WICHE Access Innovation Collaboration
Western Interstate Commission for Higher Education

SPRC Suicide Prevention Resource Center

A SUICIDE PREVENTION TOOLKIT FOR RURAL PRIMARY CARE

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Overview

- Toolkit Development
- Why Rural?
- Why Primary Care?
- Primary Care Suicide Prevention Model
- Overview of Toolkit Components
- Next Steps

Toolkit Development

- WICHE/Mental Health Program – HRSA
- SPRC—SAMHSA
- Formative evaluation
  - Reviewers (AHEC provider and community committees)
  - Pilot webinar – U CO – interdisciplinary health professions students in rural track
  - American Association of Suicidology Conference—panel presentation
- Launch June 2009

Why Rural?

- Suicide rates are higher for nearly every demographic group in rural vs non-rural*
- The gap between rural and urban suicide rates is widening*
- Access to mental health services is less in rural vs. non-rural
  - One-third of the most rural counties (population < 2,500) have no mental health professional**

* Singh GK, Siahpush M. The increasing rural urban gradient in US suicide mortality, 1970,-1997 Am J Public Health. 2003 July 2003;93(5):1161-1167

** Advancing Suicide Prevention, Fall/Winter 2004-5

Suicide Mortality Rural vs. Urban by Gender

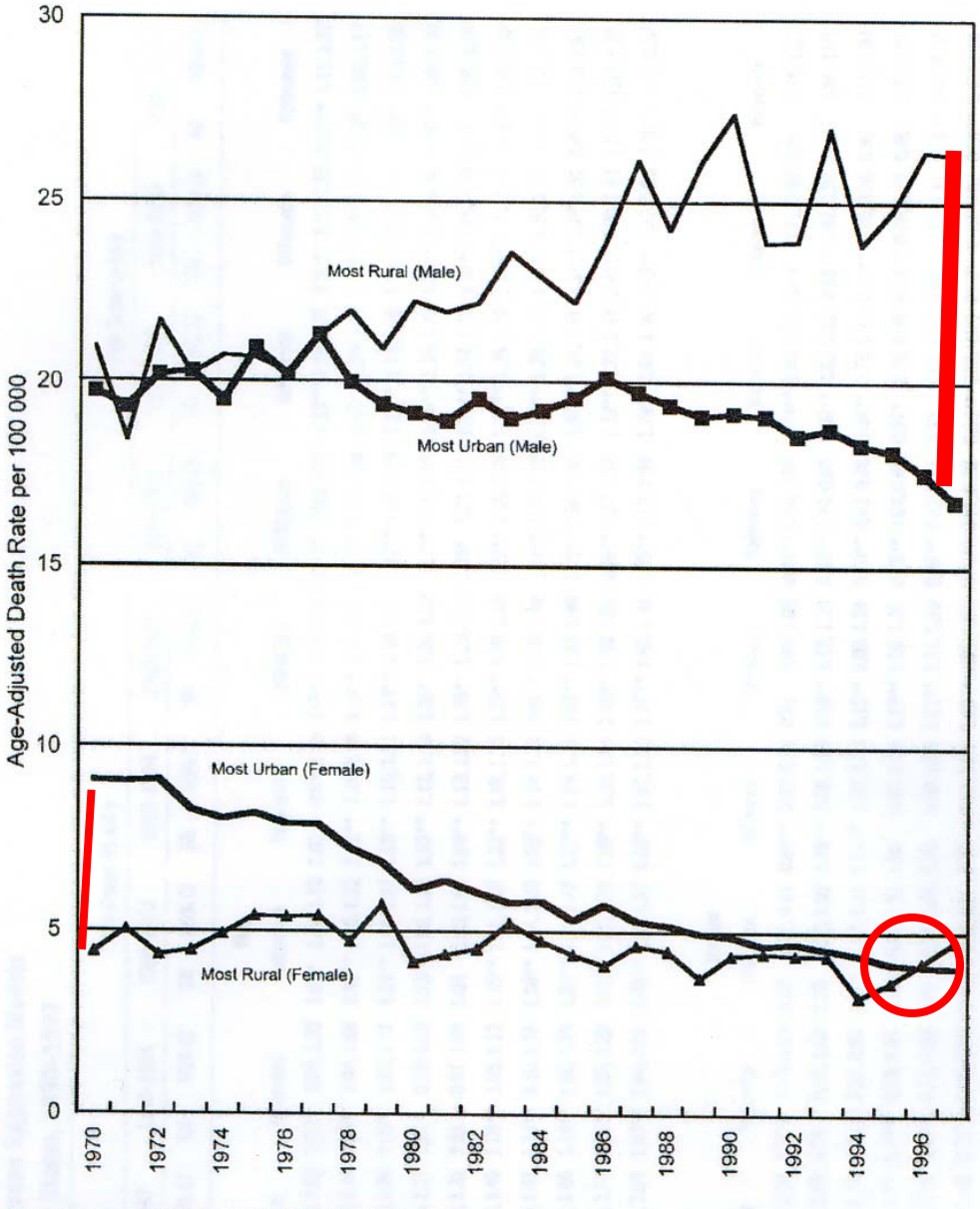
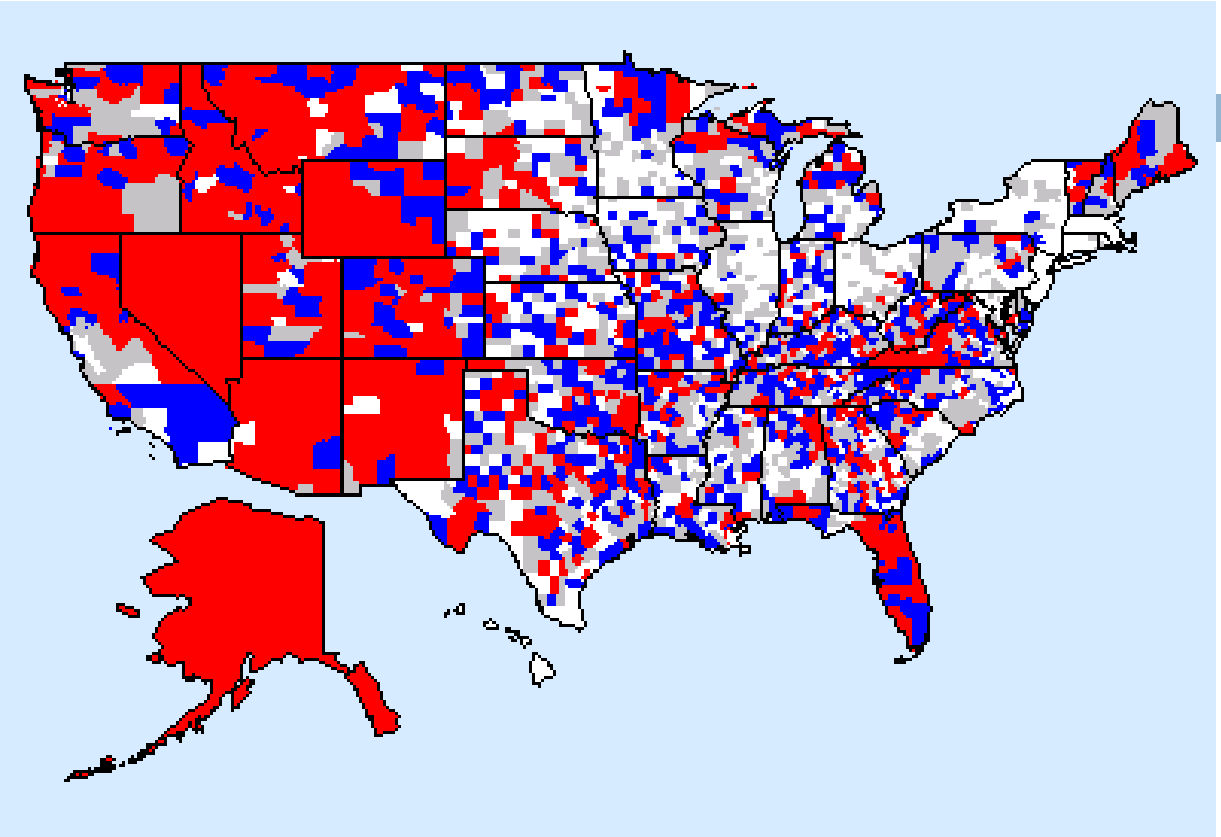


FIGURE 1—Age-adjusted US suicide mortality rates for the most urban counties (metropolitan, 1 million people or more) and the most rural counties (fewer than 2500 people): 1970 to 1997.

Singh GK, Siahpush M. The increasing rural urban gradient in US suicide mortality, 1970,-1997 Am J Public Health. 2003 July 2003;93(5):1161-1167

Suicide, by county



http://www.cdc.gov/ncipc/maps/default.htm

- Red 75th national percentile
- Blue 50th national percentile
- Gray 25th national percentile
- White <25th national percentile

Why Primary Care?

- Suicide decedents are twice as likely to have seen a PC provider than a MH provider prior to suicide*
- Reach working-aged men
- Many key risk factors identified in PC settings
- Supports integration of PC & MH
- Chronic disease management rubric
- Patient education roles should include
  - Suicide warning signs and response
  - Safe firearm storage

* Luoma J, Martin C, Pearson J. Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence Am J.Psychiatry 159:6 (2002) 909-916.

Contact with Primary Care and Mental Health Prior to Suicide

All Ages	Month Prior	Year Prior
Mental Health	19%	32%
Primary Care	45%	77%

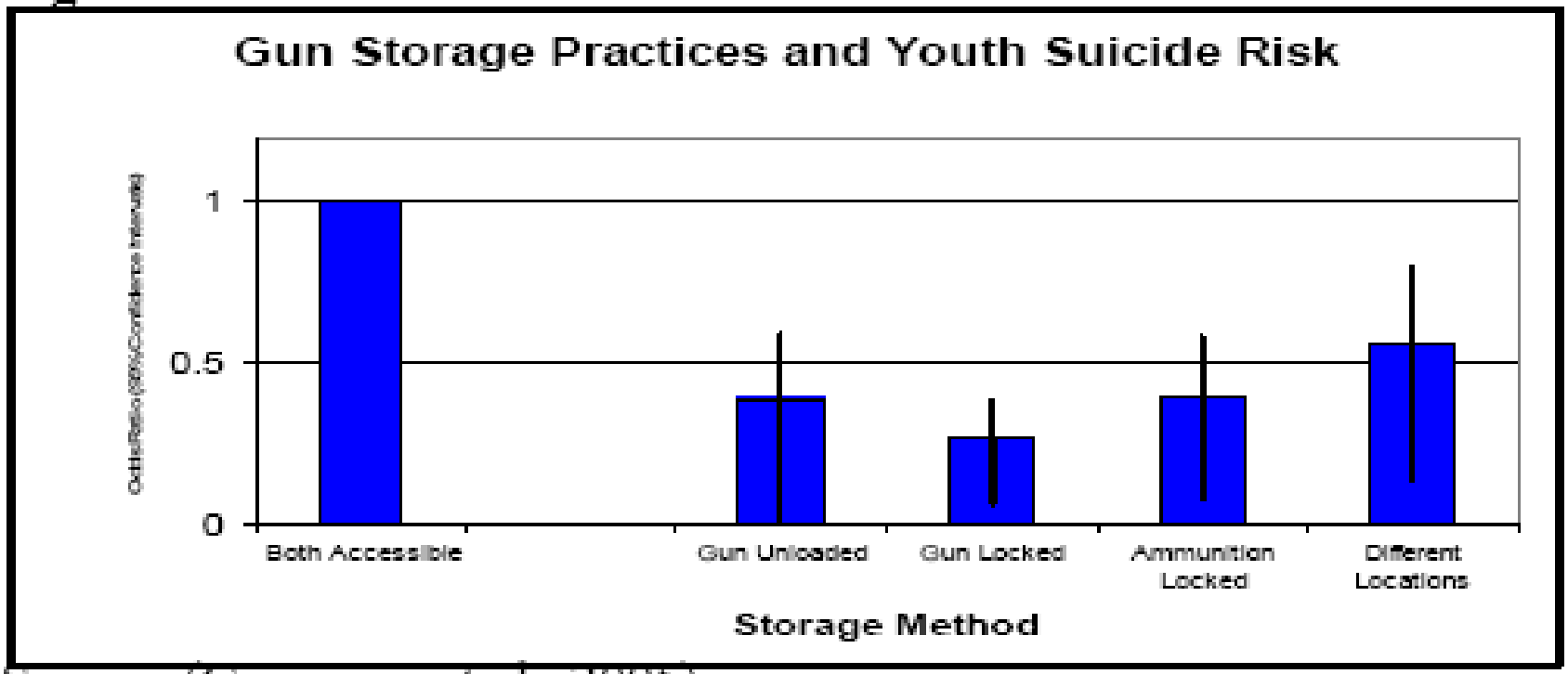
Contact w/ PC by Age	Month Prior
Age <36	23%
Age >54	58%

Contact w/ MH by Gender	Month Prior	Year Prior
Men	18%	35%
Women	36%	58%

- Luoma J, Martin C, Pearson J. Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence Am J.Psychiatry 159:6 (2002) 909-916.

Safe Firearm/Ammunition Storage

Figure 3.



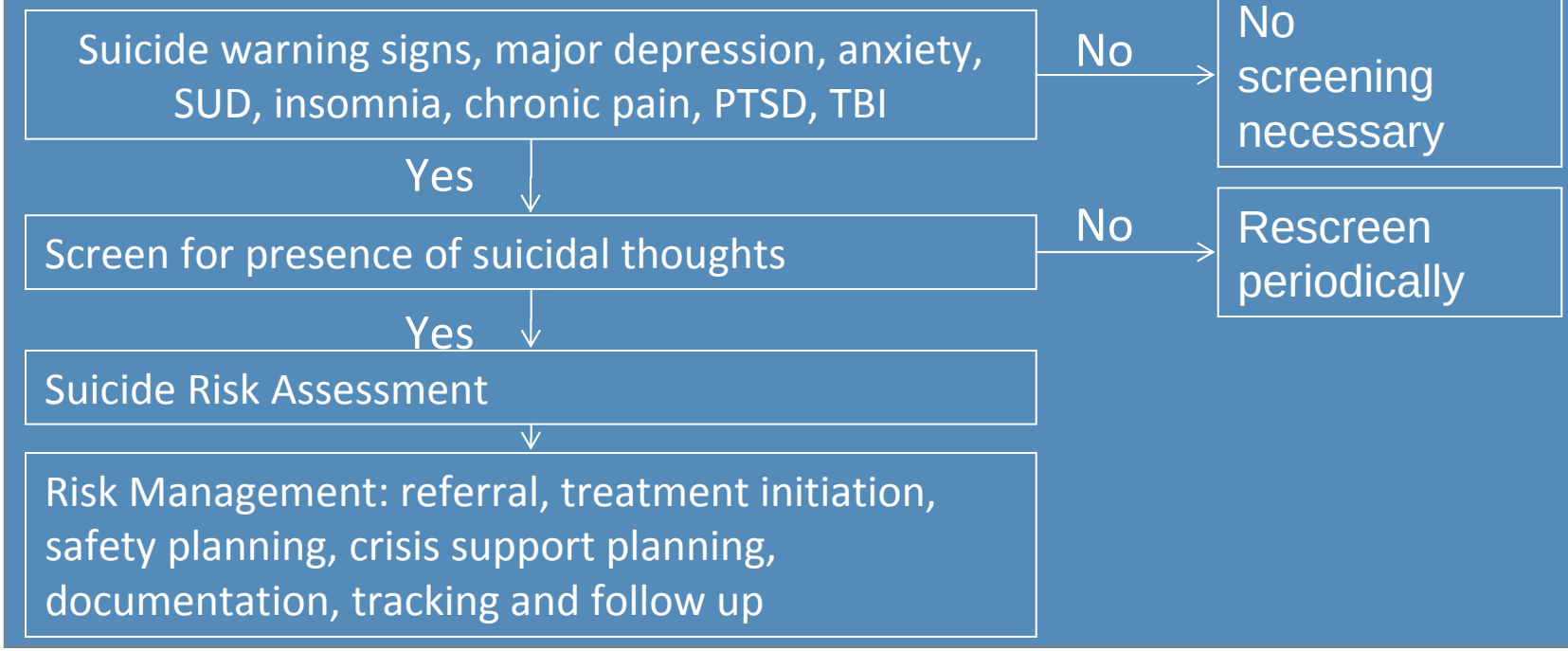
Source: (Grossman et al., 2005)

Primary Care Suicide Prevention Model

Prevention

1.Staff vigilance for suicide warning signs & key risk factors
2.Universal depression/SA screening for adults and adolescents
3.Patient education:
Safe firearm storage
Suicide warning signs & 1-800-273-TALK (8255)

Intervention



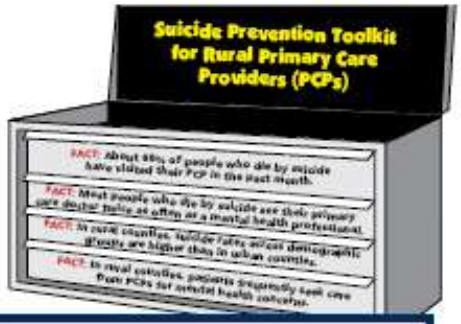
Toolkit: Overall Layout

- Six sections
  - Getting started
  - Educating clinicians and office staff
  - Developing mental health partnerships
  - Patient management tools
  - Patient education tools
  - Resources
- The Toolkit is available in 2 forms
  - Hard copy, spiral bound ordered through WICHE
  - Electronic copy (www.sprc.org)

1. Getting Started

QUICK START GUIDE

How to use the Suicide Prevention Toolkit



STEP 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.

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

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

STEP Develop a referral network to facilitate the collaborative care of suicidal

1. Getting Started

Office Protocol Development Guide

To be used with instruction sheet to create an office protocol that may be referred to when a potentially suicidal patient presents

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…

✓ _____ **should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).**

✓ **Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).**

If a 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 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)

2. Educating Clinicians and Office Staff

- Primer with 5 brief learning modules
  - Module 1- Prevalence & Comorbidity
  - Module 2- Epidemiology
  - Module 3- Effective Prevention Strategies
  - Module 4- Suicide Risk Assessment
    - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
  - Module 5- Intervention
    - Referral, PCP Intervention, Documentation & Follow-up

Primer

Suicide Prevention Toolkit for Rural Primary Care

A Primer for Primary Care Providers

Western Interstate Commission for Higher Education (WICHE) Mental Health Program

and

Suicide Prevention Resource Center (SPRC)

SPRC Suicide Prevention Resource Center

WICHE Mental Health Program

Across the West · Across the Nation · Across the Boundaries

THE WICHE Center for Rural Mental Health Research: supported by the Federal Office of Rural Health Policy; Health Resources and Services Administration (HRSA), Public Health Service, Grant Award, *U7CRH03715* [illegible]. Any opinions/findings/ conclusions/ recommendations expressed in this material are those of the author and do not necessarily reflect the views of HRSA or SAMHSA.

Module 1- Prevalence and Comorbidity

Prevalence of Suicide

More than 32,000 deaths by suicide occur each year in the U.S.[i]

Suicide rates across demographic groups are higher in rural counties than in urba[illegible] counties.[ii]

Suicide is the second leading cause of death in persons 25-34 years old in the U.S.

Suicide is the third leading cause of death in persons 15-24 years old in the U.S.[iii]

Suicide was the eleventh leading cause of death (all ages) in U.S.[iv]

In Primary Care:

Up to 88% of people who die by suicide had contact with their primary ca[illegible] physician (PCP) in the year prior to their death.
Up to 66% had contact with their PCP in the month prior to their suicide.[v]
These same individuals were more than twice as likely to have seen their PCP as[illegible] mental health professional in the year and month prior to their suicide.[vi]

Comorbidity

Mental illness is neither a necessary nor sufficient condition for suicide, but is strongly associated with suicide

More than 90% of people who die by suicide have a mental health disorder [illegible] substance abuse disorder, or both. (For youths under 16, that percentage is muc[illegible] lower, but still significant.)

More than 50% of suicides are associated with a Major Depressive Episode.

At least 25% of suicides are associated with a substance abuse disorder, especiall[illegible] with alcohol abuse or dependence.

Ten percent of suicides are associated with a psychotic disorder such a[illegible] Schizophrenia[vii]

Aggressive treatment of psychiatric and substance use disorders is an important pa[illegible] of a comprehensive, primary-care based approach to suicide prevention.

4

Patients in whom warning signs or other risk factors are detected should be asked about suicidal thoughts as well. In other words, it is essential to screen for suicidality if there is any suspicion that a patient might be suicidal.

Key Risk Factors

- Prior Suicide Attempt
- Major Depression
- Substance Use Disorders

Other Risk Factors

- Other mental health or emotional problems
- Chronic Pain
- Insomnia
- PTSD
- Traumatic Brain Injury (TBI)
- Events or recent losses leading to humiliation, shame or despair

Some or all of the Sample Questions in Module 4 for inquiring about Thoughts of Suicide can be used for informal screening of patients. The key is to ask directly about thoughts of suicide or ending one's life as part of the screening. Practice asking the question(s) several times before trying it in a clinical situation.

Sample screening question:

- Sometimes people with our condition (or in your situation), feel like they don't want to live anymore; or sometimes they think about killing themselves. Have you been having any thoughts like these?

A positive response to this screening requires additional assessment (Module 4). More formal suicide screening instruments, such as paper and pencil questionnaires, are also available for use in primary settings or can be devised using the question above or questions in Module 4. These instruments should always be used as an augment to the clinical interview.

4. Educating Patients about Suicide Warning Signs

Just as we educate the public on the warning signs of strokes and heart attacks, we should provide basic information to the public on the warning signs of suicide. For severe warning signs, the appropriate response may be to call 911 or go to a hospital emergency department. For other situations it may be appropriate to call the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). Calls to this number are routed to a nearby certified crisis center with trained counselors. Counselors are

8

Aggressive treatment of psychiatric and substance use disorders is an important part of a comprehensive, primary-care based approach to suicide prevention.

3. Developing Mental Health Partners

- Letter of introduction to potential referral resources--template
  - Increasing vigilance for patients at risk for suicide
  - Referring more patients
  - SAFE-T card for Mental Health Providers
  - Invitation to meet to discuss collaborative management of patients
  - NSSP recommends training for health care professionals
  - Nationally disseminated trainings for MHPs

3. MH Partners

SAFE-T

Suicide **A**ssessment **F**ive-step **E**valuation and **T**riage

for Mental Health Professionals

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
  Co-morbidity and *recent onset of illness increase risk*
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- Family history: of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- Change in treatment: discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- Internal: ability to cope with stress, religious beliefs, frustration tolerance
- External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- Ideation: frequency, intensity, duration--in last 48 hours, past month and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1-3
- Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

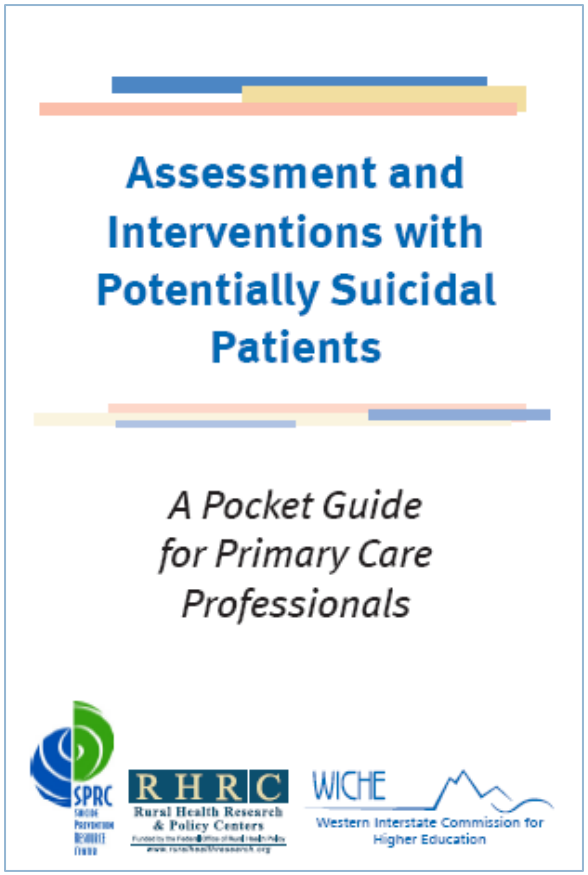
3. MH Partners – Telemental Health

- Web-based guide for developing a telemental health capacity (created by the U CO Denver as part of SAMHSA's Eliminating Health Disparities Initiative) www.tmhguide.org
- Resources for
  - Clinicians/Administrators
  - Consumers
  - Policymakers
  - Community Members
  - Media

3. MH Partners

- SAMHSA mental health and substance abuse treatment locator guides (www.samhsa.gov)
- Veterans resource locator (http://www.suicidepreventionlifeline.org/Veterans/ResourceLocator.aspx)

4. Patient Management—Pocket Guide



Suicide Risk and Protective Factors[1]

RISK FACTORS

- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).

  ***Co-morbidity** with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: also oppositionality and conduct problems.
- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- **Family history:** of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- **Chronic medical illness** (esp. CNS disorders, pain).
- **History of or current abuse or neglect.**

PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk.

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance.
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports.

4. Patient Management—Pocket Guide

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

SPRC RHRC Rural Health Research & Policy Centers WICHE Western Interstate Commission Higher Education

Screening: uncovering suicidality[2]

- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought of hurting yourself?
- Have you ever thought about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans[3]

- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide? How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:

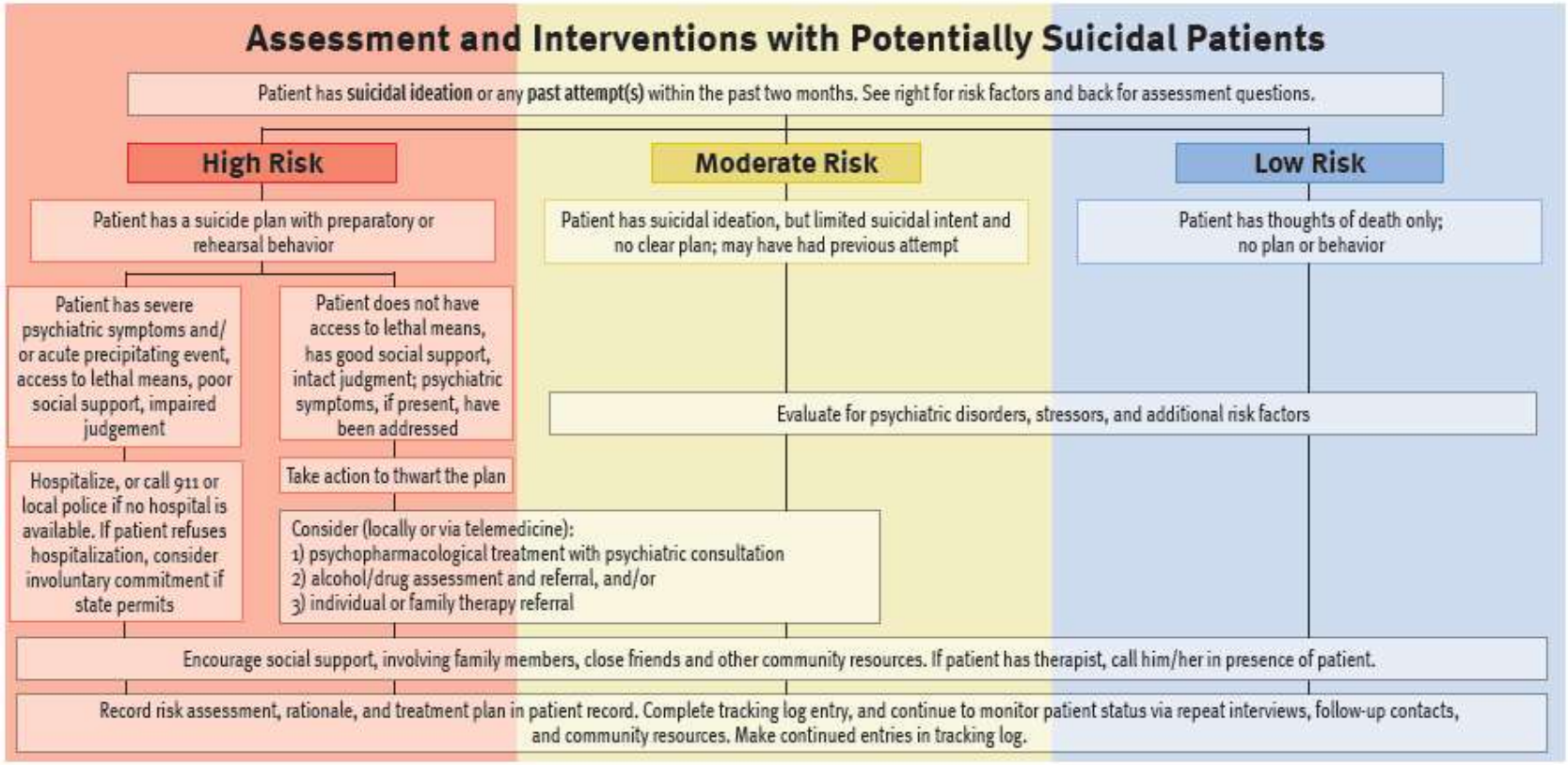
[1] SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).

[2] Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

[3] Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.

4. Patient Management—Pocket Card

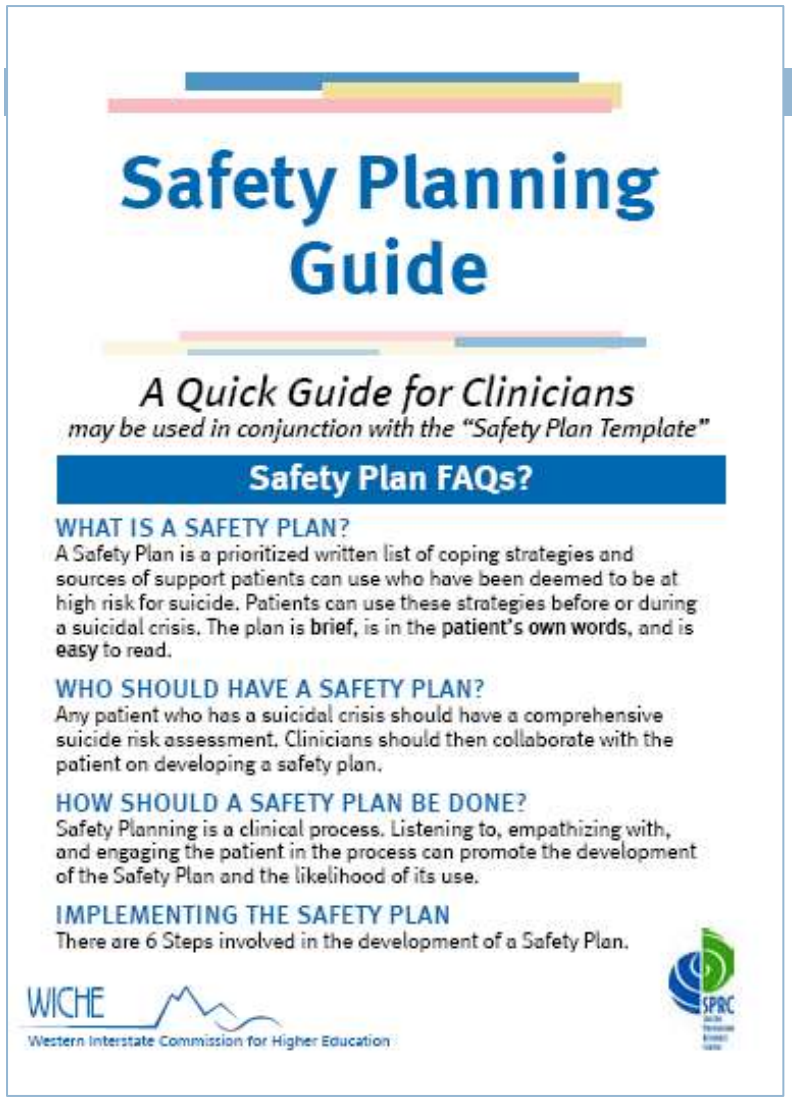
Assessment and Interventions with Potentially Suicidal



4. Patient Management

- "Safety Plan" (Brown and Stanley, 2008)
  - Collaboratively developed with patient
  - Template that is filled out and posted
  - Includes lists of warning sings, coping strategies, distracting people/places, support network with phone numbers
- "Crisis Support Plan" (Rudd, 2006)
  - Provider collaborates with Pt and support person
  - Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed

4. Patient Management



Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

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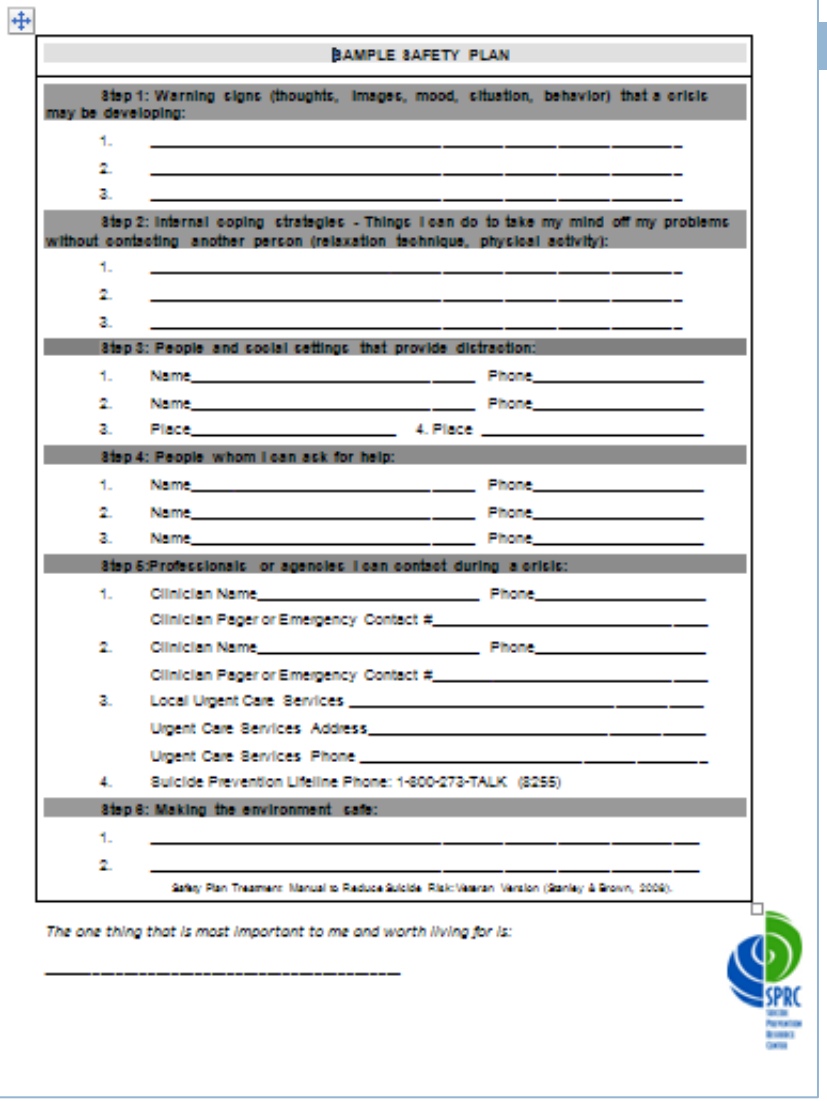

SAMPLE SAFETY PLAN

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk:Veteran Version (Stanley & Brown, 2008).

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

_____

Stanley B, Brown G. (2008). Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. Washington DC: Department of Veterans Affairs. http://www.mentalhealth.va.gov/College/suicide.asp Accessed November 4, 2009.

4. Patient Management

CRISIS SUPPORT PLAN

FOR: _____ *DATE:* _____

I understand that suicidal risk is to be taken very seriously. I want to help _____ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - _____
  - _____
- Help_____ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms & ammunition
  2. Remove or lock up:
     - knives, razors, & other sharp objects
     - prescriptions & over-the-counter drugs (including vitamins & aspirin)
     - alcohol, illegal drugs & related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict

Suicide Prevention Resource Center Training Institute. (2008) Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. Newton, MA: Education Development Center, Inc.

4. Patient Management - Tracking Log

- Log & Instruction sheet
- Provider uses:
  - Update PCP on suicide status of a patient
  - Remind provider of recent interventions or problems with regard to the patient's treatment

Suicidality Treatment Tracking Log (for Patient Chart)

Patient Name _____ Medical Record #_____ Primary Care Provider_____

Session Date								
V = Visit P = Phone C = Cancellation NS = No Show	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS	V P C NS
Suicidal thoughts?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Suicidal Behaviors?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Risk: H = High M = Moderate L = Low	H M L	H M L	H M L	H M L	H M L	H M L	H M L	H M L
Medication Prescribed?	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds	Yes No Meds
Medication Dosage/Start Date								
Medication Adherence	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Medication Side Effects								
Other Interventions								
Mental Health Provider	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____

Suicide Status Tracking discontinued (date ____/____/____) because: Suicidality Resolved_____Dropped out _____Other _____

5. Patient Education

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

6. Resources

- Resource list for providers
  - Associations & Organizations
  - Other resources with links for downloading or ordering
- Posters and brochures for clinics

Next Steps

Next Steps

- Formal pilot testing
- Dissemination
  - Conferences
  - Rural health
  - Primary care associations and guilds

Next Steps

- Further development ideas
  - Additional tools
    - Financing
    - Preventing suicides among PC providers and staff
    - Postvention
  - Tailoring for specific patient groups (e.g., pediatrics, veterans, military, elders)
  - Translation into training curricula for clinicians and staff

Questions?

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www.sprc.org