Henry Ford Zero Suicide Prevention Guidelines

Suicide remains a major public health crisis; it is the 10th leading cause of death and one of only three of the leading causes of death that are on the rise in the United States. In 2016, more than 45,000 Americans age 10 and older died by suicide, with firearms remaining the most common method. Suicide rates increased in nearly every state since 2016, with Michigan sustaining a 31-37 percent increase. There are a number of reasons why people take their own life, with recent estimates that more than half of people who died from suicide did not have a known mental disorder at the time of their death.

Contributing factors to suicide include:

- Mental illness
- Relationship problems or losses
- Substance misuse
- General health problems
- Housing, legal, job or financial stress

THE BIRTH OF ZERO

Henry Ford Behavioral Health Services (BHS) was the pioneer in conceptualizing Zero Suicide as a goal in 2001 and developing a care pathway to assess and modify suicide risk. This landmark work was recognized with The Joint Commission's Codman Award and the American Psychological Association's Gold Award to name a few. More importantly, this work led to zero suicides for 18 months in 2009-2010, and a statistically relevant decrease in suicide rates within Henry Ford BHS from its inception.

In the years since Henry Ford first established the concept of having "zero" as the suicide goal for its patients diagnosed with depression, a worldwide Zero Suicide movement has emerged. Mental health organizations and governments across the globe have embraced the idea and designed a growing number of programs intended to prevent suicide deaths. However, many health systems and organizations have struggled to eliminate suicide and the statistics clearly speak to the ineffectiveness of those models.

In 2018, Henry Ford is again at the forefront of developing a new model to eliminate suicide. Enclosed is our blue print for success. As with any initiative, fidelity to the model is essential as is the revision of the model as new research becomes known. As we embark on our high reliability journey, these guidelines will be a cornerstone of what we promise to ourselves and every patient and family.

TABLE OF CONTENTS

Suicide Risk Assessment 3
Risk Factor Stratification and Interventions 4
Weapon Safety Protocol 6
Self-Management Tools 7
Family Involvement 8
Community Resources 8
Caring/Comfort Cards 9
Suicide Prevention Process Maps 10
Appendix 1: My Safety Plan 12
Appendix 2: Self-Help Books 13
Appendix 3: Understanding and Helping Someone Who is Suicidal brochure 16
Appendix 4: Suicide: Tips for Parents brochure 18
Appendix 5: Psychiatric Community Resources 19
Appendix 6: Support Groups 20
Appendix 7: Caring/Comfort Card for Recently Discharged Hospital Patients 22
Appendix 8: Caring/Comfort Cards for Outpatient Care 23

Cathrine Frank, M.D.
Chair, Henry Ford Department of Psychiatry
Phone: (313) 874-6887
Email: cfrank4@hfhs.org
Web: henryford.com/ZeroSuicide

SUICIDE RISK ASSESSMENT

One of the cornerstones of Henry Ford's Zero Suicide Model is that clinicians cannot predict suicide, but they can and must assess suicide. Each assessment leads to determining risk factors and the modification of those risk factors leads to a reduction in suicide risk and rates. Key tenets of our model include:

- Every patient must be assessed for suicide risk at every encounter. Clinicians are often adept at assessing suicide risk at intake and then may not thoroughly evaluate risk again unless the patient professes to suicidal thoughts, plan, or intent.
- Suicidal ideation, or lack thereof, is not a valid predictor of suicide. Suicidal ideation, plan, and intent, are risk factors but there are many others that are of equal importance including hopelessness, anhedonia, and chronic pain to name a few.
- Modifications of risk lead to elimination of suicide. The results of the risk assessment drive clinical innovations that are structured to modify the risk factors.
- When Zero Suicide debuted in 2001, BHS divided risk into high, moderate, and low. Our revised guidelines have four levels of risk: acute, high, moderate, and low. Of note, there is no category of "no risk" as every patient who comes to a mental health facility by definition has risk of suicide.
- Access to an array of intensity of care: inpatient, partial hospitalization, IOP, and outpatient are essential interventions to modify suicide risk. In the outpatient arena, the risk level determines how quickly the patient must be evaluated by a psychiatrist: same day for acute risk, within 48 hours if high risk, within a week if moderate risk.
- Modifications or innovations to change risk must be evidence-based; this is the case in both psychotherapy as well as psychopharmacology. The two major psychotherapies that the literature supports to modify suicide risk are CBT and DBT. Staff must be trained and proficient in these modalities.
- Weapon removal is essential – particularly firearms and stashes of medications to overdose. Availability of lethal weapons increase suicide risk.
- Family involvement is essential to modify suicide risk. Families often are the eyes and ears of patient wellness as well as decompensation. Families/significant others must be allies in Zero Suicide.
- Self-management tools to support the patient on his or her path to wellness and the development of increased coping strategies is essential to modify suicide risk. A Safety Plan is one essential element of self-management. A new format for the Safety Plan is enclosed.
- Community involvement is another element to help support the patient and family between appointments and allow the patient to develop support systems outside of the therapy session and their home. Such interventions can be one tool to modify social factors including isolation.
- Comfort or caring cards are one of the best-researched and effective strategies that inpatient as well as outpatient facilities can use to reduce suicide risk during times that patients are statistically at risk: the 7-30 days post inpatient discharge and following missed outpatient appointments.

RISK FACTOR STRATIFICATION AND INTERVENTIONS

At each patient encounter, an assessment of risk and protective factors must be completed. The risk assessment dictates the strategies to modify risk.

ACUTE RISK:
- Severe depression
- Current mania
- Current psychosis
- Current intoxication with alcohol or substances
- Suicidal plan
- Suicidal intent
- History of suicide attempt in the last 30 days
- Severe anhedonia
- Hopelessness
- PHQ-9 Question #9 with response of 2 or 3.

HIGH RISK:
- Moderate depression
- History of suicide attempt in the last year
- Alcohol abuse/substance abuse within the last month
- Severe anxiety/panic
- Acute stressor; particularly real or perceived loss
- Impulsivity (particularly in teens and young adults)
- Chronic non-lethal self-injury
- Global insomnia
- Opiate abuse within the last year
- Inpatient psychiatric care in last year
- Mental health emergency room visit within last three months

MODERATE RISK:
- Mild depression
- Current hypomania
- Drug use disorder within the last five years
- Moderate anxiety/panic
- Suicidal ideation
- History of suicide attempts (more than one year ago)
- Family history of suicide
- Chronic severe pain
- Transgender
- Military veteran
- Current eating disorder
- Traumatic brain injury within the last year

LOW RISK:
- Anxiety disorder (not moderate or severe)
- Depressive disorder, in remission
- Bipolar disorder, in remission
- Psychotic disorder, in remission
- Any other mental health or personality disorder

PROTECTIVE FACTORS:
- Safety Plan
- Access to psychiatric care
- Reasons for living:
  - Family: Responsibility to and would not abandon
  - Coping skills
  - Parenthood, especially for mothers
  - Individual meaning of suicide
  - No acceptable method available
  - Spiritual beliefs
  - Presence of supports
  - Relationship with treatment team
  - Fear of suicide, death, and dying
  - Belief that suicide is immoral or will be punished

INTERVENTIONS TO MODIFY RISK

Risk determines the treatment intervention:
- Level of care: IPD, PHP, IOP, OPD
- Somatic treatments (medication, ECT, TMS)
- Psychotherapy: must be evidence-based, particularly CBT and DBT
- Remove weapons from the home
- Involve family: this must always be considered
- Community referrals
- Self-management tools

Risk determines the timeliness and access to care. This includes not only access to a medical psychiatric provider (psychiatrist or APP) but also to a psychotherapist. Any patient with acute, high, or moderate risk should have a psychotherapist involved in their care or documentation as to why such treatment is either not recommended or refused.

OUTPATIENT TREATMENT PROTOCOL

Suicide risk mandates a psychiatric evaluation:
- Same day if acute risk
- Within 48 hours if high risk
- Within seven days if moderate risk with anxiety disorders or mood or psychotic disorders not in remission
- If low risk, timing of psychiatric evaluation relates to patient's current needs and response to treatment
- If a patient is in treatment with a psychiatrist or APP already, the patient's frequency of contact should be dictated by a change in risk level as well as response to treatment
- A patient who comes to BHS for the first time or for any patient under the care of a BHS therapist, must be referred to a psychiatrist or APP based on risk level assigned

Suicide risk mandates a psychotherapy referral:

- Same day if **acute risk**; appointment within 72 hours
- Same day if **high risk**; appointment within five days
- Same day if **moderate risk** with anxiety disorders or mood or psychotic disorders not in remission; appointment within seven days
- If **low risk** referral or need for ongoing psychotherapy relates to patient's current needs and response to treatment
- If a patient is in treatment with a psychotherapist, the patient's frequency of contact should be dictated by a change in risk level as well as response to treatment

WEAPON SAFETY PROTOCOL

1. Complete Risk Assessment at the initial evaluation and at all subsequent encounters.

- Protocol will be initiated for **all** patients regardless of assigned risk factor

2. Identify if weapons are in the home

- Obtain patient's agreement to identify all weapons (firearms and stashes of medications) and agree to their removal
- Have patient identify a support person with correct phone number and address
- Have patient sign a release form allowing you to contact the support person

3. Establish individual Safety Plan

IF THE PATIENT **AGREES** TO WEAPON REMOVAL:

- Contact support person with patient in the room to implement plan for weapons removal
- Secure agreement of support person to call back the same day that weapons have been safely removed
- Instruct support person to speak directly with therapist/provider or call after hours psychiatry number <insert number> to confirm removal
- Return of weapons or ammunition to the home is never recommended.
- Do not direct patients or the support person to bring any weapons to BHS sites.

IF THE PATIENT **DOES NOT AGREE** TO WEAPON REMOVAL:

- If patient refuses removal of weapons, but agrees to allow communication with a support person, educate the support person regarding the risks of weapon availability and the need to continue to encourage the patient to allow weapon removal.
- If patient refuses removal of weapons, and does not agree to allow communication with a support person, educate the patient regarding the risk of suicide with weapon availability. Ensure that weapon removal is discussed at every encounter and the content of the conversation is documented.

4. Re-evaluate risk at each meeting. Always document all of the above in the patient record.

SELF-MANAGEMENT TOOLS

RATIONALE:
Patients with chronic as well as acute mental illness need information to become effective managers of their own health. Patients must take better care of themselves to keep their chronic illnesses under control, and need to be trained in proven methods of minimizing complications, symptoms, and disability. Effective self-management means more than telling patients what to do. It means giving patients a central role in determining their care, one that fosters a sense of responsibility for their own health.

Using a collaborative approach, health care providers and patients must work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way. Self-management support is not didactic patient education, finger wagging, lecturing, or waiting for patients to ask for help. In order to meet this need, it is essential for patients to have the following:

- Information about suicide
- Information regarding their mental disorder
- A variety of self-management tools that allow them to learn in a variety of formats (e.g. websites, books, and community self-help groups). This allows patients to learn in a format that is best for them.
- Introduction to a cognitive problem solving approach.

PROTOCOL:

1. Self-management strategies should be discussed during the NPE as well as during subsequent sessions. A Safety Plan is an essential self-help management strategy. (SEE APPENDIX 1)
2. Patients should be given the handout: "If you are thinking about suicide….read this first." Handout available at: https://www.metanoia.org/suicide/
3. The patient should be given a list of books regarding their illness that may be beneficial to them. (SEE APPENDIX 2)
4. All patients should be introduced to basic cognitive problems solving strategies. DBT strategies to focus on in the moment of crisis should include:
    a. Core Mindfulness: wise mind, nonjudgmental stance, urge surfing, observe, describe, effectiveness
    b. Emotion Regulation: check the facts, opposite action, reduce vulnerabilities, cope ahead
    c. Distress Tolerance: tip, stop, distract, self soothe, focus on cons, radical acceptance, improve
    d. Interpersonal Effectiveness: dialectical thinking, attending to relationships, maintaining self-respect

5. Strategies may be as simple as:
    a. Identify the problem
    b. List all the possible solutions
    c. Pick one solution
    d. Try it for at least two weeks
    e. If it does not work, try another
    f. If that does not work, find a resource and discuss with your doctor or therapist.

FAMILY INVOLVEMENT

RATIONALE:
Clinicians are poor predictors of suicide risk. Recent research demonstrated in multiple studies that suicidal ideation alone is not a reliable basis for suicide risk determination. As such, collateral data from family/significant others may aid the clinician in determining acute as well as chronic suicide risk. In addition, family support to the mentally ill can be therapeutic. Lastly, involvement of family/significant others may potentially lessen claims of malpractice.

PROTOCOL:
1. A request for family/significant other involvement should be made any time an individual is an acute, high, or moderate suicide risk. Such involvement is also a helpful adjunct in patients who are deemed to be low risk.
2. The clinician should obtain informed consent in the form of a patient signature on the "Authorization to Release Medical Information".
3. Patient refusal of family/significant other involvement must be documented in the medical record.
4. All communication with family/significant others, in person or by telephone must be documented in the medical record.
5. Family/significant other should be given the handout, "Understanding and Helping Someone Who is Suicidal" for adult family patients, and "Suicide: Tips for Parents" for children and adolescent families. (SEE APPENDICES 3 AND 4)
6. The discussion of family involvement should be an ongoing process, and a part of documented therapy encounters. This is imperative in an acute or moderate risk patient who refuses family/significant other involvement, as each session should document the issue and its outcome. In addition, in those patients who grant informed consent, the clinician and patient should continue to actively discuss the benefit of family involvement in subsequent sessions.

COMMUNITY RESOURCES AND SUPPORT

RATIONALE:
Referrals or linkages between Henry Ford BHS and community resources are crucial to the success of chronic as well as acute mental health care. Such referrals serve as adjuncts to treatment with research to suggest that they improve patient care and outcomes. The referrals also play an active role in supporting patient self-management.

PROTOCOL:
1. At the new patient evaluation (NPE) and at subsequent sessions, patients with any risk for suicide should be given the handout regarding community support groups that service the area in which they live or work. (SEE APPENDICES 5 AND 6)
2. Help the patient identify the group and location most appropriate for them. If appropriate, have the patient contact the group by phone from your office.
3. Identify barriers/challenges to the patient utilizing the community support.

CARING/COMFORT CARDS

RATIONALE:
Studies have demonstrated that caring cards are an effective strategy in the risk reduction of suicide. This simple and low cost strategy has been replicated in more than 11 well controlled studies.

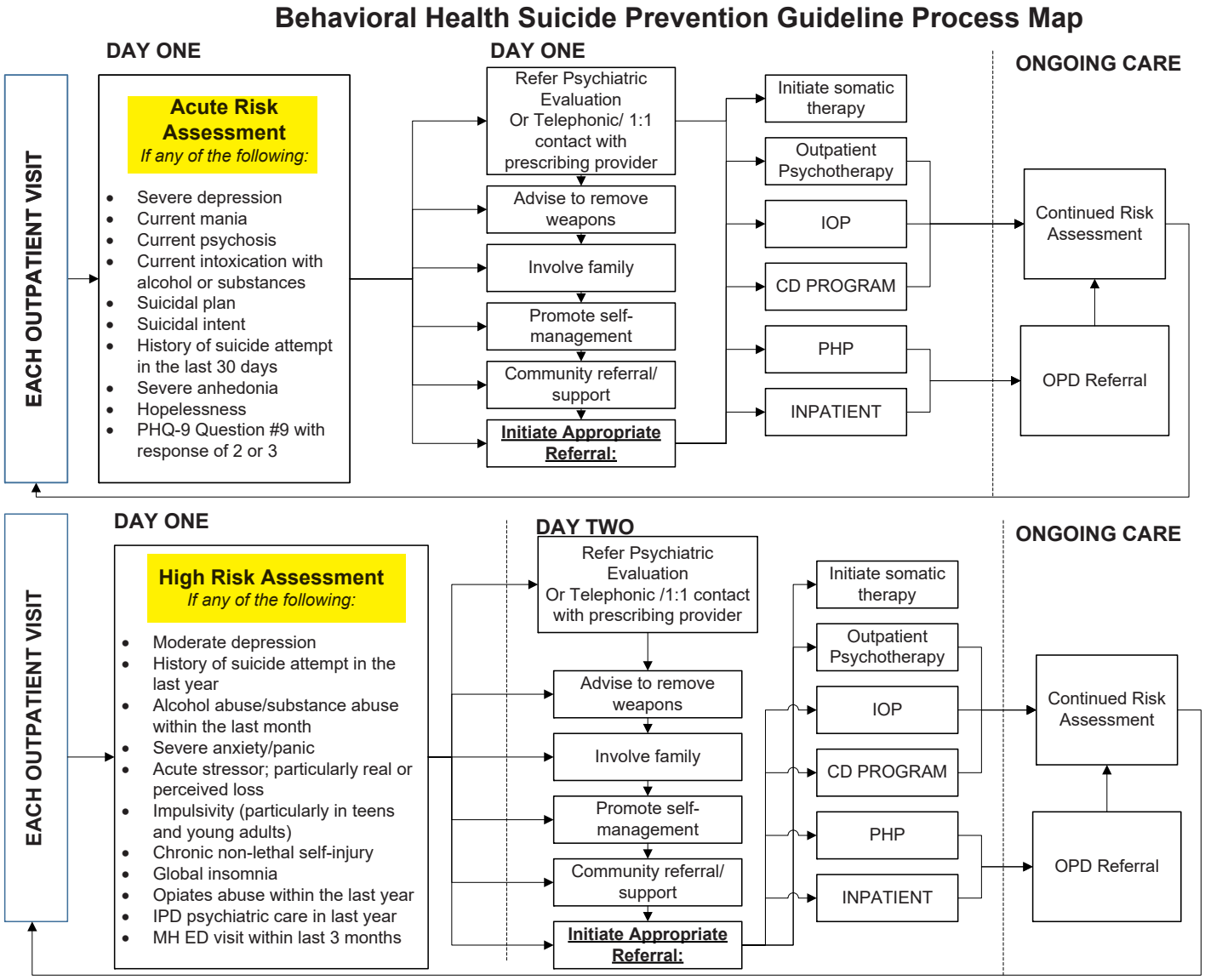
PROTOCOL:
- Caring cards must be sent to all patients discharged from our inpatient and residential units on the day of discharge (SEE APPENDIX 7)
- Caring cards should be sent to patients in outpatient care:
    - At time of the first missed appointment
    - At any time a patient is considered an acute risk
    - At time of noncompliance with treatment.

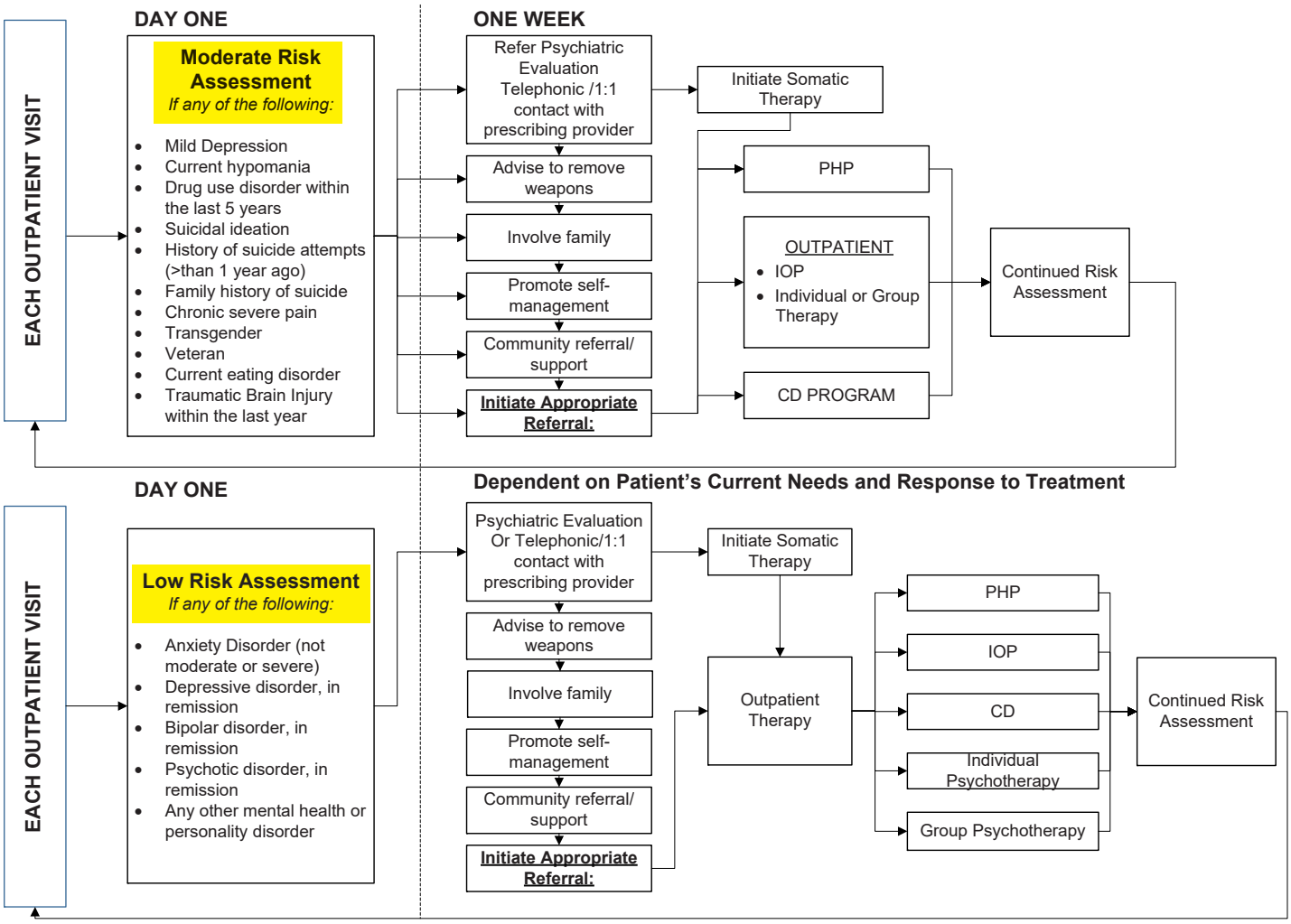
    (SEE APPENDIX 8)

Original Study: Motto, J. A., & Bostrom, A. G. A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*. 2001; 52(6), 828-833.

SUICIDE PREVENTION GUIDELINE PROCESS MAP

The following process map highlights our Zero Suicide Model as it relates to our ambulatory clinics. The flow highlights the determination of various levels of suicide risk and the interventions mandated within a specified time frame to modify suicide risk with the goal to decrease suicidal behavior and thoughts.





Appendix 1: Patient Safety Plan

MY SAFETY PLAN

FIRST STEP: Recognize my warning signs of a crisis developing (such as suicidal thoughts, destructive behavior, low mood). My warning signs are:

1. _____
2. _____
3. _____

SECOND STEP: Things I can do to feel better? What helps me soothe myself? (such as exercise, listening to music, journaling, watching TV)

1. _____
2. _____
3. _____

THIRD STEP: What are my important reasons to live?

1. _____
2. _____
3. _____

FOURTH STEP: Positive things that I can focus on right now (such as a nice memory, something positive that happened, something good in my life, people who care about me):

1. _____
2. _____
3. _____

FIFTH STEP: If these coping strategies do not work, who can I contact?

1. _____
2. _____
3. _____

SIXTH STEP: If these calls do not help, who should I contact?

1. My therapist: _____
2. My psychiatrist: _____
3. Suicide prevention Hotline: 1-800-273-(TALK) 8255

w

SEVENTH STEP: If the above steps are not helpful and I feel I may take my life, I will call 9-1-1 or go to the nearest emergency room.

Appendix 2: Self-Help Resources

SELF-HELP BOOKS

ALCOHOL AND SUBSTANCE ABUSE

Beattie, M. (1997). Codependent no more: How to stop controlling others and start caring for yourself (2nd ed.). Center City, MN: Hazelden Publishers and Educational Services.

Black, C. (1987). It will never happen to me. New York: Ballantine Books.

Ellis, A., & Velten, E. (1992). When AA doesn't work for you: Rational steps to quitting alcohol. New York: Barricade Books, Inc.

Fletcher, A. M. (2001). Sober for good: New solutions for drinking problems: Advice from those who have succeeded. New York: Houghton Mifflin Company.

Gorski, T.T. (1992). The staying sober workbook: A serious solution for the problems of relapse, Revised Edition. Independence, MO: Herald House Independence Press.

Hazelden Foundation. Dual disorders recovery book: A twelve step program for those of us with Addiction and an emotional or psychiatric illness. (1993). Center City, MN: Hazelden Publishers and Educational Services.

Horvath, T. (2003). Sex, drugs, gambling, & chocolate: A workbook for overcoming addictions. Atascadero, CA: Impact Publishers, Inc.

Marshall, S. (2003). Young, sober and free: Experience, strength, and hope for young adults. Center City, MN: Hazelden Publishers and Educational Services.

ANGER MANAGEMENT

Beck, A.T. (1999). Prisoners of hate: The cognitive basis of anger, hostility, and violence. New York: Harper Collins Publishers.

Enright, R.D. (2001). Forgiveness is a choice: A step-by-step process for resolving anger and restoring hope. Washington DC: American Psychological Association.

Weisinger, H. (1985). Dr. Weisinger's anger work-out book. New York: William Morrow.

ANXIETY

Anthony, M.M., & Swinson, R.P. (1998). When perfect is not good enough: Strategies for coping with perfectionism. Oakland, CA: Harbinger Publications, Inc.

Benson, H. (2000). The relaxation response (updated and expanded ed.). New York: Whole Care, Avon Books.

Brantley, J. (2003). Calming your anxious mind. Oakland, CA: New Harbinger Publications, Inc.

Kahn, P., & Doctor, R.M. (2000). Facing fears: The sourcebook for phobias, fears, and anxieties. New York: Checkmark Books.

Greenberger, D., & Padesky, C.A. (1995). Mind over mood: Change how you feel by changing the way you think. New York: Guilford Press.

Hallowell, E.M. 1997). Worry: Hope and help for a common condition. New York: Ballantine.

Markway, B.G., Carmin, C.N., Pollard, C.A. & Flynn, T. (1992). Dying of embarrassment: Help for social anxiety and phobia. Oakland, CA: New Harbinger Publications, Inc.

Peurifoy, R.Z. (1988). Anxiety, phobias, & panic: A step-by-step program for regaining control of your life. New York: Warner Books.

Rapee, R.M. (1998). Overcoming shyness and social phobia: A step-by-step guide. Northvale, NJ: Jason Aronson Inc.

Wilson, R.R. (1988). Breaking the panic cycle. Rockville, MD: Anxiety Disorders Association of America.

BIPOLAR DISORDER

Fieve, R. (1997). Moodswing: Dr. Fieve on depression (2nd revised ed.). New York: Bantam Books.

Jamison-Redfield, K. (1996). Touched with fire: Manic depressive illness and the artistic temperament. New York: Free Press Paperbacks.

Jamison-Redfield, K. (1996). Unquiet mind: A memoir of moods and madness. New York: Vintage Books.

Miklowitz, D.J. (2002). The bipolar disorder survival guide: What you and your family need to know. New York: Guilford Press.

Mondimore, M.D., Francis Mark. (1999). Bipolar disorder: A guide for patients and families. Baltimore, MD: The John Hopkins Press.

DEPRESSION

Anthony, M.M., & Swinson, R.P. (1998). When perfect is not good enough: Strategies for coping with perfectionism. Oakland, CA: Harbinger Publications, Inc.

Burns, D.D. (1980). Feeling good. New York: William Morrow.

Burns, D.D. (1989). The feeling good handbook. New York: Penguin.

Burns, D.D. (1999). Ten days to self-esteem. New York: Harper Trade.

DePaulo, R. (2001). Understanding depression: What we know and what you can do about it. New York: John Wiley Press.

Ellis, T.E., & Newman, C.F. (1996). Choosing to live: how to defeat suicide through cognitive therapy. Oakland, CA: New Harbinger Publications, Inc.

Endler, N.S, (1990). Holiday of darkness. Toronto, Ontario: Wall & Thompson, Toronto.

Greenberger, D., & Padesky, C.A. (1995). Mind over mood: Change how you feel by changing the way you think. New York: Guilford Press.
Irwin, C. (1998). Conquering the beast within: How I fought depression and won…and how you can, too. New York: Random House

Jamison-Redfield, K. (1997). Unquiet mind: A memoir of moods and madness. New York: Vintage Books.

Manning, M. (1995). Undercurrents: A therapist's reckoning with depression. San Francisco: Harper.

Wright, J.H. & Basco, M.R. (2001). Getting your life back: The complete guide to recovery from depression. New York: Free Press Paperbacks.

Thase, M.E., & Lang, S.S. (2004). Beating the blues: New approaches to overcoming dysthymia and chronic mild depression. New York: Oxford University Press.

Young, J.E., & Klosko, J.S. (1994). Reinventing your life: The breakthrough program to end negative behavior. New York: A Plume Book.

GRIEF/BEREAVEMENT

Felber, M. (2000). Finding your way after your spouse dies. Notre Dame, IN: Ave Maria Press.

Hickman, M.W. (1999). Healing after loss: Daily meditations for working through grief. New York: Avon Books.

Kushner, Harold (1981). When bad things happen to good people. New York: Avon Books.

Rando, T.A. (1991). How to go on living when someone you love dies. New York: Bantam Books.

Walton, C. (1996). When there are no words: Finding your way to cope with loss and grief. Oxnard, CA: Pathfinder Publishing of California.

PAIN

Catalano, E.M. & Hardin, K.N. (1996). The chronic pain control workbook: a step-by-step guide for coping with and overcoming pain. Oakland, CA: New Harbinger Publications.

Caudill, M. (2001). Managing pain before it manages you (revised ed.). New York: Guilford Press.

Jamison, Robert (1996). Learning to master your chronic pain. Sarasota, FL: Professional Resource Press.

SCHIZOPHRENIA

Mueser, K.T., & Gingerich, (1994). Coping with schizophrenia: A guide for families. Oakland, CA: New Harbinger Publications, Inc.

Torrey, E. Fuller (1995). Surviving schizophrenia: A manual for families. New York: Harper Collins.

Appendix 3: Family Handout

UNDERSTANDING AND HELPING SOMEONE WHO IS SUICIDAL

Be Aware of the Warning Signs

There is no "typical" suicide victim. It happens to young and old, rich and poor. Fortunately, there are some common warning signs which, when acted upon, can save lives. Here are some signs to look for.

A suicidal person might be suicidal if he or she:

- Talks about committing suicide
- Has trouble eating or sleeping
- Experiences drastic changes in behavior
- Withdraws from friends and/or social activities or loses interest in hobbies, work, school, etc.
- Prepares for death by making out a will and final arrangements
- Gives away prized possessions
- Has attempted suicide before
- Takes unnecessary risks
- Has had recent severe losses
- Is preoccupied with death and dying
- Loses interest in their personal appearance
- Increases their use of alcohol or drugs

What to Do

Here are some ways to be helpful to someone who is threatening suicide:

- Be direct. Talk openly and matter-of-factly about suicide. Show interest and support.
- Be willing to listen. Allow expressions of feelings. Accept the feelings.
- Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
- Don't dare him or her to do it.
- Don't act shocked. This will put distance between you.
- Don't be sworn to secrecy. Seek support.
- Offer hope that alternatives are available but do not offer glib reassurance.
- Take action. Remove means, such as guns or stockpiled pills. Do not return them or tell where the weapons were placed.

Be Aware of Feelings

Many people at some time in their lives think about committing suicide. Most decide to live, because they eventually come to realize that the crisis is temporary and death is permanent. On other hand, people having a crisis sometimes perceive their dilemma as inescapable and feel an utter loss of control. These are some of the feelings and things they experience:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of depression
- Can't make the sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't seem to get control

How to Partner with the Patient's Treatment Team

- Help monitor symptoms such as depressed mood, suicidal thoughts, ability to sleep and eat, drug and alcohol use.
- Encourage the person to educate themselves about their illness through the use of books and websites.
- Promote the use of community support groups.
- Encourage and monitor compliance with treatment including talking medication as prescribed and keeping therapy appointments.

If the Patient Feels Suicidal, Immediately Contact:

1. The person's doctor or therapist
2. The local emergency room
3. A suicide prevention or crisis center

Adapted from the American Association of Suicidology at www.suicidology.org

Appendix 4: Parent Handout

Suicide: Tips for Parents

Be aware that the following factors may be a warning or risk for suicide:

- Depression and other mental health disorders
- Noticeable change in behavior, high anxiety or agitation
- Talking, writing, or communicating about suicide or death
- Inability to sleep
- Buying a gun
- Past suicide attempts or suicidal behaviors
- Substance use (drugs and alcohol)
- Hearing about someone else's suicide

Precautions to take:

- Remove all weapons including firearms from the home
- Lock up prescription and over the counter medications
- Monitor your teen's behavior more closely
- Ask your teen daily about his/her mood and for the presence of suicidal thoughts
- Screen contacts with problematic peers or others

What to do if your teen feels suicidal:

- Work with your teen on his/her safety plan
- Contact his/her therapist or psychiatrist
- Call a crisis number (National Crisis Hotline 1-800-273-8255)
- Go to the Emergency Room
- Call 911

Adapted from the American Association of Suicidology at www.suicidology.org

Appendix 5: Community Resources

PSYCHIATRIC COMMUNITY RESOURCES

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. The Lifeline is comprised of a national network of over 160 local crisis centers, combining custom local care and resources with national standards and best practices. Call the Lifeline at **1-800-273-TALK (8255**).

Local 24-hour Crisis Lines
Macomb County Crisis Line: (586) 307-9100
Oakland County Crisis Line: (800) 231-1127
Wayne County Crisis Line: (800) 241-4949
Washtenaw County Crisis Line: (734) 662-2222
UNITED WAY Emergency assistance: Dial #211

24 Hour Crisis Text Line
www.crisistextline.org
Text 741741 when in crisis. Anywhere, anytime. A live, trained crisis counselor receives the text and responds quickly. The crisis counselor helps you move from a hot moment to a cool calm to stay safe and healthy using effective active listening and suggested referral. You can reach out through Facebook Messenger. Using the "Send Message" at facebook.com/crisistextline button will connect you to a live Crisis Counselor.

Trans Life Line
www.translifeline.org
FREE hotline for transgender people experiencing a crisis. This includes people who may be struggling with their gender identity and are not sure if they are transgender. If you are not sure if you should call or not, then please call us.
US: 877-565-8860
Canada: 877-330-6366

Veterans Crisis Line
www.veteranscrisisline.net
The Veterans Crisis Line connects veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs' responders through a confidential hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for Deaf and hard of hearing individuals is available.

Appendix 6: Support Groups

SUPPORT GROUPS

National Alliance for Mental Health
www.nami.org
NAMI is offered in thousands of communities across the United States. Through NAMI state organizations and affiliates, NAMI education programs ensure hundreds of thousands of families, individuals and educators get the support and information they need.
Call (800) 950-NAMI, (517) 485-4049 or text "NAMI" to 741741

NAMI Metro (Oakland, Wayne and Macomb Counties)
www.namimetro.org
NAMI provides excellence in support, education and advocacy as a grassroots volunteer organization dedicated to maximizing the quality of life for all who are impacted by mental illness and eliminating the associated stigma. NAMI will be the most effective resource in support, education and advocacy for all who are impacted by mental illness.
Help Lines: (248) 773-2296 or (248) 277-1500

- NAMI Metro Novi Family Support Group
  2nd Tuesday of every month, 7 p.m.
  St. John Providence Park Hospital
  47601 Grand River Ave., Novi
  (Heart Institute Center, Conference Room B or E) Contact: (248) 348-7197

- NAMI Metro Royal Oak Family Support Group
  3rd Tuesday of every month, 7 p.m.
  William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI, 48037
  Administration Bldg., lower level conference room
  Contact: (248) 879-5896

- NAMI Metro North Oakland Family Support Group
  2nd Wednesday of every month, 7 p.m.
  Orion Township Library, 825 Joslyn Rd., Orion, MI
  Contact: (248) 620-0273

- NAMI Metro Eastside Family Support Group
  1st and 3rd Monday of every month, 7 p.m.
  Henry Ford Medical Center – Cottage, Conference Room 1 (1st Floor)
  159 Kercheval, Grosse Pointe, MI
  Contact: Barb (313) 886-8004

- NAMI Metro Downtown Detroit Family Support Group
  2nd Saturday of every month, 12:30 p.m.
  Sacred Heart Activities Building, 3451 Rivard St. Detroit, MI, 48207
  Contact: Cynthia (313) 873-9019 or Zoe (313) 784-9391

- NAMI Metro Dearborn Family Support Group
  2nd & 4th Monday of every month, 6:30 p.m.
  First Presbyterian Church, 600 N. Brady St., Dearborn, MI
  Contact: (313) 563-1245 or Shirley (313) 292-3324

- NAMI Metro Wyandotte Family Support Group
  3rd Wednesday of every month, 10 a.m.
  Henry Ford Wayandotte Hospital – Rehab building, 5th Floor Conference Room 5-Allen
  2333 Biddle Ave., Wyandotte, MI 48192
  Contact: Shirley (313) 292-3324

- NAMI Metro Macomb Family Support Group
  2nd Tuesday of every month, 7 p.m.
  Henry Ford Macomb Hospital Medical Pavilion (4th Floor Conference Rooms 6 & 7)
  16151 19 Mile Rd. Clinton Township, MI
  Contact: Laura (586) 453-7170 or laurac@namimetro.org

- NAMI Metro Rochester Family Support Group
  1st Wednesday of every month, 7 p.m.
  Crittenton Hospital, Room 2E Second Floor
  1101 W. University Drive, Rochester, MI
  Contact: terriandsue@gmail.com

- NAMI Metro Farmington Hills Connection Peer-Led Recovery Support Group
  1st & 3rd Thursday of every month, 7 p.m.
  Botsford Hospital – Zieger Administration & Education Center Classroom A/B
  28050 Grand River Ave., Farmington Hills, MI
  Contact: Tina (313) 570-1289

- NAMI Metro Southfield Connection Peer-Led Recovery Support Group
  1st & 3rd Tuesday of every month, 7 p.m.
  St. John Providence Hospital Medical Building 8th Floor, Room 8-C
  22250 Providence Drive, Southfield, MI
  Contact: NatashaE@namimetro.org

- NAMI Metro Macomb Connection Peer-Led Recovery Support Group
  2nd Tuesday of every month, at 7 p.m.
  Henry Ford Macomb Hospital Medical Pavilion (4th Floor, Conference Room 4 & 5)
  16151 19 Mile Rd. Clinton Township, MI
  Contact: Barb (810) 908-1404 or barbw@namimetro.org

Appendix 7: Caring/Comfort Cards - Inpatient

RECENT HOSPITAL DISCHARGE CARD

HENRY FORD KINGSWOOD HOSPITAL

<Date>

Dear <First Name> <Last Name>,

We wanted to check in with you as you continue your journey of wellness. We know that it can be hard to navigate at times and that change can be hard when leaving the hospital. We want you to know that we are here for you should you need continued help or support.

Please reach out to us should you find yourself in a moment of crisis or in need of other resources. Our team is always here to support you on this journey we started together.

Be well,

Your Team at Kingswood

Appendix 8: Caring/Comfort Cards - Outpatient

CARING CARD EXAMPLES

LETTER FOR PATIENTS WITH SUICIDAL IDEATIONS/HIGH PHQ9:

I am writing this letter to make sure things are getting better for you. I was very concerned about how depressed you were the last time you were here to see me. Please feel free to call our clinic if you need an appointment sooner than your follow up. We are here for you and care for your emotional wellbeing. If you are having thoughts about suicide, please call our clinic at the number below and ask to speak to me. During holidays and after office hours, please call <insert number> and ask to speak to the psychiatrist on call. Another resource that you can call is: 1-800-273-TALK (8255). Take care. I look forward to seeing you.

FOLLOW-UP LETTER FOR PATIENTS REQUESTING REFILLS BUT NO APPOINTMENT MADE:

I hope things are going well for you. You requested a refill of your medications. However, upon reviewing your chart, I noticed that the last time you were seen by me was on _____. At your last visit, you were encouraged to follow up in _____ months. In order to refill your prescriptions, I would like to see you. I am very concerned about your wellbeing and want to make sure that the medications continue to help you and that you are being offered safe quality care. Please call our office at <insert number> to make an appointment.

Thank you so much and I hope to hear from you soon. Take care.

LETTER FOLLOWING MISSED APPOINTMENT:

I hope things are going well for you. You had an appointment with me today but did not make it. I am very concerned about your wellbeing and want to make sure that the treatment plan that we are working on together is helpful to you and that you are making progress. Please call our office at <insert number> to make a follow-up appointment.

Thank you so much and I hope to hear from you soon. Take care.