Every 13 minutes, 1 person will die from suicide in the United States.

The suicide rate for individuals with serious mental illness and mood disorders, such as depression or bipolar disorder, is 25x that of the general public.

Males take their own lives at nearly 4x the rate of females and represent 77.9% of all suicides.

The highest rates of suicides (per 100,000):
- Ages 45-54
- Ages 75+

Second leading cause of death:
- Ages 15-24
- Ages 25-34

Suicidal thoughts, plans, and attempts increased for ages 18-25.
National Strategy for Suicide Prevention

• Developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention

• The National Strategy for Suicide Prevention (NSSP) is a comprehensive, multi-sectoral strategy to reduce suicide in America.

• Details 13 goals and 60 objectives for reducing suicide over 10 years, including:
  o Integrating suicide prevention into health care policies
  o Encouraging transformation of health care systems to prevent suicide
  o Changing the way the public talks about suicide and suicide prevention
  o Improving the quality of data on suicidal behaviors to develop increasingly effective prevention efforts
Most states are currently using the NSSP in revising and updating their state plan.

Some activity is occurring for every objective, particularly for youth suicide prevention.

Critical sectors for youth suicide prevention include behavioral health, juvenile justice, foster care, middle and high school, colleges, and transition age youth.

Efforts to integrate, coordinate and sustain youth suicide prevention efforts across sectors are challenging.
CDC Vital Signs: Suicide rising across the U.S. More than a mental health concern
**Problem:** Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

- Increase 38 - 58%
- Increase 31 - 37%
- Increase 19 - 30%
- Increase 6 - 18%
- Decrease 1%

Nearly 45,000 lives lost to suicide in 2016.

Suicide rates went up more than 30% in half of states since 1999.

More than half of people who died by suicide did not have a known mental health condition.
Percentage increases in state suicide rates

Top 10

<table>
<thead>
<tr>
<th>State</th>
<th>Sex</th>
<th>Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *</th>
<th>Modeled AAIPC †</th>
<th>Current Rate Change (State Rank) ‡</th>
<th>Overall Percent Change (State Rank) **</th>
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<tbody>
<tr>
<td>ND</td>
<td>Both</td>
<td>13.3 (n/a) 14.6 (+ 1.3) 16.0 (+ 1.4) 16.6 (+ 0.6) 18.4 (+ 1.9) 20.9 (+ 2.5)</td>
<td>+2.9 % (p&lt;01) 14</td>
<td>+7.6 (5)</td>
<td>+57.6 % (1)</td>
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<tr>
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<td>Male</td>
<td>21.4 (n/a) 24.6 (+ 3.2) 28.0 (+ 3.4) 27.1 (+ 0.9) 29.6 (+ 2.5) 32.7 (+ 3.0)</td>
<td>+2.5 % (p&lt;01)</td>
<td></td>
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<tr>
<td></td>
<td>Female</td>
<td>5.6 (n/a) 4.5 (- 1.0) 3.7 (- 0.8) 5.7 (+ 2.0) 6.7 (+ 1.0) 8.5 (+ 1.8)</td>
<td>+3.9 % n/s</td>
<td></td>
<td></td>
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<tr>
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<td>+2.4 % (p&lt;01) 18</td>
<td>+6.4 (9)</td>
<td>+48.6 % (2)</td>
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<tr>
<td></td>
<td>Male</td>
<td>23.6 (n/a) 28.3 (+ 4.6) 24.3 (- 4.0) 27.3 (+ 3.0) 31.0 (+ 3.7) 32.5 (+ 1.5)</td>
<td>+1.9 % (p&lt;05)</td>
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<td></td>
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<tr>
<td></td>
<td>Female</td>
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<td>+3.6 % (p&lt;01)</td>
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<td>+2.7 % (p&lt;05) 17</td>
<td>+6.5 (8)</td>
<td>+48.3 % (3)</td>
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<tr>
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<td>Male</td>
<td>22.5 (n/a) 21.1 (- 1.4) 21.7 (+ 0.6) 24.8 (+ 3.1) 25.4 (+ 0.8) 30.8 (+ 5.2)</td>
<td>+2.2 % (p&lt;05)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Female</td>
<td>5.3 (n/a) 4.8 (- 0.5) 5.9 (+ 1.0) 6.2 (+ 0.4) 6.6 (+ 0.4) 9.8 (+ 3.2)</td>
<td>+3.9 % (p&lt;05)</td>
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<td>+8.0 (3)</td>
<td>+46.5 % (4)</td>
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<td>Male</td>
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<td>+2.1 % (p&lt;05)</td>
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<td>Female</td>
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<tr>
<td>KS</td>
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<td>+2.2 % (p&lt;01) 19</td>
<td>+6.0 (11)</td>
<td>+45.0 % (5)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>22.7 (n/a) 25.0 (+ 2.3) 26.5 (+ 1.5) 25.6 (- 0.9) 29.1 (+ 3.5) 30.7 (+ 1.6)</td>
<td>+1.9 % (p&lt;01)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Female</td>
<td>4.6 (n/a) 6.0 (+ 1.4) 5.7 (- 0.3) 5.4 (+ 0.3) 6.8 (+ 1.4) 8.4 (+ 1.6)</td>
<td>+3.2 % (p&lt;05)</td>
<td></td>
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<tr>
<td>SD</td>
<td>Both</td>
<td>15.7 (n/a) 15.8 (+ 0.1) 17.1 (+ 1.3) 19.3 (+ 2.2) 19.7 (+ 0.4) 22.6 (+ 2.9)</td>
<td>+2.5 % (p&lt;01) 10</td>
<td>+7.0 (7)</td>
<td>+44.5 % (6)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>27.6 (n/a) 26.3 (- 1.3) 27.9 (+ 1.8) 30.1 (+ 2.2) 32.0 (+ 1.6) 33.6 (+ 1.8)</td>
<td>+1.8 % (p&lt;01)</td>
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<td></td>
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<tr>
<td></td>
<td>Female</td>
<td>4.2 (n/a) 5.8 (+ 1.6) 6.4 (+ 0.6) 8.3 (+ 2.0) 7.3 (- 1.0) 11.3 (+ 4.0)</td>
<td>+5.8 % (p&lt;01)</td>
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</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Sex</th>
<th>Age-Adjusted Annual Rate per 100,000 Persons [Change from Prior Period] *</th>
<th>Modeled AAPC †</th>
<th>Current State Rank ¤</th>
<th>Overall Rate Change (State Rank) ¶</th>
<th>Overall Percent Change (State Rank) **</th>
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<tr>
<td>ID</td>
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<td>18.3 (-0.9)</td>
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<td>21.9 (+0.3)</td>
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<tr>
<td></td>
<td>Male</td>
<td>28.4 (n/a)</td>
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<td>31.1 (-2.0)</td>
<td>34.9 (+3.8)</td>
<td>34.7 (-0.2)</td>
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<tr>
<td></td>
<td>Female</td>
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<td>6.1 (-1.1)</td>
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<td>9.0 (+2.9)</td>
<td>9.5 (+0.5)</td>
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<td></td>
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<td>22.9 (+1.9)</td>
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<td>3.6 (n/a)</td>
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<td>5.1 (+0.4)</td>
<td>5.8 (+0.6)</td>
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<tr>
<td>WY</td>
<td>Both</td>
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<td>23.4 (+2.7)</td>
<td>22.5 (-0.9)</td>
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<td>28.9 (+3.5)</td>
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<tr>
<td></td>
<td>Male</td>
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<td>39.3 (+4.5)</td>
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<td>41.5 (+5.2)</td>
<td>47.1 (+5.6)</td>
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<td>9.4 (+0.2)</td>
<td>10.7 (+1.4)</td>
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<td>16.0 (+1.1)</td>
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<tr>
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<td>Male</td>
<td>21.3 (n/a)</td>
<td>22.5 (+1.2)</td>
<td>22.3 (-0.1)</td>
<td>24.6 (+2.2)</td>
<td>26.1 (+1.5)</td>
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<tr>
<td></td>
<td>Female</td>
<td>5.4 (n/a)</td>
<td>4.7 (-0.7)</td>
<td>6.0 (+1.3)</td>
<td>6.2 (+0.2)</td>
<td>7.0 (+0.8)</td>
</tr>
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</table>
Youth Suicide Statistics

• In 2016, 5,723 of the 44,965 Americans who died by suicide were between the ages of 15-24

• An additional 436 were between the ages of 10-14

• Suicide is the second leading cause of death between ages 10-24

• Highest rate of youth suicide is in Alaska - 45.6 versus 13.2 for the nation as a whole
<table>
<thead>
<tr>
<th>Rank</th>
<th>10-14 years</th>
<th>15-19 years</th>
<th>20-29 years</th>
<th>30-39 years</th>
<th>40-49 years</th>
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<td>1</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Unintentional Injuries</td>
<td>Malignant Neoplasms</td>
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<td><strong>Suicide</strong></td>
<td><strong>Suicide</strong></td>
<td><strong>Suicide</strong></td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
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<td>Homicide</td>
<td>Homicide</td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
<td>Unintentional Injuries</td>
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<td>4</td>
<td>Homicide</td>
<td>Malignant Neoplasms</td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
<td><strong>Suicide</strong></td>
<td>Liver Disease</td>
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<td>5</td>
<td>Congenital Malformations</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Homicide</td>
<td>Liver Disease</td>
<td>Chronic Lower Respiratory Ds</td>
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<td>6</td>
<td>Heart Disease</td>
<td>Congenital Malformations</td>
<td>Diabetes Mellitus</td>
<td>Liver Disease</td>
<td>Diabetes Mellitus</td>
<td>Diabetes Mellitus</td>
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<td>Chronic Lower Respiratory Ds</td>
<td>Chronic Lower Respiratory Ds</td>
<td>Congenital Malformations</td>
<td>Diabetes Mellitus</td>
<td>Cerebro-Vascular</td>
<td><strong>Suicide</strong></td>
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<tr>
<td>8</td>
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<td>Cerebro-Vascular</td>
<td>Complicated pregnancy</td>
<td>Cerebro-Vascular</td>
<td>Homicide</td>
<td>Cerebro-Vascular</td>
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Source: CDC vital statistics
Suicide rates among all persons by age and sex—United States, 2016

Source: CDC vital statistics
Suicide rates by ethnicity and age group -- United States, 2012-2016

<table>
<thead>
<tr>
<th>Age Group in years</th>
<th>Eur-Amer NonLatino</th>
<th>Afr-Amer NonLatino</th>
<th>Native American Non-Latino</th>
<th>Asian-PI Non-Latino</th>
<th>Latino</th>
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<td>00-04</td>
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<td>65+</td>
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</tr>
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</table>

Source: CDC Vital Statistics
Statistics

Suicide Rate by Age for American Indian/Alaska Native Compared to United States (Average 2000–2013)

Source: WISQARS Fatal Injury Reports, 1999–2013
Suicide by method among persons aged 10-24 years – United States, 2016

- Firearms: 46.2%
- Suffocation: 38.1%
- Other: 5.3%
- Poisoning: 7.2%
- Fall: 3.2%

Source: CDC vital statistics
Suicide rates among persons aged 10-24 years by state -- United States, 2016 (U.S. avg 9.4)

Source: CDC vital statistics
Suicide rates among persons aged 10-24 years by age group – U.S., 1999-2016

Source: CDC vital statistics
Self-inflicted injury among all persons by age and sex--United States, 2015

Source: CDC WISQARS NEISS
Suicidal ideation and behavior among high school students by category and sex* -- United States, 2015

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of all students</th>
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</thead>
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<tr>
<td>Seriously consider suicide</td>
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<tr>
<td>Suicide plan</td>
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</tr>
<tr>
<td>Attempted suicide</td>
<td></td>
</tr>
<tr>
<td>Suicide attempt with medical</td>
<td></td>
</tr>
</tbody>
</table>

Source: CDC Youth Risk Behavior Survey
* During the 12 months preceding the survey
^One or more times
Percentage of high school students who report suicidal behavior* by sex – U.S., 1990-2015

Source: Youth Risk Behavior Surveillance System

*At least one attempt during the 12 months preceding the survey
• Garrett Lee Smith State and Tribal Youth Suicide Prevention grants (age 10-24)
• Since 2005, every state has received at least one grant
• Cross site evaluation has shown decrease in youth suicide deaths and attempts compared to matched counties year following implementation
THE IMPACT OF GLS SUICIDE PREVENTION PROGRAM ON YOUTH SUICIDAL BEHAVIOR

Lucas Godoy Garraza (ICF International); Christine Walrath (ICF International); David Goldston (Duke CSSPI); Hailey Reid (ICF International), Richard McKeon (SAMHSA)
Results: Difference in Suicide Mortality

Solid lines represent the estimated outcome trajectory following GLS training implementation. Dashed lines represent the estimated outcome trajectory during the same period had GLS not been implemented. 90% and 50% confidence intervals around the trajectory are represented by dark gray and light gray, respectively.
Results: Difference in Nonfatal Attempts

Solid lines represent the estimated outcome trajectory following GLS training implementation. Dashed lines represent the estimated outcome trajectory during the same period had GLS not been implemented. 90% and 50% confidence intervals around the trajectory are represented by dark gray and light gray, respectively.
Improving Post Discharge Safety

• The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) demonstrated reduction in suicidal behavior for suicidal people discharged from EDs doing telephonic follow up.

• White Mountain Apache/Johns Hopkins University Center for American Indian Health
  o Almost 40% reduction in suicides from 2006-2012
  o Centerpiece is tribally mandated reporting and follow up
Preventing Suicide: A Toolkit for High Schools

- Assists schools in designing and implementing strategies to prevent suicide and promote behavioral health

- Includes tools to implement a multifaceted suicide prevention program that responds to the needs and cultures of students
NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org
The Elements of Zero Suicide in a Health Care Organization

*Continuous Quality Improvement

Create a leadership-driven, safety-oriented culture

Pathway to Care
- Identify and assess risk
  - Screen
  - Assess
- Evidence-based care
  - Safety Plan
  - Restrict Lethal Means
  - Treat Suicidality and MI
- Continuous support as needed

Electronic Health Record
A System-Wide Approach Saved Lives: Henry Ford Health System

Launch: Perfect Depression Care

Suicide Deaths/100k HMO Members

Education Development Center Inc. ©2015 All Rights Reserved.
Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

“The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.”
WITHOUT IMPROVED SUICIDE CARE, PEOPLE SLIP THROUGH GAPS

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

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THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

Suicidal Person

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

- Collaborative Safety Plan

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

- Collaborative Safety Plan

- Treat Suicidal Thoughts and Behavior

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Adapted from James Reason's “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
Resource: Using the C-SSRS

Access at: www.zerosuicide.com
ASQ-Ask Suicide Screening Questions

- In the past few weeks, have you wished you were dead? Yes/No
- In the past few weeks have you felt that you or your family would be better off if you were dead? Yes/No
- In the past week, have you been having thoughts about killing yourself? Yes/No
- If yes, how? When?

If yes to any of the above, ask acuity question:
- Are you having thoughts about killing yourself right now?
ASQ-Ask Suicide Screening Questions

• If yes to question 5- imminent risk-stat safety/full mental health evaluation-can’t leave until evaluated for safety-keep in sight- remove all dangerous articles from room- alert physician or clinician responsible for care.

• If no to 5 but yes to any 1-4
• Brief safety assessment to determine if full mental health evaluation is needed-alert physician or clinician

Give to all
• Lifeline -800-273-(TALK)-8255
• Crisis Text Line- Text “HOME” to 741-741
ASQ-Ask Suicide Screening Toolkit

- ASQ information sheet
- ASQ tool
- Brief Suicide Safety Assessment Guide
- Nursing Script
- Parent Guardian Flyer
- Resource List
- Educational Videos
Suicide Assessment Five-step Evaluation Triage

RESOURCES
- Download this card and additional resources at www.sprc.org
- or at www.stopasuicide.org
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05–15–06.pdf

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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

SAFE-T
Suicide Assessment Five-step Evaluation and Triage

1. IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2. IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3. CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior and intent

4. DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk.

5. DOCUMENT
Assessment of risk, rationale, intervention and follow-up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)
Suicide Assessment Five-step Evaluation Triage

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change, for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS
   - Current/past psychiatric diagnoses (especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
   - Key symptoms: ideation, impulsivity, hopelessness, anxiety/patients, global implosion, command hallucinations
   - Suicide behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
   - Family history of suicide, attempts or Axis I psychiatric diagnoses requiring hospitalization
   - Precipitants (stressors): triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illnesses (e.g., CRS disorders, pain). History of abuse or neglect. Intoxication
   - Access to firearms

2. PROTECTIVE FACTORS
   - Protective factors, even if present, may not counteract significant acute risk
   - Internal ability to cope with stress, religious beliefs, frustration tolerance, absence of psychoses
   - External responsibility to children or beloved pets, positive therapeutic relationships, social support

3. SUICIDE INQUIRY
   - Specific questioning about thoughts, plans, behaviors, intent
   - Ideation: frequency, intensity, duration... last 72 hours, past month and worst ever
   - Plan: timing, location, lethality, availability, preparatory acts
   - Behavior: past attempts, aborted attempts, risk variables (tying noose, loading gun), vs. non-suicidal self-injurious actions
   - Intent to intent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
   - Explore ambivalence: reasons to die vs. reasons to live
   - Explore impulsivity: when indicated, esp. precipitants, and is character disordered or parasuicidal may dealing with loss or humiliation.

   Inquire in four areas listed above.

4. RISK LEVEL/INTERVENTION
   - Assessment of risk level is based on clinical judgment, after completing steps 1-3
   - Readiness as patient or environmental circumstances change

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric diagnosis with severe disturbance, or local precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide plan</td>
<td>Admission generally, medication unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal thoughts without plan, but no intent or behavior</td>
<td>Referral crisis center, crisis lines, diagnosis, contact with significant others, accommodation. Referral instructions. If emergent, follow-up plan</td>
</tr>
<tr>
<td>Low</td>
<td>Minimal risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Referral crisis center, crisis lines. Medication. Assessment of priority and suicide risk.</td>
</tr>
</tbody>
</table>

(Risk chart is intended to represent a range of risk levels and interventions. Not intended for clinical decisions.)

5. DOCUMENT: Risk level and rationale, treatment plan to address/reduce current risk (i.e., medication, setting, C.T., contact with significant others, consultation). Referral instructions. If emergent, follow-up plan

Substance Abuse and Mental Health Services Administration
Suicide Prevention App for Health Care Providers

Suicide Safe Helps Providers:

- Integrate suicide prevention strategies into practice and address suicide risk
- Learn how to use the SAFE-T approach
- Explore interactive sample case studies
- Quickly access and share information and resources
- Browse conversation starters
- Locate treatment options

Learn more at bit.ly/suicide_safe.

Free for Apple® and Android™ mobile devices
Assessing and Managing Suicide Risk

http://www.sprc.org/training-events/amsr
Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com
Resource: Structured Follow-up and Monitoring

Access at: www.zerosuicide.com
Thank you.

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

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