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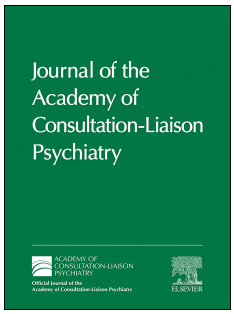

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Clinical Pathway for Suicide Risk Screening in Adult Primary Care Settings: Special Recommendations

Lynsay Ayer*[a], Lisa M. Horowitz[b], Lisa Colpe[b], Nathan J. Lowry[b], Patrick C. Ryan[b], Edwin Boudreaux[c], Virna Little[d], Stephen Erban[c], Soett Ramirez-Estrada[e], Michael Schoenbaum[b]

*Corresponding Author: Lynsay_ayer@rand.org

[a] RAND Corporation, 1200 South Hayes St., Arlington, VA 22202, USA

[b] National Institute of Mental Health, 6001 Executive Blvd., North Bethesda, MD, 20852, USA

[c] University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655, USA

[d] Concert Health, 550 W B St 4th Floor, San Diego, CA 92101, USA

[e] Conviva Care Center, 7686 Nob Hill Road, Tamarac, FL 33321, USA

Abstract

Suicide is a serious public health concern. On average, 80% of suicide decedents had contact with primary care within one year of their suicide. This and other research underscore the importance of screening for suicide risk within primary care settings, and implementation of suicide risk screening is already underway in many practices. However, while primary care practices may be familiar with screening for other mental health concerns (e.g., depression), many feel uncomfortable or unprepared for suicide risk screening. To meet the increasing demand for evidence-based suicide-risk screening guidance, we provide a clinical pathway for adult primary care practices (to include family medicine, internal medicine, women's health). The pathway was developed by experts with research, clinical expertise and experience in suicide risk screening and primary care. We also provide detailed guidance to aid primary care practices in their decisions about how to implement the clinical pathway.

Keywords: primary care, suicide, screening, pathway, adult, workflow

Introduction

Converging evidence suggests that suicide risk screening in general medical settings like primary care could substantially improve risk identification and suicide prevention in adults. The National Center for Health Statistics estimates that 89.4% of adults in the US visited any health care provider (including but not limited to primary care) in 2019 (1). A recent systematic review found that on average, 80% and 44% of suicide decedents had contact with primary care within one year and one month of suicide, respectively (2). In contrast, 31% of suicide decedents had contact with mental health care in the year prior to death. These data emphasize that primary care visits present a key opportunity to implement critical, potentially life-saving suicide risk screening (3). This positions the primary care setting as an ideal venue to identify people at risk for suicide and bridge them to mental health care.

Almost a decade ago, the U.S. Preventative Services Task Force (USPSTF) reviewed studies (published between 2002 and 2012) on suicide risk screening in primary care and concluded that the research to determine immediate benefits of primary care-based suicide risk screening were inconclusive (4). This reflects that research on identification and treatment of suicide risk has focused particularly on patients in emergency care settings, since that is modally where individuals at risk are directed and self-refer. Indeed, the prevalence of suicide risk is higher in emergency than primary care (17). Importantly, however, suicide risk screening instruments have been validated across inpatient and outpatient settings, and across psychiatric and general medical populations (5-8). Further, research has demonstrated that screening for suicide risk paired with plausibly scalable interventions in health care settings can reduce suicidal behavior (9). Together, this suggests that systematic suicide prevention efforts in primary care may be clinically beneficial.

Recent studies using a broader range of samples have enabled researchers to learn more about the acceptability of screening for and prevalence of suicide risk in various care settings (10-13). These studies have consistently found that implementing suicide risk screening protocols in primary care is feasible and increases detection of patients at risk for suicide who would have otherwise been missed. For example, a suicide risk screening study conducted in a rural primary care clinic found that most participants (96%) believed primary care providers should screen patients for suicide and 91% of patients rated the actual screening process as neutral or positive (14). The remaining 9% who rated the experience negatively registered fears that they would be judged negatively or that the screening made them uncomfortable.

While we recognize the need for additional research on the opportunities – and costs – of screening and other specific suicide prevention efforts in adult primary care settings, our current work is motivated by the fact that practitioners are already beginning to implement systematic screening in primary care, but without established, evidence-based clinical pathways to guide them. For example, Parkland Hospital System in Dallas, TX developed a quality improvement program to universally screen patients. They found that 3.9% of patients overall screened positive, across all their care settings, including screener positive rates of 6.3% among ED patients and 2.1% among patients in outpatient clinics (10). Similarly, the Veterans Administration recently implemented universal screening for suicide risk across its various care settings (15).

With increasing interest in and demand for suicide risk screening and assessment in primary care, we see practical and clinical value in offering evidence-informed guidance on how suicide prevention can be implemented systematically, particularly for practices which may not have the same infrastructure and resources afforded to larger hospital systems. For example,

what is the difference between "screening" and "assessing," and who should be screened and how often? What decision rules should be applied to manage patients with certain suicide risk screening scores, to address their needs and to minimize the chance of causing harm? Such recommendations have recently been published for suicide risk screening in certain other settings and populations (16, 17). Similar pathways assist providers in screening and treating conditions like lung cancer and substance use disorders (18, 19). However, comparable guidance for suicide risk screening in adult primary care practice is less developed and tends to focus on a specific screening tool.

To bridge this gap in clinical practice, we created a small *ad hoc* workgroup to develop a clinical pathway prototype for identification of suicide risk in adult patients presenting to primary care settings. All workgroup members – the authors here – were experts in suicide prevention and/or primary care. Most have led or participated in clinical trials involving identification and treatment of suicide risk, and implementation of specific suicide prevention and other mental health interventions in general medical settings. The workgroup drew on input from additional experts, as described further below (and per the Acknowledgements). The clinical pathway described explicitly includes flexibility in its various elements, reflecting our intent that this be a reference and starting point for primary care practices that decide to develop, improve, and implement screening and follow-up care protocols for patients at risk for suicide.

Material and Methods

Pathway Workgroup: While issues relating to identification and treatment of suicide risk in primary care have long been considered within health-care-focused suicide prevention efforts, as a practical matter, the discussions that turned into the current project began at a multistakeholder public meeting organized by the National Institute of Mental Health in 2017

(https://www.nimh.nih.gov/archive/events/2017/state-of-suicide-prevention-in-emergency-care). Participants heard about research and practice-based initiatives to implement systematic suicide risk screening, particularly in emergency care – the meeting's proximate focus – but also in additional health care settings. A recurrent theme of the presentations and associated discussion was the importance of standardized clinical pathways for such efforts and a general recognition that few such workflows had been articulated to date.

With this impetus, some of the participants at the NIMH meeting joined together to create an *ad hoc* group to consider potential next steps. Members reached out via their professional networks to additional colleagues with an interest in suicide prevention. Ultimately, several dozen people participated in some form, from multiple disciplines and types of organization (see Acknowledgements). Members participated in kind, except as noted in the Acknowledgements; the group was self-convening, i.e., not under the auspices of any existing organization. This group met periodically over several years, with discussion focusing mainly on two candidate workflows: universal (i.e., every patient at every encounter) suicide risk screening for adult in general hospital emergency departments, and "indicated" suicide risk screening for adults in primary care. Members anticipated that adult workflows could be adapted for children, such as adding steps to comply with a given jurisdiction's age of medical consent.

These initial efforts did not yield final products. Some members from this group joined with others to develop and publish pathways for suicide risk screening in certain pediatric settings (16); and another subset regrouped in 2020 with the aim of finalizing a screening pathway for adults in primary care, reported here.

Pathway Development: The co-authors of this manuscript reviewed the primary care and psychiatric literature, including grey literature, to identify studies and other, related clinical

pathways that could inform the development of a suicide risk screening clinical pathway for adult primary care settings. We relied upon expert opinion of workgroup members when empirical evidence was insufficient to inform certain aspects of the clinical pathway.

The authors met periodically via telephone or videoconferencing to develop and refine the pathway. Differences of opinion were resolved through additional discussions over email and telephone. We did not follow a formal decision-making process; rather, we pursued, and reached, consensus throughout (except as noted below). The overall goal of ensuring the pathway would be generalizable helped to mitigate disagreement over specific details that may apply only in certain situations, screening tools, or settings. An initial draft of the clinical pathway was shared with an expert group of primary care clinicians. Their feedback was incorporated into the final version reported here, and they are among the authors.

As noted above, the group's aim was to offer a clinical pathway for screening adult primary care patients for suicide risk that could serve as a resource for primary care clinicians or practices who were considering how to implement such screening. We imagine that such as reference pathway might represent a kind of economy of scale for primary care stakeholders, as many participants in NIMH's 2017 meeting had articulated. We emphasize that some details must be decided locally, such as the specific suicide risk screening instrument to use.

Results

The workgroup ultimately produced three documents that will provide guidance for primary care practices interested in implementing suicide risk screening: An Introductory Document (Appendix A), Pathway Diagram (Appendix B), and Implementation Guidance (Appendix C).

Introductory Document

The Introductory Document (Appendix A) is intended to provide an epidemiological justification for implementing a 3-tiered suicide prevention platform in Primary Care settings. The section also aims to orient care providers, managers, and administrators to the approach taken by the pathway. It may serve as an 'elevator pitch' summary that those exploring the implementation of the pathway can provide to stakeholders at their organization to begin the process.

Pathway Diagram

The Pathway Diagram (Appendix B) provides a visual depiction of the recommended screening process and demonstrates the divergent and common pathways that can lead to low, moderate, and high/imminent risk. There is generic pathway diagram in Appendix B that can be used as a basis for primary care practices to design their screening protocol.

Implementation Guidance

Appendix C is a companion piece to the pathway diagram that contains information and guidance about *how* to conduct suicide risk screening in practice. The document outlines general principles of screening adults for suicide risk, key decisions and tradeoffs, as well as special considerations for unusual circumstances that may occur in practice along the way.

Discussion

Drawing on knowledge from previous research and a workgroup of experts, a suicide risk screening pathway for adults in primary care settings was developed (Appendix B). Given the dramatic increase in the suicide rate over the past several decades and the current prevalence of suicidal behavior in the adult population, pathways are crucial to ensure that individuals at risk

for suicide are identified and receive the help they need without overburdening a busy primary care practice.

To date, most efforts to incorporate universal screening practices have occurred in health systems that serve patients known to be higher risk (such as the VA Health system and emergency departments) or in hospital systems that include higher risk inpatient psychiatric and/or emergency department services along with outpatient care in their suicide risk screening protocols. However, systematic, evidence-based suicide risk screening in adult primary care settings has recently emerged as a promising area for suicide prevention (20, 21). Given that a considerable portion of adults who die by suicide present to a primary care physician in the months prior to their death (22, 23), screening in primary care represents an opportunity to identify individuals at risk and intervene.

To ensure screening is both accurate and feasible, supporting clinicians with evidence-based tools and clinical pathways is an important first step in reducing suicide. Importantly, the clinical pathway developed in this paper is intended to be flexible, allowing for sites to adapt the pathway into established primary care workflows. For example, this pathway can be used by healthcare systems implementing Zero Suicide or other comprehensive suicide prevention frameworks to assist their screening efforts; alternatively, the pathway can also be used by practices focusing more narrowly on managing patients that screen positive for suicide risk.

Limitations

The work presented in this paper should be considered with the following limitations in mind. While the pathway put forward in this article is based on evidence-based pathways for youth (16, 24), and based on observations from medical settings that are conducting effective

screening, it has not yet been tested through research. Future implementation research can be used to document and address barriers and facilitators to using the pathway. Studies are also needed to determine whether pathway utilization increases screening implementation fidelity and adherence to best practices as well as whether it improves timely identification of suicide risk and referral to appropriate care. Each setting will need to adapt the pathway to incorporate important nuances that fit into their own milieu. In addition, the process of developing this pathway did not strictly adhere to established expert consensus methods such as the Delphi approach (25). The pathway workgroup also acknowledges that ensuring that the pathway is culturally sensitive will be critically important and will need to be tested to ensure equitability for underserved and high risk populations.

Conclusions

Primary care providers are on the frontlines of the public health problem of suicide and are uniquely positioned to save lives. Utilizing a clinical pathway to identify and effectively manage those at risk for suicide can provide a roadmap for sustainable and feasible suicide prevention. To support ongoing efforts to standardize screening in primary care settings, a workgroup created a detailed, evidence-based clinical pathway to guide clinicians. This pathway is intentionally flexible and can be adapted to meet the needs of individual primary care workflows. Primary care settings present an invaluable opportunity to identify individuals at risk for suicide: this clinical pathway incorporates evidence-based strategies to further support frontline primary care physicians as partners in suicide prevention.

APPENDIX A: **Introduction to the Clinical Pathway for Suicide Risk Screening: Why Screen for Suicide in Primary Care?**

Background

Suicide is a leading cause of death worldwide. In 2019, almost 46,000 adults died by suicide in the United States, a number that has tripled since 1999 (26, 27). Suicide is the 4th leading cause of death for adults 18 to 65 years old. Notably, of adults who had died by suicide, 80% had contact with primary care within the year prior to their death and 44% in the month prior to their death (22, 28). This positions primary care settings as an ideal venue to identify patients at risk for suicide so that they can be linked to the care and supports that they need.

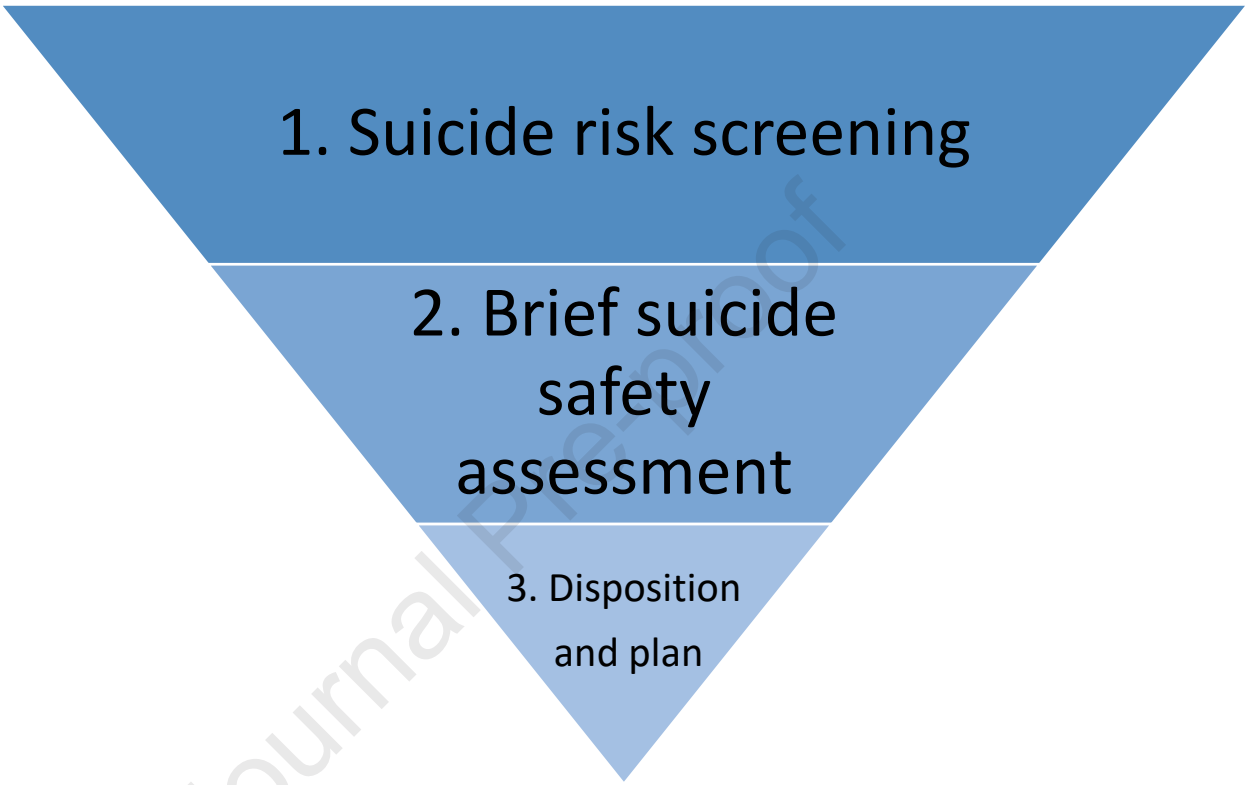
Development of a Clinical Pathway for Suicide Risk Screening

The Suicide Risk Screening clinical pathway material was generated to orient primary care providers, managers, and administrators to the tools needed to implement suicide risk screening procedures for their adult patients. A similar pathway for screening youth at risk for suicide has been developed separately (16).

This clinical pathway provides general guidance and considerations to take under advisement in screening adult patients for suicide risk in primary care in general, along with more specific recommendations for using common, validated suicide risk screening tools (i.e., the Ask Suicide-Screening Questions (ASQ (29)) and the Patient Health Questionnaire-9 (PHQ-9; (30)). Broadly, the pathway uses a three-step approach to screening (see Figure A.1.): Step 1) Brief screening for suicide risk at various intervals in an ongoing primary care cycle; Step 2) a brief suicide safety assessment for patients who score positively on a screener in step 1; and,

Step 3) determining disposition and course of action for patients determined to be at imminent risk, in need of further evaluation or at low risk for suicide.

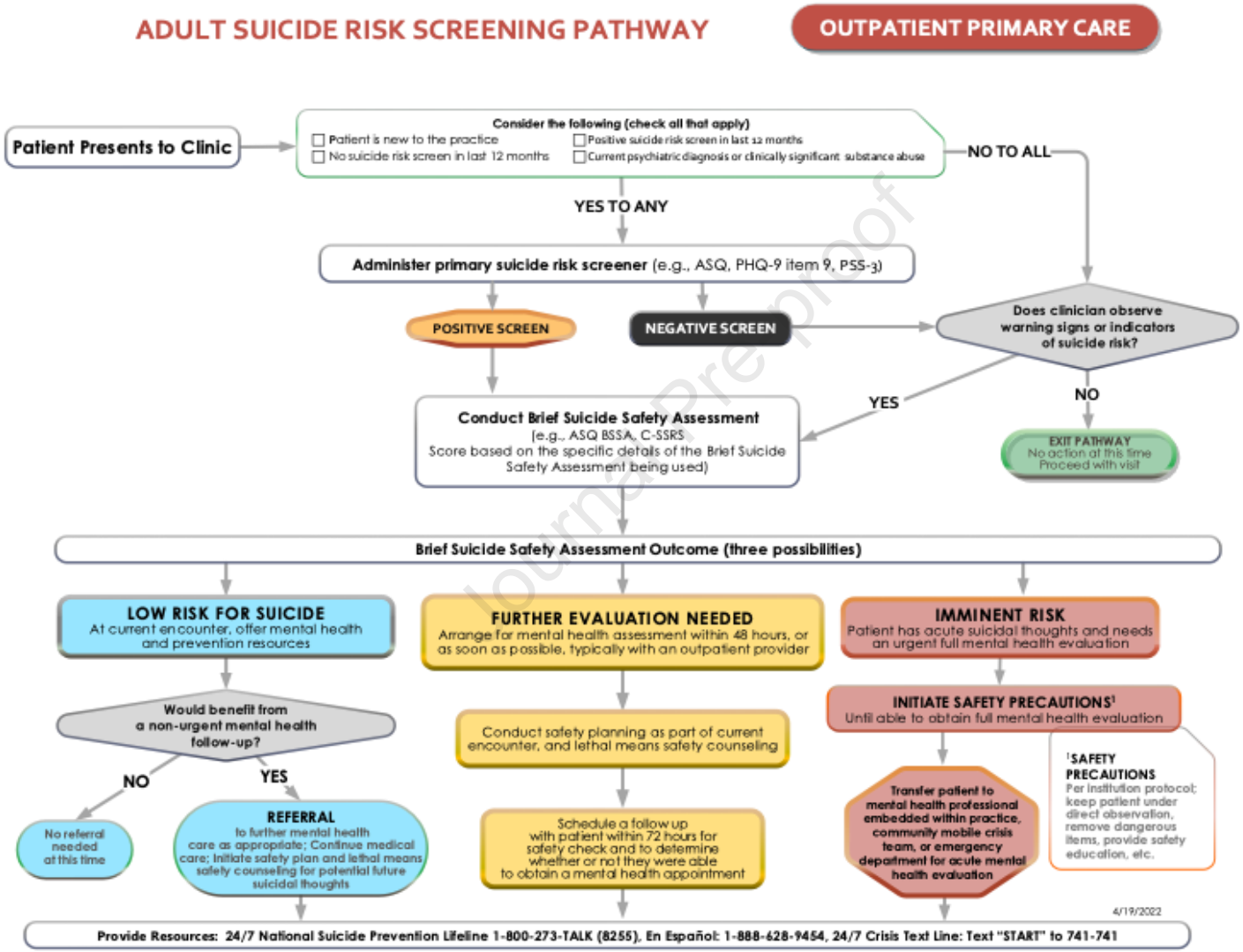
Figure A.1. Graphic depiction of three-step approach to suicide risk screening



Suicide risk screening using this type of three-step approach is gaining traction in primary care and other outpatient practices. Where implemented, between 90 - 95% of patients screened for suicide risk were found to be negative; the remaining 5-10% having either a history of suicidal thoughts/behavior or with a positive risk identification (which accounts for about 2% of adults in outpatient settings) (20). This highlights the importance of both early identification of these patients in a health system they frequent with some regularity as well as the feasibility of conducting potentially life-saving screening without overwhelming clinic resources. With pre-planning to identify approaches and personnel responsible for executing each tier of a suicide

risk screening program, as well as the implementation of clearly articulated courses of action associated with each risk level, such a screening program can be thoughtfully integrated and routinely administered in primary care.

APPENDIX B: **Adult Suicide Risk Screening Pathway Diagram**



APPENDIX C: **Adult Primary Care Suicide Risk Screening Clinical Pathway Guidance**

General principles of suicide risk screening

Using a Clinical Pathway to Guide Suicide Risk Screening

Using a clinical pathway is like having a roadmap. It can help guide medical providers through the screening and assessment process, as well as outline the next steps for patients at risk for suicide. Importantly, these pathways are flexible and can be adapted to meet the workflow and nuances of any given setting. Having a detailed process in place will save time and resources.

The clinical pathway outlined in this paper offers different choice points but boils down to three main steps, which are discussed in detail below.

1. Brief Screen
2. Brief Suicide Safety Assessment
3. Disposition

Screening vs Brief Suicide Safety Assessment vs. Full Mental Health Evaluation

Identifying people at risk of suicide involves three steps: screening, brief suicide safety assessment, and disposition. Sometimes disposition will involve a comprehensive mental health evaluation.

Suicide risk screening is a rapid way to identify someone who needs further assessment for suicide risk. It can be completed through a variety of methods, including verbal interview, self-report paper/pencil forms, or computerized instruments. We do not expect brief screening tools to predict who will die by suicide; instead, we simply need the screener to have a strong signal for identifying anyone who will require further evaluation via a brief suicide safety assessment. The screening tool should have strong sensitivity and specificity to minimize false negatives and false positives.

A brief suicide safety assessment provides further assessment of suicide risk for the purpose of immediate triage. It is primarily designed to determine if the individual requires immediate attention, such as same-day evaluation by a behavioral health provider or connection to a crisis center, versus an appointment with an outpatient behavioral health provider within 7 days. Because this is a triage step, the provider will determine whether a full mental health evaluation is needed, and if so, how urgently.

A full mental health evaluation is a more comprehensive assessment conducted by a mental health professional that confirms and formulates risk and guides next steps. This includes a comprehensive suicide risk assessment and typically identifies protective factors (reasons to live) and other clinical risk factors, such as mental health symptoms, excessive alcohol or substance use, and acute triggers (stressors).

Iatrogenic Risk

A common myth related to suicide is the idea that asking someone about suicide will "put the idea into their head." However, several studies have refuted this myth (31-34) and have determined that it is safe to ask people about suicide. In fact, the best way to help a person who may be struggling with suicidal thoughts is to ask them directly, and then actively listen to the answer and bridge them to mental health care.

Prior to Implementation

Education

Training is an important part of implementing a Clinical Pathway. Example training resources are available at the Zero Suicide Website www.zerosuicide.edc.org and the ASQ Toolkit website www.nimh.nih.gov/ASQ.

Referrals

Some patients who screen positive for suicide risk will require same day mental health evaluations, while others will require outpatient mental health care referrals. When referrals are not available, resources like the National Suicide Lifeline, safety planning, lethal means safety counseling (see resource section) can be utilized. Prior to implementing screening, establish an action plan for those in need of same day mental health evaluations. This can include the patient's own mental health provider, on-site behavioral health providers, local crisis centers, crisis hotlines, and, if no other options, the emergency departments. For practices with no co-located behavioral health, it is important to establish a list of outpatient mental health providers or agencies in their community that can be provided to the patient. It is highly recommended to connect with local mental health care providers in advance of implementation to discuss accelerated, collaborative transitions of care. Providers should inform these mental health professionals that they are going to screen for suicide risk and ask if they can accommodate any patients that need further evaluation. Building these connections will allow you to make a smooth transition for patients in the future. These behavioral health clinicians should be accessible, affordable, and culturally and linguistically representative of the patient population being screened. Additionally, in areas where resources are low, telehealth alternatives may supplement limited access to mental health care providers.

Step 1: Conducting Suicide Risk Screening

Screening for suicide risk should take less than a minute. It is a rapid method of identifying patients "at risk" for suicide. This is a way to flag someone who may need further mental health evaluation.

Choosing a Suicide Risk Screening Tool

There are a variety of suicide risk screening tools available to medical providers. Providers should choose an evidence-based tool so as not to over or under detect suicide risk. Staff should receive training to administer the tool. Example of tools include:

- Ask Suicide-Screening Questions (ASQ)
- Columbia Suicide Severity Rating Scale (C-SSRS) triage version
- Patient Health Questionnaire (PHQ-9)
- Patient Safety Screener (PSS)

For a longer list of screening tools, please refer to The Joint Commission's website or (35).

A Note about Using a Depression Screen for Suicide Risk Detection

Some medical settings use depression screening as a proxy for suicide risk screening or to select which patients to screen for suicide risk. Screening for depression is important because it is widespread and a risk factor for suicide. However, depression screening is not adequate to identify people at risk for suicide. Several studies (36-44) have highlighted that depression screening alone is inadequate to identify all patients at risk for suicide. Depression screening is best utilized in conjunction with suicide risk screening, as screening for both depression and suicide risk are important. Notably, adding a suicide risk screening tool should only add an additional 30 seconds to a clinician's workflow, and may recognize

someone who otherwise may have passed through the healthcare setting with their suicide risk undetected. The American Medical Association recently sent an alert about the insufficiency of using the PHQ-9 item 9 as a sole item to screen for suicide risk.

Using PHQ-9 item 9 for Suicide Risk Detection:

Many outpatient practices utilize the 9th item of the PHQ-9 as a suicide risk screen. While this will identify some people at risk for suicide, and is better than not screening at all, current research has shown that it is not sufficient for accurately identifying suicide risk in primary care settings. Instead, PHQ-9 should be paired with a validated suicide risk specific screening tool (see tools section) that asks directly about suicidal thoughts and behavior. Using a suicide risk specific screening tool paired with a clinical pathway is feasible and will not overburden a busy outpatient practice.

Who to Screen

New and existing patients who can answer questions should be screened for suicide risk. Most steps for screening and management are kept the same regardless of the patient's history within the practice.

When to Screen

When screening is implemented in your practice, existing patients should be screened at next available visit. While there is limited evidence suggesting how often an individual should be screened, at least once a year is considered best practice. Patients should be screened for suicide risk if:

1. They are new to the practice
2. They have not been screened in the past 12 months
3. They had a positive suicide risk screen in the past 12 months
4. They have a current psychiatric diagnosis or clinically significant substance abuse

If a patient refuses to complete the screening tool, they are free to do so and this should be documented in the healthcare record. Screening can be offered at subsequent visits even if the patient does not wish to be screened at one visit.

How to Screen

Depending on the selected tool, screening can be administered through a variety of methods, including verbal asking, self-report paper/pencil forms, or computer questionnaires. Generally, if trained, any medical provider (nurse, medical assistant, physician, etc.) can administer suicide risk screening. Results from a suicide risk screen should be scored in real time and before the patient leaves the office to allow for the proper steps if they screen positive or if they require acute care.

Where to Screen

During the visit, suicide risk screening is best completed by the patient in privacy, away from other patients or accompanying visitors and either via self-report on paper or computer tablet or verbally administered by a trained staff member. Practices may also find it useful to incorporate suicide risk screening into other routine screening processes, such as vitals assessment or mental health

questionnaires. Incorporating suicide risk screening into the general workflow avoids potential for stigmatization.

Screening Outcomes

Negative Screens

The majority (~95%) of patients that present with medical chief complaints to an outpatient primary care clinic will screen negative and no further action will be needed. These patients are not considered at current risk for suicide and the visit should proceed as usual. However, the clinician should watch for any of the following indicators or warning signs of suicide:

- Talking about wanting to die or to kill oneself
- Looking to access lethal means
- Feeling hopeless or having no reason to live
- Feeling trapped or in unbearable pain
- Feeling like a burden to others
- Increased substance use
- Increased irritability, agitation, anxiety, or recklessness
- Significant changes in sleep patterns
- Withdrawal or isolation
- Exhibiting rage or seeking revenge
- Displaying extreme mood swings

If the clinician observes any of these indicators or warning signs of suicide risk, they can administer a brief suicide safety assessment, if in their clinical judgment, the patient needs further assessment for suicide risk. The clinician can also offer mental health and suicide prevention resources.

How to Manage Patients Who Screen Positive

Each suicide risk screening tool will have a different way of determining risk. For example, if screening with the PHQ-9, any non-zero response to item #9 indicates suicide risk. If screening with the ASQ, a positive response to any one of the four items is considered a positive screen. After a patient screens positive for suicide risk, they will move to the second step, the brief suicide safety assessment, described below. Not every patient with suicidal thoughts is an emergency. Most patients with suicidal thoughts detected in your practice will not need emergency measures. Only patients who are determined to be at high or imminent risk should receive full safety precautions (constant observation, etc.) or transfer patient to mental health professional embedded in the practice, be sent to a crisis center or the ED. Most patients that screen positive will be non-imminent or non-acute positives and may require further evaluation or resources like the National Suicide Lifeline or the Crisis Text Line, but not emergency measures.

Step 2: Conducting a Brief Suicide Safety Assessment

A brief suicide safety assessment should take about 10 or 15 minutes. This is the middle step of the process and an important step because it helps the provider determine what should happen next for the patient. Different from the screen which simply identifies risk, this is a conversation with the patient that assists in further triage by evaluating the frequency of suicidal thoughts, plans, psychiatric symptoms, suicide attempt history, risk and protective factors, etc. There are tools to use as a guide for the conversation, such as the C-SSRS Suicide Risk Assessment (triage version) and the ASQ Brief Suicide Safety Assessment (ASQ BSSA).

A brief suicide safety assessment can be conducted by a mental health professional, if the office has one, or a trained physician, nurse practitioner, or physician assistant. It is meant to be brief and should not be a full mental health evaluation. A person who administers the brief suicide safety assessment should have training on how to recognize suicide risk. Online trainings for both the C-SSRS, and the ASQ BSSA are available.

A list of evidence-based brief suicide safety assessments, also known as suicide risk assessment tools can be found on The Joint Commission's website. Full mental health evaluations are conducted by mental health clinicians who are trained to conduct more comprehensive assessments.

Step 3: Determine Disposition

After completing the brief suicide safety assessment or hearing about the results of the brief suicide safety assessment, the PCP determines next steps by selecting one of three dispositions:

1. **Imminent (High) Risk: Patient requires an emergency psychiatry evaluation:** This is an emergency – the patient has active, current (acute) thoughts of attempting suicide and needs an emergent full mental health evaluation. This can be completed by a crisis service, a mental health professional who is either on site or who performs such evaluations for the clinic, or an emergency department. It is also possible to contact with a patient's current mental health provider and alternative safety plan for imminent risk is established. This is very rare for patients presenting with medical chief complaints but may occur. Although uncommon, you should have a plan ready for how you will manage a patient who is found to be at imminent risk for suicide.

   Patients at imminent risk for suicide need compassionate care. Importantly, the patient should not be left alone. Someone should sit with them until they depart your office. They should be told that you are concerned for their safety and are going to help keep them safe. Office safety precautions should be explained so they know what to expect and so these precautions are not perceived as punitive. Potentially dangerous objects in the room or in the patient's belongings should be removed, and this can include medical implements, belts, shoelaces, pills, knives, firearms, ropes, etc. If a mental health clinician is not embedded within your practice, a mobile crisis team should be notified. If these resources are not available, the patient should be sent to the ED for emergency evaluation. If the patient leaves your office, they should be told that as a responsible healthcare provider you must ensure their safety and will need to take precautions by calling 911. This piece may be different for each state according to laws of mandated reporters.

2. **Moderate Risk: Further Evaluation is Needed**. This is not an emergency, the patient is not an imminent risk, but patient will require further mental health evaluation from a mental health professional as soon as possible. This is a patient who endorses some past suicidal ideation or behavior, but it is not current, active, or acute. If mental health evaluation is not available within your practice, refer to outpatient mental health clinician. Make a safety plan with the patient and counsel them on lethal means safe storage or removal. Schedule a follow up phone call with patient within the week for safety check and to determine whether they were able to obtain a mental health appointment. If a mental health appointment is not possible, consider telehealth or having the patient come back to your office to check in with you until they are evaluated by a mental health clinician. Patient should be given the National Suicide Lifeline and Crisis Text Line resources upon discharge. If the patient chooses not to be further evaluated, this should be documented that the patient refused standard practice.

3. **Low Risk:** No further evaluation is needed at this time. The patient might benefit from non-urgent mental health follow-up. Develop or review a safety plan (see safety plan section below) with the patient in case they have future suicidal thoughts and send home with mental health resources and if wanted, a referral for mental health follow up. The patient should be given the National Suicide Lifeline and Crisis Text Line resources in case future suicidal thoughts arise.

Importantly, as described in the three levels above, it is not always an emergency if a patient discloses thoughts of suicide:

- Only the patients who are deemed at "imminent or high risk for suicide" require full safety precautions, including a 1:1 observer, and searched belongings
- Patients who screen "moderate risk for suicide" are not in immediate danger and therefore do not require safety precautions and do not need to be sent to the ED
- The majority of adults who present with medical chief complaints and screen positive for suicide risk are non-imminent cases.

Follow-up and continuity of care

Once a patient screens positive for suicide risk, next steps can be determined. If a mental health appointment is not feasible for patients requiring further evaluation, consider telehealth or having increased density of appointments until they can be evaluated by a mental health clinician.

In addition, clinicians may consider the practices below:

1. Caring contacts
    a. Follow-up care is a critical way to support patients after a positive screen. An office staff member can schedule a follow-up call, virtual visit, or brief in-person visit within 72 hours. This follow-up is an opportunity to determine whether patients requiring further evaluation successfully linked to mental health care, the current accessibility of lethal means, and if the patient has experienced any changes in suicidal ideation.
2. Rescreen at next appointment
    a. This step is critical to determine if the patient is experiencing increased suicidal ideation, or any occurrences of suicidal behavior.
3. Communication with the patient's outside mental health clinicians

If the patient has met or meets with a mental health clinician, establishing contact may provide additional insight into the patient's suicide risk. Regardless of disposition, all patients should receive the National Suicide Prevention Lifeline and Crisis Text Line resources.

Effective Interventions You Can Do in Your Office

Safety Planning

To support individuals who screen positive for suicide risk, safety planning is an evidence-based, brief, and effective technique to reduce suicide risk. Collaborating with the patient and if possible, the family, clinicians can help patients establish effective coping techniques in order to prepare for possible crisis events.

Safety planning helps the patient create a list of resources, distraction activities, and emergency procedures in the event they are experiencing suicidal thoughts. The safety plan should be personalized to each patient and includes:

- Patient's own warning signs and triggers for suicidal thoughts (e.g., when my ex calls, when I have pain)

- Coping strategies (e.g., writing in a journal, exercising, meditating)
- Social contacts
- Emergency contacts
- Back-up plans, such as calling the National Suicide Prevention Lifeline, texting the Crisis Text Line, or contacting a mobile crisis team
- Reducing access to lethal means

Developing a safety plan with the patient can be led by any staff member with sufficient training, including the primary care provider, nursing staff, physician assistants, or social workers. To guide the process, consider utilizing a safety planning tool such as the Stanley Brown safety planning tool, or the Virtual Hope Box.

Lethal Means Safety Counseling

A "lethal mean" is an object that a person may use to attempt suicide. Common lethal means include pills, poison, firearms, ropes, belts, knives, and other objects. It is important to make a person's environment safe before a crisis ensues because suicidal crises may intensify unexpectedly. While it is not always possible to prevent someone from attempting suicide, reducing access to lethal means can reduce the possible lethality of an attempt.

It is important to inform patients that these measures are temporary methods to manage suicide risk in the home and are commonly utilized suicide prevention strategies. Lethal means counseling should be personalized for each patient and account for cultural or occupational circumstances (e.g., patients may carry a firearm as part of law enforcement).

Access to lethal means is a risk factor for suicide. Common methods to reduce access to lethal means include:

- Temporarily removing firearms from the home
- Storing firearms and ammo separately, and ensuring the key or combination code is not kept with the patient at risk
- Limiting access to potentially fatal medications (e.g., opioids, over-the-counter pills)
- Removing knives or ropes from the home
- Locking up household cleaners or other poisonous products

Collaborative Care Models

Collaborative Care is a promising model to connect medical patients with mental health resources shown to reduce suicidal thoughts (45). Collaborative Care provides a systemic approach to help primary care and health care practices identify, treat, and track patients with depression, anxiety, and risk for suicide. For more information on collaborative care models, visit: AIMS Center for Collaborative Care.

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Declaration of interests

☒ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

☐The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: