/Adolescent (≥12 years old)</th>
<th>Child (&lt;12 years old)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ask Questions 1 and 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Have you thought about being dead or what it would be like to be dead? Have you wished you were dead or wished you could go to sleep and never wake up? Do you wish you weren’t alive anymore?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you had any actual thoughts of killing yourself?</td>
<td>Have you thought about doing something to make yourself not alive anymore? Have you had any thoughts about killing yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If YES to 2, ask questions 3, 4, 5, and 6; if NO to 2, go directly to question 6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Have you been thinking about how you might do this?</td>
<td>Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Have you had these thoughts and had some intention of acting on them?</td>
<td>When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn’t do anything about it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it? What was your plan? When you made this plan (or worked out these details), was any part of you thinking about actually doing it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If YES, ask:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was this within the past 3 months?</td>
<td>How long ago did you do this?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Responses | Interventions
---|---
YES to #1 or #2 | Consider referral to Behavioral Health
YES to #3 or #6 (more than 3 months ago) | Consult Behavioral Health; Consider patient safety precautions
YES to #4, #5, or #6 (less than 3 months ago) | Refer to Behavioral Health; Implement patient safety precautions
Within the past month...

1) Have you wished you were dead or wished you could go to sleep and not wake up?

2) Have you had any actual thoughts of killing yourself?

If NO, skip to question 6.

3) Have you been thinking about how you might do this?

Method

4) Have you had these thoughts and had some intention of acting on them?

Intending

5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Specific plan

6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Actual behavior

Was this within the past 3 months?

Factors that may decrease risk (protective factors):

- Positive social support
- Family connectedness; sense of responsibility to family
- Pregnancy / parenthood
- Religiosity / spirituality
- Positive coping skills
- Positive problem solving skills
- Compliant in therapy / treatment

Factors that may increase risk:

**Modifiable:**

- Alcohol / substance use
- Psychiatric disorder(s)
- Impulsiveness and poor self control
- Hopelessness
- Recent losses (physical, financial, personal)
- Co-morbid health problem or illness
- Lack of connections
- Access to means (firearms; medications)
- Contagion (recent exposure to another’s suicide)
- Non-compliant in treatment or not in treatment

**Non-modifiable:**

- Previous suicide attempt(s)
- Family history of suicide
- History of abuse (physical; sexual; emotional)
- Age, gender, race (elderly or young adult; NA youth)
- Relationship status (unmarried; living alone)
- Sexual orientation (LGBTQ)

Questions: A flowsheet or smart form within Epic guides the PHS clinician through a cascade of up to six questions from the C-SSRS. At a minimum, the clinician asks Q1, Q2 (ideation), and Q6 (behavior). Use alternative phrasing for children under age 12; see page 5. The assessment tool informs, but does not replace, clinical judgment. If there is a suspicion of suicide risk, initiate the referrals and safety precautions at the level deemed appropriate.

Clinical triage: Based on their replies to the questions, patients qualify as minimal, moderate, or high risk. Clinical responses are stated generally here; the Epic environment may recommend orders, care management, and/or safety precautions that are specific to the care setting and facility.

Understanding the factors that may increase or decrease suicide risk may help the development of a treatment plan, including the appropriate treatment setting. Treating modifiable risk factors means helping the patient achieve safer conditions, thus reducing the risk of suicide.
Care Pathway Roles and Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer the initial Patient Safety quick screen</td>
<td>Primary Support LPN/MA</td>
</tr>
<tr>
<td>(3 questions, the PHQ-2 and question #9 from the PHQ-9) and follow up with the full PHQ-9.</td>
<td></td>
</tr>
<tr>
<td>Administers the C-SSRS (up to 6 questions)</td>
<td>Primary care providers (PCPs); ED triage nurses (with optional additional evaluation by ED providers; clinicians (nurses, HODs, etc.) on inpatient units and Behavioral Health units</td>
</tr>
<tr>
<td>Implement Patient Safety precautions</td>
<td>Nurses, Primary Support LPN/MA</td>
</tr>
</tbody>
</table>

Warning Signs

Researchers have identified a number of acute warning signs that may precede the onset of suicidal behaviors (e.g., within hours to a few days). These acute signs should alert the clinician that there is an increased risk for the expression of suicidal behaviors, especially in those patients with other risk factors. Those acute warning signs are:

- Talking or writing about death, dying, or suicide
- Threatening to hurt or kill oneself
- Looking for ways to kill oneself; seeking access to pills, weapons, or other means

Other signs that may alert the clinician to consider a mental health evaluation:

- Hopelessness
- Rage, anger, or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there’s no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family, or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life
- Giving away valued possessions

In children and adolescents:

- Change in personality: sad, withdrawn, irritable, anxious, tired, indecisive, or apathetic
- Change in behavior: difficulty concentrating on school, work, or routine tasks
- Change in sleep patterns: insomnia, often with early waking or oversleeping, nightmares
- Change in eating habits: loss of appetite and weight, overeating
- Fear of losing control: acting erratically, harming self or others

Risk Factors

See the risk factors listed in the diagram on page 6.

Estimating the patient’s risk for suicide is enhanced by identifying the factors which could increase or decrease risk. No single risk factor or set of risk factors can predict who will die by suicide. Likewise, one specific protective factor or set of protective factors will not ensure safety. Because of the different strengths of their associations with suicide-related behaviors, all factors are not equal in their influence on the individual. Suicide risk is almost always time limited. Within an individual, the contribution of each factor to their suicidality will vary over the course of their lives.

Some risk factors are immutable (e.g., age, gender, and race/ethnicity), while others are situation-specific (e.g., loss of housing, exacerbation of pain in a chronic condition, or onset of psychiatric symptoms) and can sometimes be modified. Treating the modifiable risk factors may help to make the patient safer and can significantly reduce the risk of suicide.
Risk factors in children include symptoms of psychopathology (e.g., depression, ADHD, aggression), feelings of worthlessness, parental psychopathology, family conflict, and a history of abuse.

**Patient Education and Support**

### Patient Education: Suicide Risk

<table>
<thead>
<tr>
<th>Patient Goal</th>
<th>Key Messages for the Patient</th>
</tr>
</thead>
</table>
| Understand suicide risk. | • Suicide most often occurs when stressors and health issues converge to create an experience of hopelessness and despair. Conditions like depression, anxiety, and substance problems, especially when unaddressed, increase risk for suicide.  
• In a clinical setting, a person can be screened for suicidal risk and medical conditions that may influence suicidal ideations or behaviors that can be treated. |
| Recognize the warning signs. | • You can't always tell when someone is considering suicide, but possible warning signs are:  
  o Talking about suicide — for example, making statements such as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born"  
  o Getting the means to take your own life, such as buying a gun or stockpiling pills  
  o Withdrawing from social contact and wanting to be left alone  
  o Having mood swings, such as being emotionally high one day and deeply discouraged the next  
  o Being preoccupied with death, dying or violence  
  o Feeling trapped or hopeless about a situation  
  o Increasing use of alcohol or drugs  
  o Changing normal routine, including eating or sleeping patterns  
  o Doing risky or self-destructive things, such as using drugs or driving recklessly  
  o Giving away belongings or getting affairs in order when there is no other logical explanation for doing this  
  o Saying goodbye to people as if they won't be seen again  
  o Developing personality changes or being severely anxious or agitated, particularly when experiencing some of the warning signs listed above |
| Take medications as prescribed. | • Side effects from medication often happen and typically recede over time.  
• You may feel symptom response after two weeks but will need a longer length of time (6 to 12 months) for full response.  
• Take the medication as prescribed, even after you feel better.  
• Do not stop taking the medication without calling your Provider. |
| Keep your appointments. | • It may take several months and many visits to adjust your treatment to help you feel as well as possible. |
| Communicate with your providers. | • Tell your provider if you have any allergies or existing health conditions.  
• Tell your provider about all the prescription and over the counter medications you are taking (including vitamin and dietary supplements).  
• If you have any questions about or problems with your medication between visits, contact your provider as soon as possible.  
• Discuss thoughts of death or hurting yourself with your medical or behavioral healthcare provider. |
**Patient Education: Suicide Risk**

<table>
<thead>
<tr>
<th>Patient Goal</th>
<th>Key Messages for the Patient</th>
</tr>
</thead>
</table>
| **Parent/Guardian/Caregiver:**  
Know the warning signs (see above).  
Ask questions.  
Offer support.  
Respond immediately when someone attempts suicide. | • Asking about suicidal thoughts or feelings won’t push someone into doing something self-destructive. In fact, offering an opportunity to talk about feelings may reduce the risk of acting on suicidal feelings. Be sensitive, but ask direct questions, such as:  
  o How are you coping with what’s been happening in your life?  
  o Do you ever feel like just giving up?  
  o Are you thinking about dying?  
  o Are you thinking about hurting yourself?  
  o Have you ever thought about suicide before, or tried to harm yourself before?  
  o Have you thought about how or when you’d do it?  
  • Listen attentively and avoid interrupting.  
  • Offer reassurance that things can get better. When someone is suicidal, it seems as if nothing will make things better. Reassure the person that with appropriate treatment, he or she can develop other ways to cope and can feel better about life again.  
  • If a friend or loved one talks or behaves in a way that makes you believe he or she might attempt suicide, don’t try to handle the situation alone:  
    o Get help from a trained professional as quickly as possible. The person may need to be hospitalized until the suicidal crisis has passed.  
    o Encourage the person to call a suicide hotline number. In the U.S., call the National Suicide Prevention Lifeline at **800-273-TALK** (800-273-8255) to reach a trained counselor. Use that same number and press “1” to reach the Veterans Crisis Line.  
  • If someone has attempted suicide:  
    o Don't leave the person alone.  
    o Call 911 or your local emergency number right away. Or, if you think you can do so safely, take the person to the nearest hospital emergency room yourself.  
    o Try to find out if he or she is under the influence of alcohol or drugs or may have taken an overdose.  
    o Tell a family member or friend right away what’s going on. |

**Materials:**  
• **Teen Suicide Prevention video** (Mayo Clinic)

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**Measurement and Reporting**

Each care setting within Presbyterian audits suicide risk assessment and considers the Joint Commission’s requirements relevant to suicide, as part of the accreditation process.

**Clinical Definitions**

- **means**: The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs, guns, knives, etc.).
- **methods**: Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).
- **protective factors**: Factors that make it less likely that individuals will develop or engage in a suicidal behavior. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.
- **risk factors**: Factors that make it more likely that individuals will develop or engage in a suicidal behavior. Risk factors may encompass biological, psychological, or social factors in the individual, family, or environment.
- **safety plan**: Written list of warning signs, coping responses, and support sources that an individual may use to avert or manage thoughts, feelings, impulses, or behaviors related to suicide.
- **self-directed violence (or self-harm)**: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as non-suicidal or suicidal.
- **suicidal behavior**: Acts and/or preparation toward making a suicide attempt or toward a death by suicide.
suicidal ideation  Thoughts of engaging in suicidal behaviors; contemplating ending one’s own life. These thoughts may arise in people who feel completely hopeless or believe they can no longer cope with their life situation. Suicidal ideation can vary greatly from fleeting thoughts to preoccupation to detailed planning.

suicidal intent  Evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

suicidal plan  A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt, often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

suicide  Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

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

suicide risk assessment  The purpose of a suicide risk assessment in a healthcare setting is to manage the patient safely to the appropriate level of care. Clinicians may evaluate risk factors and protective factors with a focus on identifying modifiable targets for intervention. Clinicians may be concerned that asking about suicide will instigate suicidal thoughts or actions, but no data support this assumption. Instead, a patient may appreciate the opportunity to discuss suicidal thoughts. Sometimes the only clue a patient gives to being suicidal is expressed to a clinician during an office visit. Evidence-based tools exist to prompt the patient to verbalize these issues.

PHS patients may be screened initially when asked question number nine from the Patient Health Questionnaire Nine Item (PHQ-9) – “Over the last two weeks, how often have you been bothered by thoughts you would be better off dead or of hurting yourself in some way?” Patients who screen positive are subsequently assessed using six questions from the Columbia-Suicide Severity Rating Scale (C-SSRS) that can evaluate the suicide risk as minimal, moderate, and high.

Evidence/Resources

The Columbia Suicide Severity Rating Scale (C-SSRS): Supporting Evidence (The Columbia Lighthouse Project / Center for Suicide Risk Assessment) 2018

Additional References

Related Care Model Topics
- Depression in Adults

Clinical Practice Guidelines
- Clinical Triage Guidelines Using the C-SSRS

Training
- Detecting and treating suicide ideation (Joint Commission tip sheet)
- Suicide Prevention Toolkit for Primary Care Practices (SPRC)
- Suicide Risk Screening Ambulatory and Urgent Care (Epic tip sheet) [PHS login required]
- Suicide Risk Screening ED & Room Safety Check (Epic tip sheet) [PHS login required]

Policies and Procedures
- Behavioral Patients in the Emergency Department PC.PDS.277
- Patient Suicide Risk Prevention PC.PDS.179
- Suicide HH and Hospice PHH.PR.025

Other Resources
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Detecting and treating suicide ideation in all settings (Joint Commission)
- Joint Commission requirements relevant to suicide
- National Suicide Prevention Lifeline
- Suicide Prevention in Primary Care (SAMHSA)
- Suicide Prevention Program (NMDoH)
- Suicide Prevention Resource Center: New Mexico (SPRC)
- Suicide Risk Management Training for Clinicians (VA)
- Suicide: New Mexico Facts and Figures 2017 (AFSP)
- Zero Suicide in Health and Behavioral Health Care

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