



SUICIDE PREVENTION

HOW-TO GUIDE

This how-to guide offers actionable, evidence-based best practices on suicide prevention, enabling primary care physicians and other members of the care team to overcome key barriers to operationalizing integrated behavioral health (BH) 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 BH care within practices.



TERMINOLOGY:

- When “primary care physician (PCP)” is utilized in this document, it is inclusive of physicians across specialties—including family medicine, internal medicine, pediatrics, and obstetrics and gynecology. While not trained in primary care, non-primary care specialties, such as cardiology, gastroenterology, neurology, and oncology, can also benefit from integrating behavioral health into their practices to support their patients.
- While “patient” will be used throughout, note that this also encompasses the families and caregivers, who play an important role in integrated care.



CHILD AND ADOLESCENT

A Developmental Approach to Child and Adolescent Mental Health Care

PCPs who serve children and adolescents have a unique opportunity to promote healthy mental and emotional development and safe, stable, nurturing relationships in families. Mental health (MH) concerns manifest differently in children than in adults; as such, pediatric approaches to behavioral health integration (BHI) can differ compared to adult practices. To that end, we have included guidance specific to child and adolescent MH care where appropriate. This type of information will be noted with the icon above.

Introduction

Studies show that 50% of patients contemplating suicide interact with their PCP within 30 days of their death.ⁱ Further, patients who bear the burden of chronic disease are at increased risk for suicidal behavior.ⁱⁱ However, clinic 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 preparation and proper training, PCPs and their care teams can effectively leverage their relationships with patients to 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.



Seattle Children's Hospital and Nationwide Children's Hospital are two institutions that have implemented Zero Suicide initiatives.

- Seattle Children's Hospital created a [Zero Suicide Initiative Pathway](#) for use with children and youth presenting for care to allow for standardized processes for suicide risk screening and assessment for triage resources across the organization. Included are versions for use in the emergency department and within inpatient BH care.
- Nationwide Children's Hospital's experience implementing Zero Suicide is described in [this short video](#), where key factors to success are highlighted, such as leadership support and focused tools and training for staff, among others.



TIP: These BHI Collaborative webinars provide practical strategies, actionable steps, and evidence-based resources for identifying and addressing suicide risk:

- [Practical strategies for managing suicidal ideation and reducing risk](#)
- [Addressing adult suicidal ideation in the primary care setting](#)
- [Dismantling Stigma for All: Addressing Physician and Patient Mental Health Including Suicide Risk](#)

Align the Team

All members of the care team, clinical and nonclinical, 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 a 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. Trainings are available for a fee through programs such as [SafeSide Prevention](#) or [SimplePractice](#), along with free trainings on reducing access to lethal means from the [American Academy of Pediatrics \(AAP\)](#) and [ZeroSuicide Institute](#). There are also [guidelines](#) and [resources](#) on how to avoid using stigmatizing language 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 (SPRC), which includes an [Office Protocol](#) to visibly outline:

- What assessment tools will be used and when
- Who should be notified in the event 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 BH experts to provide integrated care for patients. The SPRC provides [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

The list below includes examples of potential responsibilities related to identifying and addressing suicide risk that each care team member may have:

Primary Care Physicians:

- Perform ongoing assessments at future visits
- Deliver brief intervention using [motivational interviewing \(MI\) techniques](#) for patients who screen positive for suicidal risk
- Identify patients for additional evaluation by BH clinician
- Consult with BH clinician 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 clinician for additional assessment

BH Clinician:

- Conduct further assessment, if needed
- Determine and facilitate changes in treatment plan with PCP and patient as clinically indicated
- Provide brief interventions for patients (MI, 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 MH issues/co-occurring disorders
- Consult on treatment plan for complex MH issues/comorbidities that may fuel suicidal ideation



TIP: Foster a compassionate culture through [mindfulness and compassion training](#) that supports staff in creating a safe, nonjudgmental 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 clinicians
- Serve as system navigator for patients
- Advocate for patients, such as helping them communicate with clinicians and insurers
- Connect patients to social support services

Peer Support Specialists:

(either on staff or through organizations such as [Live Through This](#))

- 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
- Can take on case manager responsibilities 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 clinician 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 BH diagnosis. Suicide can manifest due to a combination of genetic, developmental, environmental, physiological, psychological, social, and cultural factors operating through diverse, complex pathways,ⁱⁱⁱ 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 changes 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
- Domestic violence



TIP: Directly ask the patient, family, or caregiver (with patient's consent) about the above warning signs and risks, as patients often do not verbalize their thoughts or intentions unprompted.

Warning Signs

Formal screening is a critical component of identifying 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 the patient that they are welcome to answer, elaborate, or not answer any of the screening questions.
- Express gratitude and appreciation for responses shared and remind the patient 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: For adult patients, consider administering screeners at home to make them 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.



BEST PRACTICE: Screening recommendations for youth vary based on their age. Best practice is to screen all youth 12 years and up, screen youth ages 8–11 who present with an MH concern, and assess youth under age 8 for suicidal thoughts/behaviors if warning signs are present.

BEST PRACTICE: Communicating confidentiality and privacy through frank conversations with patients is important. Be prepared to answer questions about how their information will be accessed and/or shared. Let them know the practice is committed to confidentiality and has policies and training in place to ensure their information stays private. Also, consider engaging your electronic health record (EHR) vendor about establishing pathways to ensure patients’ preferences can be tracked and validated.



CALLOUT: For guidance on establishing a clinical pathway for suicide risk screening in primary care, the following resources provide a starting point:

- [A Clinical Pathway for Suicide Risk Screening in Adult Primary Care](#) by the National Institute of Mental Health (NIMH)
- [Clinical Pathway for Suicide Risk Screening in Adult Primary Care Settings: Special Recommendations](#) by the Journal of the Academy of Consultation-Liaison Psychiatry

Once you’ve established an appropriate setting, anyone who is exhibiting risk factors or 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 (age 12+)



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. *If a patient has a positive response to Q9 (Suicidality) of the PHQ-9, they should be further screened.*

Assessment

Once a screener identifies an at-risk individual, a formal assessment should follow to evaluate severity and inform the initial treatment. 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 Innovations (CPI)
- SAMHSA SAFE-T risk [assessment tool](#) with C-SSRS questions embedded and triage categories
- asQ Brief Suicide Safety Assessment for [adults](#) and [children](#) (age 8–24)



Risk Severity

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

RISK SEVERITY	CRITERIA	RECOMMENDED LEVEL OF INTERVENTION	
LOW	• Passive thoughts of death • No “clear” suicidal intent • No specific or current suicide plan • Modifiable risk factors • Has access to a support system (family, friends, care provider)	Develop Safety Plan with the help of the PCP, BH clinician, family, or caregiver. Brief Intervention to assess for coping skills and stressors/dangers.	Psychopharmacology FDA-approved medications may be an appropriate consideration if depression, anxiety, psychosis, or excess negative feelings are contributing to suicidal thoughts.
MODERATE	• Suicidal ideation to die by suicide • Highly ambivalent suicide plan • No access to lethal means • Willing to comply with treatment recommendations • Has access to a support system (family, friends, care provider)	Develop Safety Plan with the help of the PCP, BH clinician, family, or caregiver. Brief Intervention to assess for coping skills and stressors/dangers. Referral to Outpatient Treatment with the integrated BH clinician.	
SEVERE/ IMMINENT	• Confirmed attempt with a lethal method or included steps to avoid detection • Specific suicide plan • Exhibiting suicidal preparatory behavior • Access to lethal means • Impaired judgment • Lack of engagement in care • Psychosis and/or chemical dependency • Lack of family and/or poor social support network	Designate an Observer until the patient has been safely transferred to the care of the BH clinician. Brief Intervention by a psychiatrist to assess immediate stressors/dangers and ensure safety. Referral to Outpatient Treatment with the integrated BH clinician. Inpatient Therapy as a last resort if patient is thought to be a danger to themselves or others, is resistant to treatment, has a chemical dependency, or is unable to maintain safety without inpatient therapy. Develop Safety Plan with the help of the PCP, BH clinician, family, or caregiver to guide/focus treatment plan once immediate danger has been managed.	



For patients at immediate high risk for harm to self or others, the PCP and patient may agree to call EMS for safe transfer to the Emergency Department for further evaluation and possible inpatient admission.

For youth patients expressing suicide risk, the integrated team will conduct a full suicide safety assessment to determine next steps. For patients at immediate high risk for harm to self or others, the integrated team and patient may agree to call community crisis services (988) for safe transfer to the Emergency Department for further evaluation and possible inpatient submission.

Developing a Safety Plan

In the case of low or moderate risk, create a safety plan with the patient for managing future suicidal thoughts. A clinical staff member or BH clinician can create a safety plan with the patient and scan it into their chart for the PCP to review later with the patient. For a sample safety plan, reference the [Stanley-Brown Safety Plan](#).

Potential aspects to incorporate into a safety plan may include but are not limited to:

- Coping strategies to manage stress
- Means restriction (securing or removing lethal means)
- Asking safety questions such as: “Do you think you need help to keep yourself safe?”
 - A “no” response does not indicate that the patient is safe, but a “yes” is a reason to act immediately to ensure safety

Ongoing management is a key element of a safety plan as patients with a history of suicide attempts are more likely to have a repeated attempt(s). Frequency of suicide risk assessment (e.g., asQ) may increase to every visit (once every 1–3 months), and can be used to monitor symptoms and assist with updates to the safety plan.



BEST PRACTICE: The national [988 Suicide & Crisis Lifeline](#) provides a patient-focused access line, a toolkit, and other free resources:

- Patients do not need to be in crisis to call
- Everyone who answers the phone gets 40+ hours of training; however, not everyone is a professional MH clinician
- Phone tree allows those who are Spanish speaking (option 2) or LGBTQIA+ under age 25 (option 3) to be transferred to crisis lines specifically for those groups
- Options are available to text or chat (only available in English)
- Access is available to a mobile crisis unit (may be available to help with practice-based crisis calls)
- Connection to resources around social drivers of health (via 211) may be available
- Police may get involved – if the call meets the criteria for a “live rescue”
- Referral to resources or additional help is based on area code of call-in number



Implementing Treatment

Even if the patient screens negative, document the findings in your EHR 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 BH team to reference when establishing a treatment plan and providing a benchmark to measure patient progress over time.

If the PCP believes that a patient would benefit from integrated BH services, or the patient requests support above what the PCP can or feels comfortable providing, an introduction to the BH clinician should occur via warm handoff. From there, the BH clinician, 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.



TIP:
Initiate a virtual or in-person “warm handoff” using and practicing [this script](#) to facilitate an introduction to a BH clinician.



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 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 a trained clinician and a suicidal individual that aims to mitigate acute risk by collaboratively completing a predetermined 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.^{iv}
- **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.^v
- **Teachable Moment Brief Intervention (TMBI)**
A suicide attempt is an opportunity to explore what the attempt meant, examine what it means to survive the suicide 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.^{vi}
- **Attempted Suicide Short Intervention Program (ASSIP)**
Over three sessions, the patient is video recorded telling their story of how they came to harm themselves. Then, an ASSIP-trained therapist and the patient 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 (e.g., Lithium), antidepressants (e.g., Bupropion, Mirtazapine), and SSRIs (e.g., Sertraline, Escitalopram) are commonly used to address suicidality, whereas agents taken for comorbidities such as anxiety and depression (e.g., Alprazolam or Lexapro) can actually heighten thoughts of suicide and suicidal behavior. For primary care clinicians with limited experience prescribing and dosing for this BH condition, the [American Medical Association’s \(AMA’s\) Psychopharmacology How-to Guide](#) and [The Waco Guide](#), an evidence-based clinical decision resource, may increase clinician competency and confidence when prescribing treatment is deemed clinically and age-appropriate.

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 patients 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, DBT Skill Training, In-The-Moment Phone Coaching, and DBT Consultation Teams for Therapists to build skills. DBT 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.

Intensive Outpatient (IOP)/Partial Hospitalization Program (PHP) services are short-term, intensive, suicide-specific day and/or evening treatment services for patients who do not need 24-hour care but require more therapeutic support than can be provided in the individual outpatient counseling setting. Alternatively, IOP can be a step down from inpatient care, a PHP, or a Residential Treatment Program (RTP).

Residential/Inpatient Services provide highly structured, suicide-specific treatment at a level of care that is designed to meet the needs of individuals who have emotional and behavioral manifestations that put them at risk of harm to self or others or would otherwise render them unable to care for themselves.



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 AMA's [Behavioral Health Coding Resource](#) to identify the relevant codes for your practice.



ADDITIONAL CPT® CODES

Additional CPT® codes may be relevant for certain BH services provided. While this list is not exhaustive, it can serve as an additional resource:

99204-99205	Evaluation and management of a new patient in an office or outpatient location (45–59, 60–75 mins)
90785	Communication difficulties during the psychiatric procedure
90863	Pharmacological management
90846	Family psychotherapy without patient
90847	Family psychotherapy with patient
90849	Multifamily group psychotherapy

Practice Spotlight



BHI in Action: Suicide Prevention Case Study

An 18-year-old male under the care of his pediatrician since toddlerhood displayed signs of social skill issues and possible neurodivergence. Despite these challenges, he excelled academically until experiencing significant family disruptions, including the passing of his father and substance use issues with his mother. Coupled with his brother leaving for college, these traumatic events led to depression.

Initially resistant to therapy, the teen agreed to medication and an increased frequency of follow-up appointments to address his depression and suicidal ideation. By offering therapy within the practice and creating a connection through a warm handoff, the pediatrician was eventually able to introduce therapy to the teen's treatment plan. However, despite initial progress, the medication's effectiveness waned, and suicidal thoughts intensified.

The practice's child and adolescent psychiatrist was quickly involved, and adjusted the teen's medication regimen, providing ongoing management. Despite continuing on a cycle of improvement and setbacks, regular communication among the care team ensures timely interventions and provides a lifeline for the teen during challenging times. Whether it's the pediatrician calling to check in after a missed appointment or the therapist reaching out with a portal message, the coordinated efforts of the care team play a pivotal role in safeguarding the teen's well-being and keeping him on a positive trajectory.

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