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Suicide Awareness, Assessment and Intervention for Allied Health Professionals

Module 2: Suicide Screening

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Disclosures

- **Presenter Disclosure:** Financial: Angela Moss received an honorarium for presenting this course. Nika Ball is an employee of continued.com. Non-financial: Nika Ball and Angela Moss have no relevant non-financial relationships to disclose.
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Learning Objectives

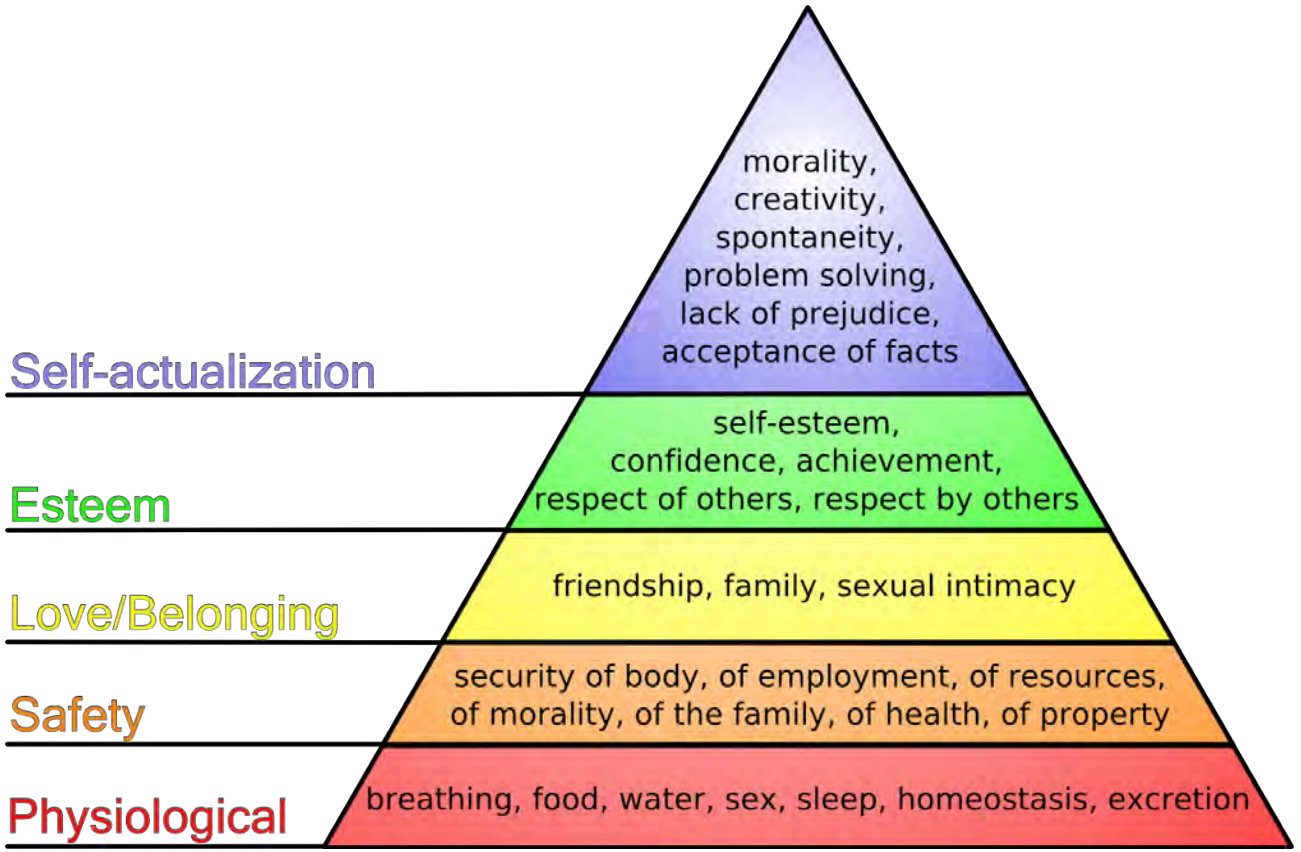
At the completion of this 75 minute module, participants will be able to:

- Identify at least 3 clinical comorbidities related to suicide
- Describe at least 3 suicide risk screening tools and differentiate which tools are best suited for varying clinical scenarios and patient populations
- Identify appropriate assessment strategies and resources related to suicide for specific high risk groups

Introduction

- Suicide affects all ages, races/ethnicities, socioeconomic groups, educational levels, and geographies
- An estimated one in seven people have been affected by suicide
- In addition to emotional cost, suicide and suicide attempts cost about $70 billion a year in combined medical and work loss costs
- Suicide rates are rising rapidly thus awareness and prevention are critical for health professionals

Maslow's Hierarchy of Needs



Comorbidities

- Major depression and other mood disorders including:
  - -Bipolar Disorder (previously called manic depressive disorder)
  - -Postpartum depression
  - -Seasonal depression
- Chronic medical illness
- Post traumatic stress disorder (PTSD)
- Substance abuse

Major Depression

People feel sad or blue when bad things happen - BUT - people typically cope and soon recover without treatment

- Everyday “blues” or sadness is not a depressive disorder
- Major or clinical depression is when depressive symptoms persist nearly every day for at least two weeks
- Hopeless feelings contribute to suicidal risk in persons with depression

Major Depression

- Believed to be caused by a decrease in neurotransmitters in the brain - many antidepressant medications work by changing the activity of neurotransmitters in the brain
- 2016 data regarding major depression found that:
  - -Approximately 16.2 million adults experienced a major depressive episode, representing 6.7% of all U.S. adults
  - -Prevalence was higher among adult females (8.5%) compared to males (4.8)
  - -Ages 18-25 have the highest prevalence (10.9%) of all age groups

Symptoms of Depression

A person who is clinically depressed would have at least one of these two symptoms, nearly every day, for at least two weeks:

- An unusually sad mood
- Loss of enjoyment and interest in activities that used to be enjoyable

Symptoms of Depression

Other symptoms include:

- Lack of energy and tiredness
- Feeling worthless or feeling guilty though not really at fault
- Thinking often about death or wishing to be dead
- Difficulty concentrating or making decisions
- Moving more slowly or sometimes becoming agitated and unable to settle

Causes of Depression

Depression has no single cause. The interaction of many diverse biological, psychological and social factors can contribute to depression. These include:

- A breakup of a relationship or living in conflict
- Long-term poverty
- Loss of a job or difficulty finding a new one
- Having an accident that results in long-term disability
- Bullying or victimization
- Being a victim of crime
- Developing a long-term physical illness
- Death of a partner, family member, or friend
- Caring full-time for a person with a long-term disability
- The effects of medical conditions such as Parkinson's disease, Huntington's disease, Traumatic brain injury, Stroke, Hypothyroidism, Systemic lupus erythematosus
- Having a baby
- Side effects of certain medications or drugs
- Stress of having another mental disorder such as schizophrenia, an anxiety disorder, or an eating disorder
- Intoxication or withdrawal from alcohol or other drugs
- Premenstrual changes in hormone levels
- Lack of exposure to bright light in the winter months

Other Mood Disorders

Bipolar Disorder:

- ~2.8% of U.S. adults experience bipolar disorder in any given year
- Equally common in males and females
- Characterized by extreme mood swings between periods of depression and mania

Other Mood Disorders

Postpartum Depression:

- ~21.9% of women will experience depression during their first postpartum year
- Contributing factors are hormonal changes, physical changes, and the responsibilities of caring for a baby
- Having “baby blues” is common, but when feelings last for two weeks or longer it may indicate a depressive disorder

Other Mood Disorders

Seasonal Affective Disorder (SAD):

- Characterized by a depressive illness during fall and winter months when there is less natural sunlight
- Generally lifts during spring and summer months

Chronic Medical Illness

- Any chronic medical illness can contribute to suicide risk due to feelings of hopelessness resulting from the illness
- There is a strong correlation between a medical illness' impact on activities of daily living, ability to participate in social activities, and suicide

Chronic Medical Illness

Chronic illnesses more commonly associated with suicide risk include:

- Arthritis
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Obesity
- Parkinson's Disease
- Huntington's Disease
- Traumatic Brain Injury
- Chronic Kidney Disease
- Chronic Pain
- Crohn's Disease
- HIV
- Hypothyroidism
- Multiple Sclerosis
- Stroke
- Systemic lupus erythematosus
- Ulcerative Colitis

Post Traumatic Stress Disorder (PTSD)

- A psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as:
  - -Natural disaster
  - -Serious accident
  - -Terrorist act
  - -War or combat
  - -Rape or other violent personal assault
- ~3.5% U.S. adults affected at any given time
- An estimated 1 in 11 people will experience PTSD in their lifetime

Post Traumatic Stress Disorder (PTSD)

People with PTSD are at higher risk for suicide because the pain caused by the trauma leads to persistent feelings of hopelessness and despair

•Less interest in activities previously enjoyed or feeling detached or estranged from others

Post Traumatic Stress Disorder (PTSD)

- Symptoms of PTSD include:

  -Intrusive thoughts such as repeated, involuntary memories, distressing dreams, or flashbacks of the traumatic event

  -Avoiding reminders of the traumatic event including avoiding people, places, activities, objects or situations that bring on distressing memories

  -Negative thoughts and feelings that may include ongoing and distorted beliefs about oneself or others

  -Ongoing fear, horror, anger, guilt, or shame

  -Less interest in activities previously enjoyed or feeling detached or estranged from others

  -Reactive symptoms including irritability and having angry outbursts, behaving recklessly, being easily startled, having problems concentrating or sleeping

Substance Abuse

- Defined as use of alcohol or other drugs which leads to problems with:
  - -Work
  - -School
  - -Home
  - -Health
  - -Legal System
- An intoxicated or impaired person has an increased risk for suicide because:
  - -Feelings of anxiety, depression and anger are intensified
  - -Effective coping strategies are inhibited
  - -A person is more likely to act on suicidal feelings

Substance Abuse

Symptoms of substance dependence are:

- Tolerance for the substance
- Problems with withdrawal symptoms
- Use of larger amounts over longer periods than intended
- Problems cutting down or controlling use
- A lot of time spent getting the substance, using it, or recovering from its effects
- Giving up or reducing important social, occupational or recreational activities
- Continued use of the substance despite knowing that use has negative consequences

Substance Abuse

- ~8% of the population age 12 and older has a substance use disorder in any given year
- Typically begins in adolescence or early adulthood, average onset age of 20
- More than twice as common in males than females
- Often co-occurs with mood, anxiety and psychotic disorders

  -People with a mood or anxiety disorder are two times more likely to have a substance abuse disorder

Screening Tools and Assessment

Screening Tools

- Useful for:
  - -Implementing standardized screening practices within specific groups or across populations
  - -Quantifying an individual's suicide risk
  - -Assessing individuals with comorbidities and/or risk factors but who are not displaying obvious warning signs
- A number of screening tools exist:
  - -Some are for general purposes, while others are designed for use with specific clinical populations or settings
  - -Some are psychometrically tested and widely disseminated, while others are not
  - -Some are available in the public domain, others are proprietary or used primarily in research
  - -Many focus on assessing depressive symptoms and do not assess comorbidities
- Screening tools should not replace simple assessment questions such as "are you thinking of harming yourself?" – particularly in acute situations

Screening Tools

General Population Tools:

The Patient Health Questionnaire-2 (PHQ-2)

- Contains 2 question – the first two questions from the PHQ-9
- Scores range from 0 to 3 for each question
- Maximum score of 6
- Screen with the complete PHQ if a positive PHQ-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

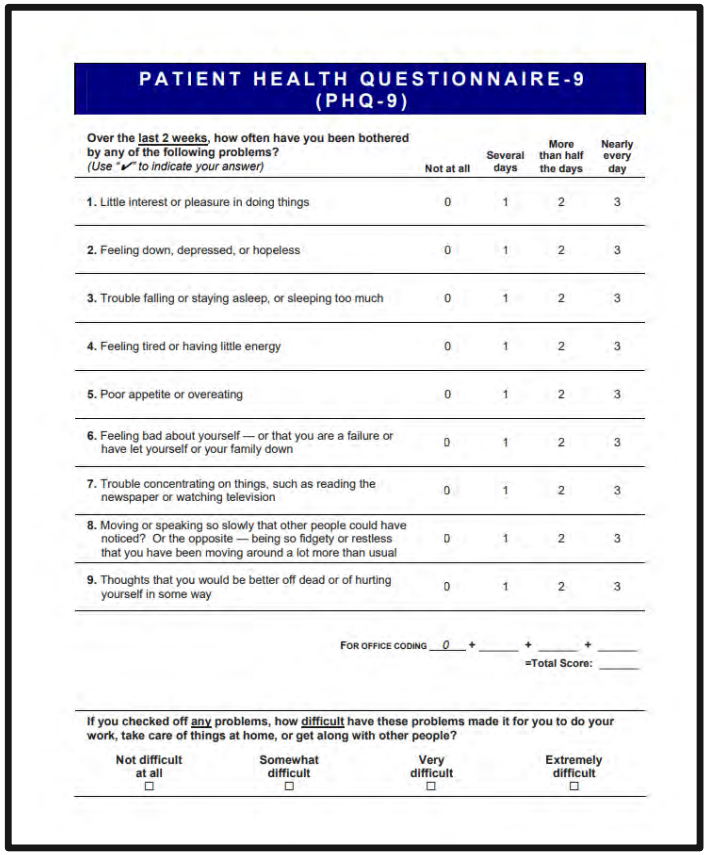
2. Feeling down, depressed, or hopeless

Screening Tools

General Population Tools:

The Patient Health Questionnaire-9 (PHQ-9)

- Contains 9 questions
- Scores range from 0 to 3 for each question
- Maximum score of 27
- Score of 10 or higher is considered to indicate mild major depression
- Score of 15 or higher indicates moderate major depression
- Score of 20 or higher indicates severe major depression
- Longer version of the PHQ-2



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

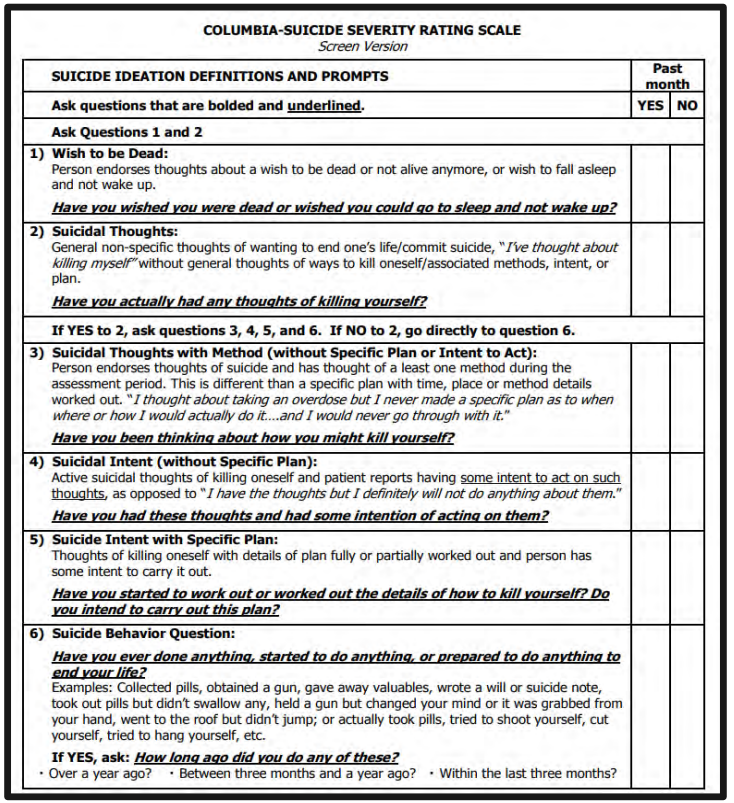
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Screening Tools

General Population Tools:

Columbia-Suicide Severity Rating Scale (C-SSRS)

- 6-item, plain-language questions used for suicide assessment
- Available in 114 country-specific languages
- Mental health training is not required to administer the C-SSRS
- Takes a few minutes to administer
- Decisions about hospitalization, counseling, referrals, and other actions are informed by the "yes/no" answers



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *How long ago did you do any of these?*** • Over a year ago? • Between three months and a year ago? • Within the last three months?		

Screening Tools

General Population Tools:

Depressive Symptom Inventory-Suicidality Subscale (DSI-SS)

- 4-item self-report questionnaire
- Each item is scored 0-4
- Higher score = higher risk
- Widely used, particularly on college campuses
- Takes about 2 minutes to complete

Suicide Behavior Questionnaire-Revised (SBQ-R)

- 4-item, self report questionnaire

Screening Tools

General Population Tools:

Beck Depression Inventory (BDI)

- 21-item, self-report inventory that measures characteristic attitudes and symptoms of depression
- Takes about 10 minutes to complete
- Reads at about 5-6 grade level

Beck Hopelessness Scale (HS)

- 20-item, self-report scale measuring negative attitudes about the future
- Originally developed to predict who would attempt suicide and who would not

Suicide Ideation Scale (SIS)

- Designed to quantify the intensity of current conscious suicidal intent
- 30-item scale, each statement graded 0-2
- Total score computed by adding individual item scores, higher score = higher risk
- Administered by a healthcare professional

Screening Tools

Youth & Adolescent Tools:

Ask Suicide-Screening Questions (ASQ) Toolkit for Youth

- Four screening questions
- Takes about 20 seconds to administer

Tool for Assessment of Suicide Risk Adolescent Version Modified (TASR-AM)

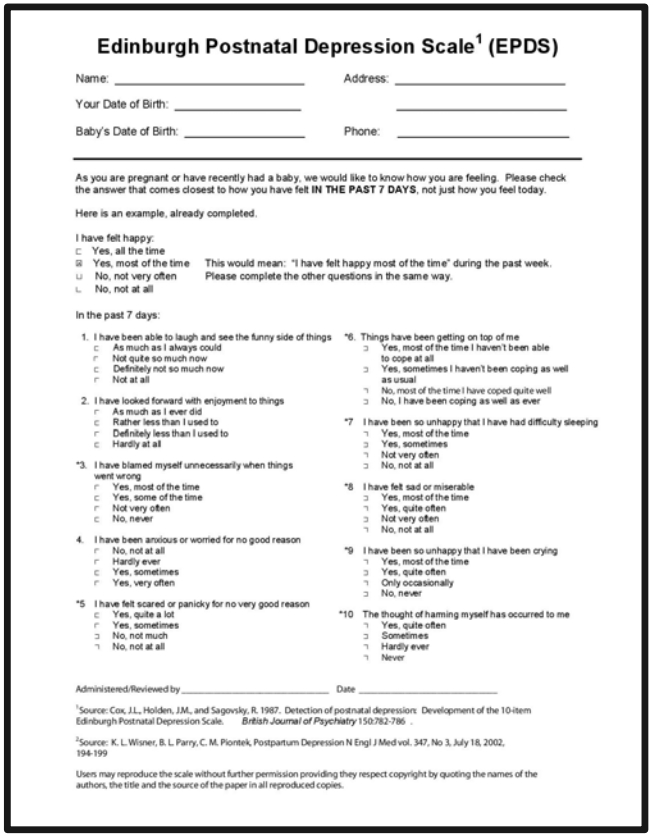
- 15-item scale with a rating to classify level of immediate suicide risk as high, moderate or low
- Completed by a healthcare provider

Screening Tools

Postpartum Tools:

The Edinburgh Postnatal Depression Scale (EPDS)

- 10-item, self-rated scale
- Designed specifically for women who are pregnant or have just had a baby
- Maximum score is 30, 10 or greater indicates possible depression
- One item specific to suicide risk
- Has also been shown to be an effective measure for general depression in the larger population



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- No, not very often — Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all
2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never
4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5 I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8 I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10 The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Screening Tools

Older Adults Tools:

The Geriatric Depression Scale (GDS)

- Long form = 30-item questionnaire which then led to the development of the short form
- Short form = 15-item questionnaire
- Short form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued
- Takes 5-7 minutes to complete

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

Scoring:

Assign one point for each of these answers:

1. NO	4. YES	7. NO	10. YES	13. NO
2. YES	5. NO	8. YES	11. NO	14. YES
3. YES	6. YES	9. YES	12. YES	15. YES

A score of 0 to 5 is normal. A score above 5 suggests depression.

Source:

- Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49.

Screening Tools

Tools for Minority Groups:

The Cultural Assessment of Risk for Suicide-Shortened (CARS-S)

- Tool that accounts for cultural competency across multiple cultural identities
- Addresses/assesses important differences in suicide presentation and risk among ethnic and sexual minority groups
- 14-item, 8-factor tool measuring depression, hopelessness, suicidal ideation, and lifetime suicide ideation, and lifetime suicide attempts
- The shorter version of the 36-item CARS tool

Screening Tools

Tools for Minority Groups:

The Cultural Assessment of Risk for Suicide (CARS)

- Tool that accounts for cultural competency across multiple cultural identities
- Addresses/assesses important differences in suicide presentation and risk among ethnic and sexual minority groups
- 39-item, 8-factor tool measuring depression, hopelessness, suicidal ideation, and lifetime suicide ideation, and lifetime suicide attempts
- Longer version of the CARS-2

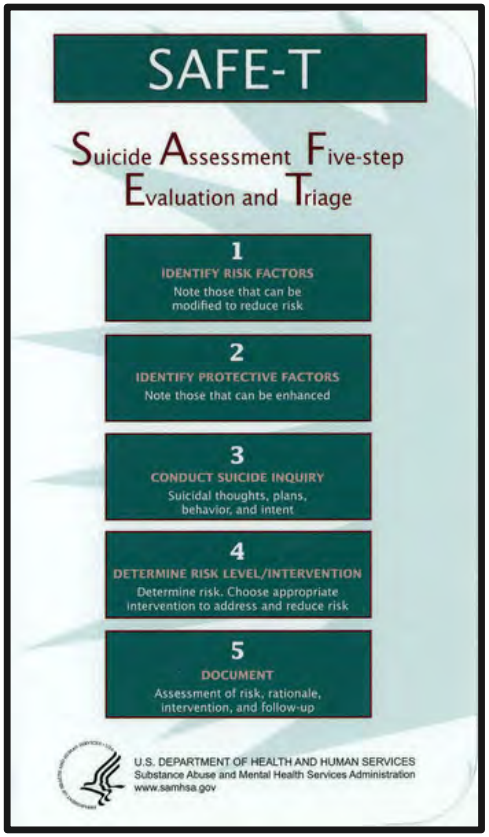
Electronic Health Records & Screening

- Electronic Health Records (EHRs) can be powerful screening tools
- Function as “early warning system” to alert clinicians about patients who should be assessed for suicide
- Algorithms assessing risk are based upon patient’s diagnoses, specifically comorbid conditions, and demographic characteristics recorded in the EHR
- Advocate for adoption at your organization

Assessment Tools

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

- Constructed as an assessment and triage tool for healthcare professionals
- Contains guidelines on risk factors to explore
- Presents stratified risk levels with accompanying recommendations
- Downloadable pocket card



Assessment for Acute Situations

- Consider whether the individual has risk factors or comorbid health problems
- Perform a quick assessment – NOTE – using a formal screening tool may be less useful in acute situations

  IF YOU SUSPECT SOMEONE MAY BE AT RISK FOR SUICIDE, IT IS IMPORTANT TO ASK DIRECTLY ABOUT SUICIDAL THOUGHTS

- To assess them, directly ask:

  "Are you having thoughts of suicide?"

  "Are you thinking about killing yourself?"

- Ask the question(s) without dread and without expressing a negative judgement

Assessment for Acute Situations

How to talk to someone who is suicidal:

- Tell the person that you care and you want to help
- Express sympathy
- Clearly state that thoughts of suicide often associated with a treatable mental disorder – this may instill a sense of hope
- Tell the person that thoughts of suicide are common and do not have to be acted on

Assessment for Acute Situations

- Encourage the person to do most of the talking
- It may be helpful to talk about specific problems the person is experiencing – LISTEN – but do not attempt to solve the problems

Assessment for Acute Situations

Three questions to determine if the person has definite intentions:

- "Have you decided how you would kill yourself?"
- "Have you decided when you would do it?"
- "Have you taken any steps to secure the things you would need to carry out your plan?"

Assessment for Acute Situations

- A higher level of planning indicates a more serious risk – BUT – absence of a plan does not ensure a person's safety

- Assess for other risk factors:
  - -Has the person been using alcohol or other drugs?
  - -Has the person made a suicide attempt in the past?

Assessment for Acute Situations

How to keep a person safe in acute situations:

AN ACTIVELY SUICIDAL PERSON SHOULD NOT BE LEFT ALONE

- If you cannot stay with the person, arrange for someone else to do so
- Give the person a safety contact available at all times, such as the National Suicide Prevention Hotline
- Call 9-1-1 if you are concerned about the person's immediate safety
- Help the person think about people or things that have helped in the past – possibly other healthcare providers, family or friends, church or support groups
- Seek assistance from law enforcement (call 9-1-1) if the person has a weapon or is behaving aggressively toward you

Case Studies

Case Study #1

Mr. T is a 47-yr-old veteran who suffers from post-traumatic stress disorder. He sustained an injury while in combat and is now on disability. He reports “feeling disconnected” because he’s moved back to his hometown and he hasn’t lived there in almost 25 years. He reports that he misses the camaraderie and the routine that was part of his military life. He was given information about local support groups for veterans but he “feels funny going because those are all guys in their ‘70’s and ‘80’s” and he feels out of place. He has started withdrawing from family and friends and reports increased pain as well as difficulty sleeping at night. His niece has been receiving an increased number of text messages from him in the past week that include phrases such as “In case I’m not around…” and “I’ve got some special things I’d like you to have to remember me by…”

Points To Consider

- What risk factors does he have?
- What warning signs is he displaying?
- Should you use a screening tool or assess for imminent risk of suicide?
- Ask what has helped in the past, counseling, connection with family, etc.
- Reinforce connectedness with others – tell him he's not alone and people are there to help him
- Make sure there are no weapons, pills, sharp objects, etc. in the house
- Determine whether to refer him to a mental health care provider, give him information on resources, stay with him

Case Study #2

Mrs. G is an 93-yr-old female who recently suffered a stroke with right upper extremity deficits and impaired ambulation. She previously had driven, completed her own grocery shopping and errands, completed her own housework, and attended religious services every week. She is using a walker and is homebound. She has difficulty cooking and completing housework but is able to manage all other home management tasks. She lives alone as her spouse recently passed away and she reports that they had just celebrated their 71st wedding anniversary. She has a large family and she states that they are very supportive but no one lives locally so she has no assistance with day-to-day needs. She reports she's very lonely during the week as she only sees family on the weekend when they are not working. She states that members from her church have offered to pick her up and take her to activities but she "doesn't want to be a burden on anyone" and wants to be able to drive herself again. Her family is worried that she may have suffered another stroke as she seems increasingly forgetful and now is having trouble managing her medications.

Points To Consider

- Multiple significant changes in her life recently
- Social support system
- Community resources
  - -Senior center
  - -Meals on Wheels
  - -Transportation options
- Depression can mask itself as dementia in the elderly
- Move to an Assisted Living Facility?

When To Refer

ALWAYS!! refer when you encounter a patient when:

- Multiple comorbidities are present
- Multiple risk factors are observed
- They are displaying warning signs
- They screen positive
- You assess them as acutely at risk

To whom to refer:

- Primary care provider
- Psychologist or psychiatrist
- Therapist
- Case manager
- Social worker
- Emergency services (9-1-1 or ED)

Summary

- Suicide is a public health problem and a leading cause of death
- Suicide does not discriminate, it affects all people
- Healthcare professionals are often the front line people to screen and assess for suicide risk
- To provide informed, evidence-based, and best practice care to all patients, ALL healthcare professionals must become educated to:
  - -Differentiate between risk factors and warning signs of suicide
  - -Develop a systematic suicide risk assessment strategy for all patient populations
  - -Develop a plan to practically manage acute suicidal crises in their clinical settings
- Healthcare professionals can advocate for suicide screening and assessment policies and procedures within their organizations

Resources

- National Suicide Prevention Lifeline

  1-800-273-TALK (8255)

  A national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week

- Text **741-741** if in crisis to talk to a trained counselor 24 hours a day, 7 days a week

- Online Resources

  www.Suicide.org

  www.CDC.gov

- Local Resources

  Example: Chicago's Sip of Hope coffee shop

Resources

- American Foundation for Suicide Prevention (AFSP)
- American Association of Suicidology
- Substance Abuse and Mental Health Services Administration Suicide Prevention Program (SAMHSA)

Resources

- Indian Health Service Suicide Prevention Program
- National Alliance for Suicide Prevention
- National Child Traumatic Stress Network
- National Institute of Mental Health
- U.S Department of Defense Suicide Prevention Office
- U.S. Department of Veterans Affairs (VA) Suicide Prevention

Cultural Competence

- For additional information regarding standards and indicators for cultural competence, please review the NASW resource: ***Standards and Indicators for Cultural Competence in Social Work Practice***
  https://www.socialworkers.org/LinkClick.aspx?fileticket=7dVckZAYUmk=&portalid=0

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