This How-to guide offers actionable, evidence-based best practices on suicide prevention enabling primary care providers and other members of the care team to overcome key barriers to operationalizing integrated behavioral health care in their practice. This resource is reflective of the generous time and direction provided by numerous suicide prevention subject matter experts with firsthand experience effectively integrating behavioral health care within primary care practices.
Studies show that over 40% of patients contemplating suicide interact with their primary care provider within days of their death. However, primary care staff may feel unprepared to respond when a patient expresses suicidal ideation or behavior. It’s important to remember that feeling unprepared or anxious when faced with such a high-stakes clinical situation is normal. With advance preparation and proper training, primary care physicians and their care teams can effectively leverage their relationships with patients and play an important role in patient safety, suicide prevention, treatment, and recovery. Being prepared to spot the signs of suicide risk and knowing how to flag patients at risk can be done by any member of the care team and are critical first steps in establishing trust, ensuring safety, engaging others, and connecting patients with the most appropriate treatment plan.

This resource and webinar provide an action plan for practices as well as evidence-based resources to streamline that process.
Align the Team

All members of the care team, clinical and non-clinical, who communicate with the patient play an important role in the patient’s safety and helping them to feel heard by providing the best care, including referral when additional interventions beyond the practice’s capabilities are necessary.

When implementing an integrated plan for suicide prevention and treatment in your practice, it is essential to train your staff and modify workflows with best practices on how to recognize and appropriately respond to suicidal ideation with compassion. You can accomplish this goal with regular training through programs such as Safeside or SimplePractice and guidelines on how to avoid using stigmatizing terms and being mindful that words matter when speaking about suicide.

To increase confidence and ensure your suicide prevention and treatment policies are effective and meaningful, make key elements of your practice procedures easy to reference using the implementation checklist from the Suicide Prevention Resource Center, which includes an Office Protocol to visibly outline:

- What assessment tools will be used and when
- Who should be notified if a patient screens positive for suicidal ideation
- How and what to document as part of the process
- Safety protocol for imminent situations

TIP:
Proactively build strong, collaborative relationships with behavioral health experts to provide integrated care for patients. This resource from the Suicide Prevention Resource Center includes a customizable outreach letter that may make outreach easier for primary care staff to establish these clinical partnerships, which may be particularly challenging in small communities or rural settings.
Primary Roles + Responsibilities

Primary Care Providers (PCPs)
• Perform ongoing assessments at future visits.
• Deliver brief intervention using motivational interviewing (MI) techniques for patients who screen positive for unhealthy substance use.
• Identify patients for additional evaluation by behavioral health (BH) specialist.
• Consult with BH specialist on treatment plan.
• Prescribe and manage pharmacotherapy if deemed appropriate.
• Manage case through notes/follow-up calls.
• Model ideal suicide prevention protocols and provide agency to staff.

Medical Assistants, Nurses, or Administrative Staff
• Inquire about adversity in the person’s life, such as job loss, divorce, financial problems, etc.
• Administer screening and assessment tools.
• Flag any individuals who screen positive to the PCP and/or BH specialist for additional assessment.

Behavioral Health Specialists (on-site/on-call/virtual)
• Conduct further assessment, if needed.
• Determine and facilitate changes in treatment plan with PCP and patient, as clinically indicated.
• Provide brief interventions for patients (motivational interviewing, goal setting).
• If licensed, offer behavioral therapy to patients.
• Connect patients to social support services such as housing or transportation as needed.

Psychiatric Consultants (MD/DO)
• Review complex cases and assist with diagnoses as needed.
• Address complex mental health issues/co-occurring disorders.
• Consult on treatment plan for complex mental health issues/comorbidities that may fuel suicidal ideation.

TIP:
Foster a compassionate culture through Mindfulness Compassion Training that supports staff in creating a safe, non-judgmental space that builds trust with patients, encourages them to speak openly about suicidal ideation, and keeps them engaged in treatment and recovery.

Secondary Roles + Responsibilities

Case Managers
• Coordinate care between providers.
• Serve as system navigator for patients and families.
• Advocate for patients, such as helping them communicate with providers and insurers.
• Connect patients and caregivers to social support services.

Peer Support Specialists (either on staff or through organizations such as Live Through This and Connections)
• Follow up after missed appointments or with anyone at high risk.
• Share personal experiences.
• Encourage and motivate patients to advocate for themselves.
• Use dialogue and feedback to help patients overcome difficult life circumstances.
• Assume case manager responsibilities, when qualified, in some instances.

Caregivers (willing family member, friend, or entrusted party)
• Provide accountability – may aid in executing care plan.
• Offer support/guidance.
• Observe and communicate with care team.
Evaluation

In an integrated health model, the primary care team is responsible for identifying patients at risk of or actively contemplating suicide and gauging their receptivity to engage with a BH specialist for further assessment and treatment.

While some patients may disclose their true feelings, others may be too ashamed or even fear repercussions of disclosing their internal thoughts. So, the more personable the evaluation process feels, the more likely the patient is to speak freely.

Risk Factors

Psychological factors are the largest known contributors to suicidal ideation, yet these thoughts and behaviors are not solely attached to a behavioral health diagnosis.

Suicide can manifest due to a combination of genetic, developmental, environmental, physiological, psychological, social, and cultural factors operating through diverse, complex pathways, including:

- Previous or family history of suicide attempts or non-suicidal self-injurious behavior
- Psychiatric disorders (anxiety, bipolar, personality disorders, PTSD, SUD, etc.)
- Medical illness (chronic pain, traumatic brain injury, neurological disorders, etc.)
- Recent change in important relationships
- LGBTQIA+ self-identification
- Occupation status
- Financial or legal hardship
- Military service
- Childhood adversity
- Genetics
- Rural residence
- Firearms or other deadly weapons in home
- Antidepressants
WATCH OUT:
The PHQ-9 alone is insufficient to evaluate suicide risk and should not be used as the sole screening tool as part of an evidence-based suicide prevention protocol. However, if your practice regularly uses this tool for universal screening, it can identify patients who require further screening.

Warning Signs
Formal screening is a critical component to suicidal behavior, but not all patients feel comfortable answering questions honestly.

Therefore, in addition to being aware of what may predispose someone to self-harm, knowing and being observant of the following warning signs is equally important:

- Talking or writing about committing suicide, even jokingly
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or being in unbearable pain
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Acting anxious, agitated, or reckless
- Drastic personality changes and/or extreme mood swings
- Noticeable changes in eating or sleeping habits
- Withdrawal from family or friends
- Showing rage or talking about seeking revenge
- Giving away prized possessions
- Doing worse in school or work

Screening
Before screening begins, establish an environment of trust by sharing appreciation for the patient being there and describing your commitment to providing comprehensive, integrated care:

- Discuss your policy of screening all patients for a variety of conditions.
- Assure them they are welcome to answer, elaborate, or not answer any of the screening questions.
- Express gratitude and appreciation for responses shared and remind them that sharing information helps you work together to provide the best care.
- Assure the patient that the confidentiality of their information will be protected in compliance with federal and state laws.

TIP:
Administer screeners at home to make a patient feel more comfortable responding honestly. Consider sending screeners electronically with the appointment reminder and request they complete the questions within 24 hours of their appointment.

Once you’ve established an appropriate setting, anyone who is exhibiting risk factors, warning signs, or has expressed ideation should be screened with an evidence-based, suicide-specific tool. To accurately identify at-risk individuals and avoid confusion among staff, your practice should consistently use a single tool, such as:

- Columbia-Suicide Severity Rating Scale Screener for Primary Care
- asQ Suicide Risk Screening Tool for adults and children

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Assessment

Once a screener identifies an at-risk individual, a formal assessment should follow to evaluate severity and inform the initial treatment plan. The assessment should be administered in a private setting and periodically repeated to track how the individual is responding to intervention and treatment and whether a change in the plan is necessary.

- Columbia-Suicide Severity Rating Scale (C-SSRS) which is accompanied by an online training module created by the Center for Practice Innovation
- SAMHSA SAFE-T risk assessment tool with C-SSRS questions embedded and triage categories
- asQ Brief Suicide Safety Assessment for adults and children

Risk Severity

While most assessment tools have a risk stratification or triage plan imbedded, some criteria to be familiar with, or consider along with clinical judgment in identifying the best course of treatment, include:

<table>
<thead>
<tr>
<th>RISK SEVERITY</th>
<th>CRITERIA</th>
<th>RECOMMENDED LEVEL OF INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>Passive thoughts of death</td>
<td>Develop Safety Plan with the help of the Primary Care Provider or Behavioral Health Specialist</td>
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<tr>
<td></td>
<td>No “clear” suicidal intent</td>
<td>Brief Intervention to assess for coping skills and stressors/dangers</td>
</tr>
<tr>
<td></td>
<td>No specific or current suicide plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Modifiable risk factors</td>
<td></td>
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<tr>
<td></td>
<td>Has access to a support system (family, friends, care provider)</td>
<td></td>
</tr>
<tr>
<td>MODERATE</td>
<td>Suicidal ideation to die by suicide</td>
<td>Develop Safety Plan with the help of the Primary Care Provider or Behavioral Health Specialist</td>
</tr>
<tr>
<td></td>
<td>Highly ambivalent suicide plan</td>
<td>Brief Intervention to assess for coping skills and stressors/dangers</td>
</tr>
<tr>
<td></td>
<td>No access to lethal means</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Willing to comply with treatment recommendations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has access to a support system (family, friends, care provider)</td>
<td>Referral to Outpatient Treatment with the integrated behavioral health specialist</td>
</tr>
<tr>
<td>SEVERE/IMMINENT</td>
<td>Confirmed attempt with a lethal method or included steps to avoid detection</td>
<td>Designate an Observer until the patient has been safely transferred to the care of the behavioral health specialist</td>
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<tr>
<td></td>
<td>Specific suicide plan</td>
<td>Brief Intervention by a Psychiatrist to assess immediate stressors/dangers and assure safety</td>
</tr>
<tr>
<td></td>
<td>Exhibiting suicidal preparatory behavior</td>
<td></td>
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<tr>
<td></td>
<td>Access to lethal means</td>
<td></td>
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<tr>
<td></td>
<td>Impaired judgment</td>
<td></td>
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<tr>
<td></td>
<td>Lack of engagement in care</td>
<td></td>
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<tr>
<td></td>
<td>Psychosis and/or chemical dependency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of family and/or poor social support network</td>
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Psychopharmacology

FDA-approved medications may be an appropriate consideration if depression, anxiety, psychosis, or excess negative feelings are contributing to suicidal thoughts.
Implementing Treatment

Even if the patient screens negative, document the findings in your EMR or designated health record system to track the patient’s wellness over time.

For those patients who screen positive, documentation of their assessment is essential for the integrated behavioral health team to reference when establishing a treatment plan and for providing a benchmark to measure patient progress over time.

If the primary care provider believes that a patient would benefit from integrated behavioral health services, or the patient requests support above what the PCP can or feels comfortable providing, an introduction to the behavioral health specialist should occur via warm handoff. From there, the BH specialist, with input from the primary care team, can create a customized treatment plan that addresses individual risk drivers.

Before establishing a treatment plan, the primary care team should reiterate their commitment to integrated behavioral health, praise the patient for honestly responding to the evaluation, and commence the warm handoff.

BEST PRACTICE: Maintain contact with patient through a dedicated member of the care team until higher level of care is implemented if a warm handoff is not possible and/or the patient is a no-show to their follow-up appointment.
Levels of Care

The following treatment modalities may be used alone or in conjunction with one another to tailor the treatment plan to the patient’s needs and willingness to engage.

Brief Intervention addresses the present situation. The BH team should screen the patient for any imminent safety concerns if one or more of the following strategies cannot be provided on the day of positive suicidal assessment:

- **Collaborative Safety Planning Intervention (SPI)**
  An intervention between trained clinician and suicidal individual that aims to mitigate acute risk by collaboratively completing a pre-determined list of potential coping strategies and a list of individuals or agencies to contact during or preceding suicidal crises to help lower the imminent risk of suicidal behavior.

- **Motivational Interviewing**
  A collaborative, goal-oriented style of communication with particular attention to language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.

- **Teachable Moment Brief Intervention (TMBl)**
  A suicide attempt is an opportunity to explore what the attempt meant and what it means to survive the suicidal attempt and help individuals identify the factors that contributed to their attempt and suicidal ideation to develop a safety plan.

- **Caring Contacts**
  A clinician or other caring individual sends eight or more messages of care, support, and connection to a suicidal individual over the course of a year or longer.

- **Attempted Suicide Short Intervention Program (ASSIP)**
  Over three sessions, the patient is video recorded telling his or her story of how they came to harm themselves. Then, an ASSIP-trained therapist and the patient/client view the recording together to develop safety planning strategies for avoiding future suicidal behavior.

Outpatient Services are ongoing interventions customized to the need and severity of risk to support a patient over time once immediate risks have been addressed:

- **Pharmacotherapy:**
  Certain drug classes such as mood-stabilizing agents (i.e., Lithium), antidepressants (i.e., Buproprion, Mirtazapine), and SSRIs (i.e., Sertaline, Escitalopram) are commonly used to address suicidality, whereas agents taken for comorbidities such as anxiety and depression (i.e., Alprazolam or Lexapro) can actually heighten thoughts of suicide and suicidal behavior. For primary care clinicians with limited experience prescribing and dosing for this condition, certain drug classes such as mood-stabilizers (i.e., Lithium), antidepressants (i.e., Buproprion, Mirtazapine), and SSRIs (i.e., Sertaline, Escitalopram) are used to address suicidality, whereas agents taken for comorbidities such as anxiety and depression (i.e., Alprazolam or Lexapro) can actually heighten thoughts of suicide and suicidal behavior. For primary care clinicians with limited experience prescribing and dosing for this condition, Alprazolam or Lexapro can actually heighten thoughts of suicide and suicidal behavior.

- **Behavioral Therapy**
  Can take place in individual or group settings, teaching patients the skills they need to navigate various situations that may lead to suicidal ideation:

- **Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP or CT-SP)**
  CBT techniques are used to identify risk factors and plan efficient and effective treatment for clients with suicide-related ideation and/or behaviors. This includes creating a relapse prevention protocol, whereby individuals participate in guided imagery exercises to rehearse what actions they can take instead of ending their life when the suicidal mode is activated.

- **Dialectical Behavior Therapy (DBT)**
  DBT utilizes four modes of treatment delivery: Individual Psychotherapy, CBT Skill Training, In-The-Moment Phone Coaching, and DBT Consultation Teams for Therapists to build skills and can be integrated into a variety of care environments, including the inpatient setting.

- **Collaborative Assessment and Management of Suicidality (CAMS)**
  CAMS is an intensive, suicide-specific framework that focuses on identifying the drivers, or triggers, that compel a person to consider suicide, creating a suicide stabilization plan and developing other means of coping and problem-solving to replace or eliminate thoughts of suicide.

**WATCH OUT:**

Avoid more than one month of medication refills, as it may result in too few follow-up appointments, which are necessary to evaluate treatment effectiveness.
Financial Considerations

Understanding how to bill for screening, evaluation, and treatment of patients experiencing suicidal ideation, including awareness of specific CPT codes, will help ensure the sustainability of a comprehensive suicide prevention and treatment protocol.

This Suicide Care Pathway Coding for Primary and Behavioral Health Care can be supplemented with the following billing code categories relevant to the assessment and treatment of patients with suicidal ideation.