Intermountain Healthcare
Suicide Assessment/ Prevention
Substance Use Disorder Management

2015 Updates

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BHCP Operations Director
Why Focus On Substance Use Disorder?

Addiction often starts in adolescence and becomes a lifelong problem.
Drug abuse is a major problem in Utah.
Patients are undertreated.
SUD is costly.
SUD has a high mortality rate.
Why Focus on SUD in Primary and Specialty Care Settings?

PCPs aren’t talking to their patients about substance use

SUD patients need medical and mental health treatment.
Summary—The Triple Aim

A complex problem requiring an integrated solution

Aligning philosophy and practice: Intermountain’s strategy for SUD care

- Improve the quality of health
- Enhance the patient experience
- Lower the cost of care
SUD identified by the patient, family, physician, employer, etc.

### Assessment

#### Treatment intensity increases if severity increases

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>OUTPATIENT TREATMENT</th>
<th>RESIDENTIAL TREATMENT</th>
<th>INPATIENT TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 0.5</td>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
</tr>
<tr>
<td>Brief and/or Early Intervention</td>
<td>1.0 Outpatient Services</td>
<td>2.1 Intensive Outpatient Services</td>
<td>3.1–3.5 Clinically Managed Residential Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.5 Partial Hospitalization Services</td>
<td>3.7 Medically Monitored High-Intensity Inpatient Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4.0 Medically Managed Intensive Inpatient Services</td>
</tr>
</tbody>
</table>

#### Treatment intensity decreases as condition improves
SBIRT - Screening, Brief Intervention, and Referral to Treatment.
Screening

SCREEN patients age $\geq 12$
at preventive care visits with the
Intermountain-Modified
NIDA Quick Screen (b)
Generally, the PCP administers the NIDA Quick Screen. OB/GYNs and other clinicians can administer this screen as well.

<table>
<thead>
<tr>
<th>In the past year, how often have you used the following?</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol: • For men, ≥5 standard drinks* a day</td>
<td></td>
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<tr>
<td>• For women, ≥4 standard drinks a day</td>
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<tr>
<td>Tobacco products (including e-cigarettes)</td>
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<td></td>
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<td></td>
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<tr>
<td>Prescription medications for non-medical reasons</td>
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<tr>
<td>Prescription medications in amounts greater than prescribed, for reasons other than prescribed, or that weren't prescribed to you</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Illegal drugs (illicit, street drugs)</td>
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</tbody>
</table>

*Definition of a “standard drink:”
• Beer or cooler (5% alcohol): 12 oz
• Malt liquor (7% alcohol): 8–9 oz
• Table wine (12% alcohol): 5 oz
• 80-proof spirits (hard liquor) (40% alcohol): 1.5 oz

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## Brief Intervention

<table>
<thead>
<tr>
<th>If you have...</th>
<th>Perform the following...</th>
</tr>
</thead>
</table>
| 3–5 minutes    | • Ask if the patient is interested in seeing their questionnaire scores.  
• Provide personalized feedback about scores using the *Substance Use Response and Report Card*.  
• Give advice about how to reduce risk associated with substance use. (See patient education on page 20 for tools to support this step.)  
• Allow the patient to take responsibility for their choices.  
• Ask the patient how concerned they are about their scores. |

| 5–15 minutes   | Above plus:  
• Weigh the good things about using the substance against the less good things.  
• Summarize and reflect on the patient’s statements about their use, emphasizing the negatives of using the substance.  
• Ask the patient how concerned they are with the negatives of using the substance.  
• Give the patient education materials to take home. |
Conversation basics: principles for effective intervention

Remind patients that you screen everyone
Affirm the patient’s privacy
Present concerns in a direct way, avoiding judgment
Use language that prompts conversation
Show empathy
Affirm the relationship
Engaging patients in the behavior change process

Motivational Interviewing

Readiness For Change
Motivational interviewing

Asking open-ended questions to elicit the patient’s concerns and context (work, family, etc.).

Listening actively and summarizing the patient’s concerns back to them.

Empathizing and clarifying the patient’s experience without judging, criticizing, or imposing your own values.

Enlisting the patient in suggesting options, setting goals, and planning details.
Readiness to change

Assess the patient’s current stage of readiness by observing patient comments.

Consider a brief intervention appropriate to that stage, as described in the table below.

If the behavior change is critical and the patient is not ready, refer to a care manager or specialist for further motivational interactions with the patient.
Patient education materials to support SBIRT

Intermountain + Krames Staywell
Patient Education Library

Consistency - Quality - Best Practice

This site is replacing "PEN" as your one-stop shop for system-approved patient education materials. Our goal is to merge Intermountain and Krames materials within Carestream and on our public web. As a first step, find Intermountain or Krames materials using one of the links below:

Intermountain Materials
- search

Enter search term: 50

Krames Staywell Materials
- videos

Visit our online library. How to use Krames On-Demand. How to use stressMed On-Demand.
Where to refer?

Self-help community support programs (such as AA, Al-Anon programs) (see sidebar)
MHI (for further assessment and treatment of moderate-risk patients)
Dayspring Chemical Dependency Program at LDS Hospital (adults only)
Specialty psychiatric clinics
Emergency departments
Withdrawal management in primary care

Alcohol withdrawal -- Symptom Triggered

Use Clorazepate (Librium) 25 mg, #20 tabs:

Day 1-2: 1-2 tabs 3-4 times daily prn for tremulousness/withdrawal;

Day 3-4: 1 tab 4 times daily until done. Patient should be seen within 1 week.
Opioids

If the medication is prescribed for pain management, you can taper by no more than 10% per day, monitoring carefully (have your care manager check in regularly, if possible).

Refer patients who fail the taper for SUD treatment.

Opioid withdrawal management should be a transition to longer term treatment.
## Medication Assisted Treatment (MAT)

<table>
<thead>
<tr>
<th>Alcohol dependence</th>
<th>Opioids</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acamprosate</td>
<td>• Narcan</td>
</tr>
<tr>
<td>• Natrexone</td>
<td>• Suboxone</td>
</tr>
<tr>
<td>• Antabuse</td>
<td>• Subutex</td>
</tr>
<tr>
<td></td>
<td>• Methadone</td>
</tr>
</tbody>
</table>
Suicide in the United States
Utah Suicide Facts

8th leading cause of death for Utahns!
Utah ranks 7th in the nation
10 suicides a week

1 in 15 Utah adults have had serious thoughts of suicide
Enough to fill the Energy Solutions Arena 13 times.

EVERY DAY IN UTAH...

- 2 youth
- 2 young adults
- 2 adult men
- 4 adult women

TREATED FOR SUICIDE ATTEMPTS

Poisoning 18.7%
Other 5.4%

CAUSES OF DEATH
- Firearm 53.1%
- Suffocation 22.8%

Adult males who die by suicide are more likely to have job, financial, substance abuse, and relationship problems.

MEN are at higher risk for suicide compared to females in every age group.

Each suicide costs an average of $1 million in medical and work loss costs.

For more information visit: www.health.utah.gov/vipp
Taking a public health approach to Suicide Prevention

Three areas of focus:

- Identification
- Prevention
- Postvention
Suicide Death - Healthcare Contact

50% individuals have contact the month before a suicide death

22% a week before their death

Only 45% had received a mental health diagnosis

Most common visit is with PCP before death
I have the SKILLS I need to engage those with suicidal desire and/or intent.
What is in the CPM

- Description of the problem
- Description of appropriate language
- Which tool to use based on location
- Description the process and tools
  - Screen standard tools *(Adult and Pediatric Screeners)*
  - Behavioral Health Providers use more in-depth forms *(Lifetime/Recent or Since Last Visit)*
- Complete a **Risk Assessment**
  - Protective factors
  - Risk factors
- Identification of appropriate level of care
- For patients going home, develop **Safety Plan**
Standard Processes Across the Organization

- ED Triage Nurse
- ED Crisis Workers
- Inpatient Behavioral Health Nurses
- Inpatient Medical Nurses
- Outpatient/Primary Care Clinics, Homecare
- Behavioral Health Clinics
- Other Specialty Services (e.g. sleep labs, arthritis clinics)
What is **not** in the CPM but critical for patient care?

Communication Skills and Clinical Judgment
# Importance of Using Common Language

<table>
<thead>
<tr>
<th>Words to Use</th>
<th>Don’t Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted suicide</td>
<td>Completed suicide</td>
</tr>
<tr>
<td>Died by suicide</td>
<td>Failed attempt</td>
</tr>
<tr>
<td>Protective factors</td>
<td>Parasuicide</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Successful suicide</td>
</tr>
<tr>
<td>Safety Plan</td>
<td>Suicidality</td>
</tr>
<tr>
<td></td>
<td>Nonfatal suicide</td>
</tr>
<tr>
<td></td>
<td>Suicide gesture</td>
</tr>
<tr>
<td></td>
<td>Manipulative Act</td>
</tr>
<tr>
<td></td>
<td>Suicide threat</td>
</tr>
</tbody>
</table>
In the Clinic Setting
When To Use the C-SSRS Screener

- Complete PHQ2 and if positive complete PHQ9
  - If question 9 is positive, complete C-SSRS Screener
  - Classify patient as Low, Moderate, High Risk
  - Implement appropriate action based on patients risk (see page 4 of CPM)
Standard Questions in the C-SSRS
(ALL ABOUT THOUGHTS AND BEHAVIOR)

WISH TO BE DEAD

THOUGHTS OF KILLING YOURSELF

THINKING ABOUT HOW

THOUGHTS WITH SOME INTENT

STARTED TO/OR WORKED OUT PLAN

DONE ANYTHING, STARTED TO DO SOMETHING, OR PREPARED TO DO ANYTHING
# Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she doesn’t provide that information.

## Suicidal Ideation

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Yes</td>
<td>Wish to be dead. Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: “I wish I wasn’t alive anymore.”</td>
</tr>
<tr>
<td>2. Have you actually had any thoughts of killing yourself?</td>
<td>Yes</td>
<td>Non-specific, active suicidal thoughts. General non-specific thoughts of wanting to end one’s life or commit suicide. Example: “I thought about killing myself.”</td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 5.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Yes</td>
<td>Active suicidal ideation with any method(s) (not plan) without intent to act. Person endorses thoughts of suicide and has thought of at least one method. Example: “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.”</td>
</tr>
<tr>
<td>4. Have you had these thoughts and had some intention of acting on them?</td>
<td>Yes</td>
<td>Active suicidal ideation with some intent to act. Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: “I have had these thoughts, and I have considered acting on them.” Note: “I have the thoughts but I definitely will not do anything about them.”</td>
</tr>
<tr>
<td>5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>Yes</td>
<td>Active suicidal ideation 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. Example: “Next Thursday when I know my husband will be at the office is, I am going to take the sleeping pills and keep the opium medicine cabinet.”</td>
</tr>
</tbody>
</table>

## Suicidal Behavior

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?  

   **In the past 3 months?**  
   **In the past 4 weeks?**  

   Example: collected pills, obtenered a gun, gave away valuables, wrote a will or suicide note, took out pills that 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.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Past month</th>
<th>What a positive response indicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Actual attempt. A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intent to die associated with the act, the act is considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is blocked so no injury results, this is considered an attempt. Aborted or self-interrupted attempt. When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior. Interupted attempt. When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. If for that reason, an actual attempt would have occurred. Preparatory acts or behaviors. Acts or preparation toward imminent making a suicide attempt.</td>
</tr>
</tbody>
</table>

Clinician Signature: ___________________________  
Date: ____________  
Time: ____________
Recommended actions based on patient responses to screening tool

Each location has a recommended set of actions depending on the patients response category:

**Low** – Continue with usual care and communication

**Moderate** – Likely needs additional assessment or plan

**High** – Likely to need a higher level of care, more observation and intervention
Suicide Prevention – CLINIC

SCREENING and ACTIONS

(+): on PHQ-9 (q. 9) or clinical suspicion of suicidal ideation or behaviors

SCREEN for suicide risk using the C-SSRS Quick Screen

Q1: Have you wished you were dead or wished you could go to sleep and not wake up?

Q2: Have you actually had any thoughts of killing yourself?

No to 1, yes to 2 OR yes to both

Q3: Have you been thinking about how you might kill yourself?

Q4: Have you had these thoughts and had some intention of acting on them?

Q5: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Q6: Have you ever done anything, started to do anything, or prepared to do anything to end your life?

ACTIONS based on positive responses (respond based on highest level of risk)

LOW RISK

- Consider referral to MHI or BH provider
- Consider patient education

Note: Patient response to question 6 may increase risk and result in additional steps.

MILD/MODERATE RISK

- Assess risk factors and facilitate evaluation for inpatient admission or complete Safety Plan with follow-up within 24-48 hours
- Educate patient

HIGH RISK

- Facilitate immediate evaluation
- Educate patient

- If in the past 4 weeks: Facilitate immediate evaluation for inpatient care and educate patient
- If 1-12 months ago: Assess risk factors and refer to MHI or BH provider and educate patient
- If >1 year ago: Consider referral to MHI or BH provider and consider patient education

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Not intended to replace physician judgment with respect to individual variations and needs.
Now What.....

Based on screener AND CLINICAL JUDGEMENT

- Low risk – normal care
- Moderate risk – referrals, further assessment and intervention
  - Risk factor assessment
  - Development of safety plan
- High risk - immediate referral for next LOC (i.e. inpatient care, meet with on-sight MHI provider)
### Suicide Prevention — Risk Assessment Tool

**Instructions:** Complete this tool after interviewing the patient (including administration of the C-SRIS Lifetime/Recent Assessment), reviewing medical records, and/or consulting with family members and/or other professionals. Check all risk and protective factors that apply.

**Purpose:** This tool enables you to estimate the patient’s suicide risk through comprehensive assessment of risk and protective factors. After you complete the tool, review the number and type of positive responses to guide your treatment plan.

**Additional resources:** Refer to the Suicide Prevention CPM for a discussion of risk factors, definitions of terms, and strategies for talking about suicide with patients.

<table>
<thead>
<tr>
<th>Suicidal and self-injurious behavior</th>
<th>Past 3 months</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual suicide attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td></td>
<td></td>
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<tr>
<td>Attempted suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent or self-interrupted attempts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other preparatory acts to kill self</td>
<td></td>
<td></td>
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<tr>
<td>Self-injurious behavior without suicidal intent</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal ideation</th>
<th>Part 1 month</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wishes to be dead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td></td>
<td></td>
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<tr>
<td>Suicidal ideation with method but without specific plan or intent</td>
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<td></td>
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<tr>
<td>Suicidal ideation for specific plan</td>
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<tr>
<td>Suicidal ideation for specific plan</td>
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<table>
<thead>
<tr>
<th>Activating events</th>
<th>Recent</th>
<th>Other significant negative event</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Describe.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Treatment history</th>
<th>Any history</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Previous psychiatric diagnoses and treatments</td>
<td></td>
<td></td>
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<tr>
<td>Hopelessness or distorted thinking</td>
<td></td>
<td></td>
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<tr>
<td>Recent major stressor or treatment</td>
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<tr>
<td>Recent hospitalization</td>
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<table>
<thead>
<tr>
<th>Other factors</th>
<th>Any</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Major illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent life events</td>
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<td></td>
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</tbody>
</table>

### Clinical status

<table>
<thead>
<tr>
<th>Clinical status</th>
<th>Current/Recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders</td>
<td></td>
</tr>
<tr>
<td>Major depressive episodes</td>
<td></td>
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<tr>
<td>Mixed effective episodes</td>
<td></td>
</tr>
<tr>
<td>Co-morbid substance use disorder or alcohol dependence</td>
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<tr>
<td>Agitation or severe anxiety</td>
<td></td>
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<tr>
<td>Preceding bereavement</td>
<td></td>
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<tr>
<td>Current medical condition(s)</td>
<td></td>
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<tr>
<td>Chronic physical illness or other acute medical condition</td>
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<tr>
<td>Sleep disturbance or other neurological condition</td>
<td></td>
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<tr>
<td>近期 suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>Aggressive behavior toward others</td>
<td></td>
</tr>
<tr>
<td>Methods for suicide (gun, pills, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

### Protective factors

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Current/Recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal reasons for living</td>
<td></td>
</tr>
<tr>
<td>External reasons for living</td>
<td></td>
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<tr>
<td>Supportive social network or family</td>
<td></td>
</tr>
<tr>
<td>Fear of death or dying due to pain and suffering</td>
<td></td>
</tr>
<tr>
<td>Feelings that suicide is a solution</td>
<td></td>
</tr>
<tr>
<td>Engaged in work or school</td>
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<tr>
<td>Pregnancy</td>
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</table>

### Other protective factors

<table>
<thead>
<tr>
<th>Other protective factors</th>
<th>Current/Recent</th>
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### Behaviors

<table>
<thead>
<tr>
<th>Behaviors</th>
<th></th>
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<tbody>
<tr>
<td>Describe</td>
<td></td>
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</table>

**Clinician Signature:**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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**Intermountain Healthcare**

Suicide Prevention Risk Assessment Tool SP/004

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**Intermountain Healthcare**

**Suicide Prevention Risk Assessment Tool SP/004**

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Risk Assessment
Identification of Risk Factors

Modifiable Risk Factors
• Anxiety
• Insomnia
• Intoxication

Non Modifiable Factors
• Gender
• Age
• Adverse events (i.e. family suicide, childhood abuse)
Modify Risk Factors

Identify a risk factor and modify in some way:

- Insomnia – Treat
- Anxiety – Treat
- Intoxication – Wait
- Guns in the home – Remove
Safety Plan or Safety Contract

Safety Plan
Helps patient clearly identify steps/actions to be taken if suicidal thoughts return

• Who to call
• What actions to take
• Action to make home safer, such as removing guns, stockpiled medications

Safety Contract
Doesn’t legally protect clinician
Doesn’t assist the patient in managing suicidal ideation/plans
Safety Plan

Suicide Prevention Adult Safety Plan

As you fill in this form, focus on your own needs and what would be helpful to you in times of crisis. Your healthcare provider may also review with you to discuss ideas.

The one thing that is most important to me and worth living for is: ____________________________________________________________

Warning signs
Signs that a crisis might be developing. What are some thoughts, daydreams, wishes, and so on that signal danger for me?
• ____________________________________________________________
• ____________________________________________________________
• ____________________________________________________________

Internal coping strategies
What takes my mind off my problems? Relaxation techniques, physical activity, hobbies, something else?
• ____________________________________________________________
• ____________________________________________________________
• ____________________________________________________________

People and social settings that can distract me
Who can I call on to distract me? Where can I go?
• Name: ______________________ Phone: ______________________
• Name: ______________________ Phone: ______________________
• Name: ______________________ Phone: ______________________

People who can help
Who can I call when I need help? Friends, family, someone else?
• Name: ______________________ Phone: ______________________
• Name: ______________________ Phone: ______________________
• Name: ______________________ Phone: ______________________

Professionals or agencies I can contact during a crisis
Who can I call for help? My doctor, a mental health provider, a suicide hotline?
• Clinician name: ______________________ Phone: ______________________ Pager or emergency #: ______________________
• Clinician name: ______________________ Phone: ______________________ Pager or emergency #: ______________________
• Local urgent care services: ______________________ Phone: ______________________
• Address: ____________________________________________________________
• Suicide prevention lifeline phone: 1-800-273-TALK (8255)

Making the environment safe
How can I make my environment safer? For example, can I remove guns, medications, and other items?
• ____________________________________________________________
• ____________________________________________________________


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Intermountain Healthcare
Healing for Life
Process Summary

Usual clinic process of PHQ2 → PHQ9

If yes to question 9 then screen using C-SSRS
Questions?