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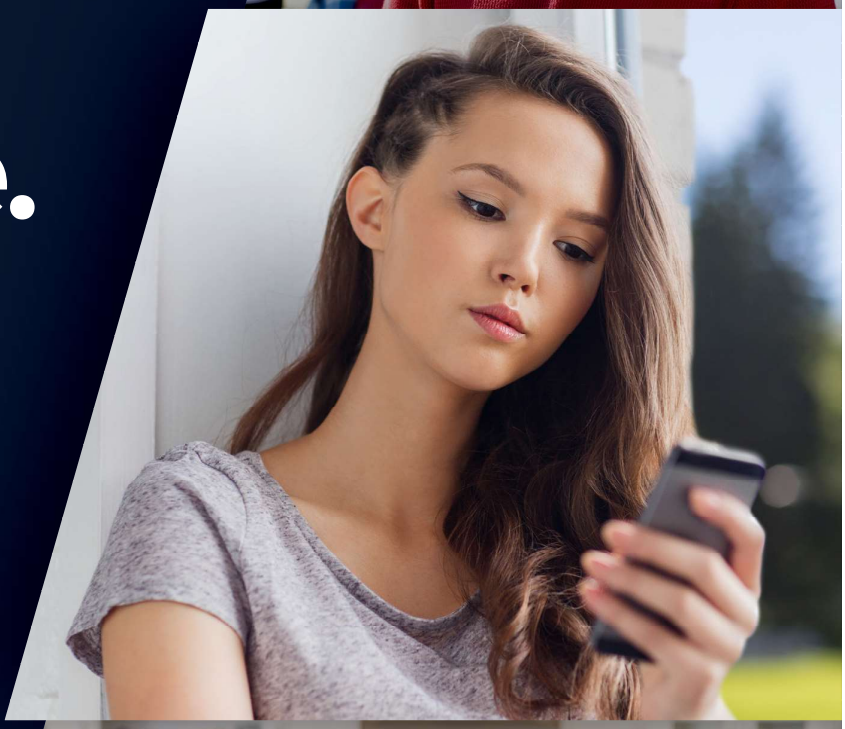

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Maryland
DEPARTMENT OF HEALTH

MARYLAND
SPIN
Suicide Prevention and Early Intervention Network

Billing for Suicide Risk Assessment

Did you know that 64% of people who attempt suicide visit their doctor during the month before their attempt?

Billing Codes for Brief Emotional/Behavioral Assessment

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When can CPT 96127 be used?

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Which insurance companies reimburse for CPT 96127?

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Is there an ICD-10 code to use with CPT 96127?

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Special Considerations for Clients with Medicare

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Primary care providers and behavioral health professionals can play a critical role in identifying people who are experiencing suicidal ideation.

Standardized Screening Instruments for Suicide Risk

Several studies support the use of the Columbia Suicide Severity Rating Scale (C-SSRS) as an intervention tool for preventing suicides and for use across multiple settings and populations. The tool and training resources are available online for free at cssrs.columbia.edu.

The Ask Suicide Questions Questionnaire has been effective in identifying suicide risk in patients in the emergency department even if they presented with medical or surgical concerns. The tool is available online for free at https://www.nimh.nih.gov/news/science-news/2013/file_143902.pdf.

Routinely screening for depression is a preventative measure that can help identify patients and connect them with needed mental health care. The Patient Health Questionnaire-9 is a depression measure available for free at http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf. The Beck Depression Inventory is another screener available at https://www.uab.edu/medicine/home/images/Beck_Depression_Inventory.pdf.

References: http://www.mentalhealthamerica.net/suicide
https://telehealth.org/blog/96127-cpt-code/
https://www.aap.org/en-us/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead?
Have you wished you were dead or wished you could go to sleep and never wake up?
Do you wish you weren't alive anymore?

If yes, describe:

Yes ☐ **No** ☐

2. Non-Specific Active Suicidal Thoughts

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you thought about doing something to make yourself not alive anymore?
Have you had any thoughts about killing yourself?

If yes, describe:

Yes ☐ **No** ☐

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*

Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

If yes, describe:

Yes ☐ **No** ☐

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*

When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?
This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.

If yes, describe:

Yes ☐ **No** ☐

5. Active Suicidal Ideation with Specific Plan and Intent

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?
What was your plan?
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?

If yes, describe:

Yes ☐ **No** ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Most Severe

Frequency

How many times have you had these thoughts? ***Write response***_____

(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Since Last Visit**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you <u>do anything</u> to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (***Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	**Yes** ☐ **No** ☐
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Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____

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References: http://www.mentalhealthamerica.net/suicide
https://telehealth.org/blog/96127-cpt-code/
https://www.aap.org/en-us/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

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If yes, describe:

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Have you thought about doing something to make yourself not alive anymore?
Have you had any thoughts about killing yourself?

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Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

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How many times have you had these thoughts? ***Write response***_____

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Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	**Yes** ☐ **No** ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Getting Started

As a provider of primary care services, you are in a unique position to prevent suicides among your patients. Research tells us that people who die by suicide are more likely to have seen their primary care provider shortly before their death than any other health care professional.

At any given time, some of your patients are having thoughts of suicide. They may come to your exam rooms presenting many different concerns, but the one they may not be telling you about could be the one that will kill them – unless you and your staff are prepared.

In This Section

Quick Start Guide

Start your suicide prevention efforts by checking out the Quick Start Guide. It will walk you step-by-step through the process of seamlessly integrating suicide prevention into your practice.

Implementation Checklist

Ensure that your efforts are organized and thorough by using the Implementation Checklist provided in this section. Check off each element of the suicide prevention efforts outlined in the Toolkit as you put it into place.

Office Protocol for Suicidal Patients Development Guide

Your practice can soon have systems in place that will allow you to intervene effectively without significantly disrupting the flow of patients. After you have familiarized yourself with the entire Toolkit, use the Office Protocol for Suicidal Patients Development Guide to establish the roles and responsibilities, as well as the procedures you will follow when you find that a patient is suicidal. If everyone in the clinic knows what he or she is expected to do, the process will be smoother than you might expect.

Office Protocol for Suicidal Patients Office Template

Use this template and the Office Protocol for Suicidal Patients Development Guide above to proactively complete an individualized Office Protocol for Suicidal Patients for your practice.

Quick Start Guide

Steps for using the Suicide Prevention Toolkit for Primary Care Practices

1. Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.

2. Meet to develop the "Office Protocol" for potentially suicidal patients. See the "Office Protocol Development Guide" instruction sheet in the Toolkit.

3. Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

4. Develop a referral network to facilitate the collaborative care of suicidal patients. Use the "Developing Mental Health Partnerships" materials in the Toolkit.

5. Read the Toolkit's "Primer." Providers may wish to study the last two sections on Suicide Risk Assessment and Intervention first. The first three sections may then be reviewed in order to gain knowledge about Prevalence, Comorbidity, Epidemiology, and Prevention.

6. Order community and patient education tools, such as suicide prevention posters and brochures, for your office. See the "Patient Education Tools" section of the Toolkit.

WICHE
Western Interstate Commission for Higher Education

Implementation Checklist for the Suicide Prevention in Primary Care Toolkit

- [ ] Discuss suicide prevention initiative with all Office Staff and determine lead coordinator for the office.
- [ ] Read Chapter 2: Educating Clinicians and Office Staff of the Toolkit (all Office Staff).
- [ ] Identify which depression and suicide screens and assessments will be utilized in your office (e.g., PHQ-9, C-SSRS); determine:
  - When will patients complete this screen/assessment (e.g., with intake paper work)?
  - Who will review it and how is this information flagged? (e.g., flag depression/suicide like any other condition for provider follow-up).
- [ ] Proactively complete Office Protocol Template in Toolkit to establish procedures for working with a suicidal patient. Information here includes:
  - What professionals can be called upon to assist with suicide risk assessment
  - Name and location of nearest Crisis Stabilization Unit or Emergency Department
  - Responsible office staff contacts for documentation and follow-up
- [ ] Have Toolkit resources and individual patient intervention templates regarding suicide assessment and safety planning available to Office Staff and clinicians such as:
  - Pocket Guide: Assessment and Interventions with Potentially Suicidal Patients
  - Safety Planning Guide: A Quick Guide for Clinicians
  - Patient Safety Plan Template
  - Crisis Support Plan
- [ ] Develop a referral network to facilitate the collaborative care of suicidal patients.
- [ ] Conduct a mock drill for safely and sensitively working with and potentially hospitalizing a patient.
- [ ] Follow-up/Outreach. Identify who will follow-up with patients who have expressed suicidal ideation and how follow-up will occur (e.g., office visit, phone call).

In case of the need for hospitalization:

- [ ] Hospitalization is always the last resort, if efforts at illness management, safety planning, and referral fail to mitigate risk.
- [ ] Identify and label where all necessary forms, such as legal Mental Health Hold and Evaluation forms, for hospitalizing suicidal patients will be kept (it is assumed that the patient's physician will fill out all necessary paperwork for hospitalization).
- [ ] Identify who will sit with the patient while waiting for transport to the emergency department if necessary.
- [ ] Identify how soon a patient should be seen back in your clinic after being evaluated by the emergency department and/or being hospitalized. How frequently should they be seen and for what duration should more intensive contact with the PCP occur?

Office Protocol for Suicidal Patients – Development Guide

The purpose of an Office Protocol for Suicidal Patients is to anticipate and have an appropriate plan in place before a suicidal patient is identified. This office suicidal patient care management plan allows providers and office staff to be prepared when treating a patient who is assessed to be at high risk for suicide. Initial assessment of a potentially suicidal patient can be conducted by a member of the office staff or by an external consultant. An office protocol template, to simplify the process of further assessing and potentially hospitalizing a high-risk patient, can be found on the following page of this Toolkit. It will help a practice to proactively answer the logistical questions related to getting additional psychiatric care for patients before a crisis occurs, and guide providers quickly and efficiently when a patient is in need of such care.

The office protocol is an essential component of a comprehensive office strategy for suicide prevention, and may be developed during staff meetings. Once the protocol is developed, it may be useful for the office to implement a "dry run" with a mock patient to ensure that the protocol can be followed seamlessly. Suicide prevention trainings, including warning signs to look for, inquiring about suicidal ideation, and how to respond to suicidal individuals, can be provided to all office staff as an in-service. See Module 3: Effective Prevention Strategies, in the Primer section of this Toolkit, for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies may require an investment of time and money, they constitute best practices for care and may save lives.

Consider involving all office staff in suicide prevention efforts. Staff members are frequently in positions to observe changes in behavior or hear patients express suicidal ideation that the patient may be reluctant to share with the provider. Office staff can play a crucial role by detecting concerning behaviors and alerting the patient's provider.

Locate specific information about your state's involuntary treatment laws and post this in the office along with contact information for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), which also offers free materials, including posters and cards with the Lifeline number. Professionals at that number can also direct practices to community mental health service providers in their area.

Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions ...

- _____ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
- _____ should be called/paged to assist with collaborative safety planning.
- Identify and call patient's support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization ...

- Our nearest Emergency Department or psychiatric emergency center is _____
- Phone # _____
- _____ will call _____ to arrange transport.
  (Name of individual or job title) (Means of transport [ambulance, police, etc.] and phone #)

Backup transportation plan: Call _____

- _____ will wait with patient for transport.

Documentation and follow-up ...

- _____ will call ED to provide patient information.
- _____ will document incident in _____
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms/instructions/chart-flagging materials are located _____
- _____ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- _____ will follow-up with patient within _____
  (Name of individual or job title) (Time frame)

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Place:** _____ 4. **Place:** _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Name:** _____ **Contact:** _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

2. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

3. **Local Emergency Department:** _____

Emergency Department Address: _____

Emergency Department Phone : _____

4. **Suicide Prevention Lifeline Phone:** 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention