C·B·H

a division of DBHIDS

CLINICAL PRACTICE GUIDELINES

Suicide Prevention

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Community Behavioral Health

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1. BACKGROUND

As part of the efforts for the **OMHSAS-issued 2025 Suicide Prevention Performance Improvement Project (SP-PIP)**, **Community Behavioral Health (CBH)** and **The City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS)** worked together to extract and analyze data related to suicide risk factors and suicide prevention efforts from multiple sources, including claims data, medical examiner's office (MEO) death records, significant incident reports, and relevant **HEDIS®** data. This multifaceted data analysis provided the DBHIDS/CBH SP-PIP team with a deeper understanding of suicide risk and protection factors in Philadelphia, encompassing both clinical and non-clinical aspects of suicide prevention. Additional data were gathered through surveys and in-person interviews, including the voices of members and providers. The compilation of quantitative and qualitative data enabled CBH to identify areas of need and to develop interventions. Additional data analysis was obtained from the **Penn Center for Mental Health (Penn)** study on the epidemiology of suicide (launched in 2020), which analyzed data from 2003 to 2024 in Philadelphia across various administrative, clinical claims, and other systems-level data sources (including jails and emergency shelters).

Preliminary data from Penn's research reflect that the suicide rate (defined as the number of individuals who died by suicide divided by the number of individuals enrolled in the defined population) in Philadelphia is lower than the national average. The suicide rate in Philadelphia was 10 to 11 per 100,000 between 2016 and 2019, and rose from 2020 to 2022 to a maximum of 13.1 per 100,000, and then reduced back to 11.7 per 100,000 in 2024. Much of this change is likely attributable to the COVID-19 pandemic.

Of note, in Philadelphia, the suicide rate for Medicaid enrollees is lower than that of non-enrollees. In 2024, the suicide rates were 7.0 deaths per 100,000 individuals among Medicaid enrollees compared to 17.4 deaths per 100,000 individuals among non-Medicaid enrollees. However, Medicaid enrollees died by suicide at younger ages. Their average age of death was 40 years, which was over seven years earlier than that of non-Medicaid enrollees.

Lethal means used to complete suicide included firearms, suffocation, blunt trauma, and poisoning. Among Medicaid enrollees in Philadelphia during the period from 2016-2024, the most common mechanisms of suicide were firearms and suffocation. There was an overall increase in the use of firearms among Medicaid enrollees, from approximately 20% of suicide deaths in 2016 up to approximately 40% of suicide deaths in 2022-2024. This may be attributable to changes in firearm ownership and policy during this period.

Medicaid enrollees who died by suicide frequently engaged with other systems of care: 83.5% had at least one physical health claim, while 78.8% had at least one pharmacy claim. A smaller proportion (52.0%) had at least one behavioral health claim. Of those with a behavioral health claim, approximately half had a claim within 90 days of their death.

In the fall of 2025, CBH requested that the entire Provider Network complete the **Zero Suicide Organizational Self-Study** as part of the PIP preparation. This assessment allowed providers to consider their internal policies and protocols in the context of the **Zero Suicide Framework**. Results of the survey identified several opportunities for growth and improvement in suicide prevention, as well as standardization related to suicide screening and safety planning efforts. One intervention to facilitate these improvements is the creation of suicide prevention clinical practice guidelines (CPG).

CBH has adopted CPGs to outline best practices for the treatment of specific disorders or certain populations. These guidelines will be used as a tool for CBH to assess the quality of care provided to its members. As such, providers are advised to review and, where appropriate, implement these practices in their care. CPGs apply to all clinical settings where members are seen with these disorders. CPGs should be used in conjunction with any level of care (LOC) specific performance standards, as well as all other required CBH, state, and federal regulations and standards.

2. PURPOSE

CBH is committed to working with our provider partners to continuously improve the quality of behavioral health care for our shared population. Whenever possible, this is best accomplished through the implementation of evidence-based practices and those informed by nationally recognized treatment guidelines, while respecting the need for individualized treatment and recovery planning. These guidelines will be maintained and updated collaboratively with providers and system stakeholders to reflect evolving evidence-based practices or changes in national guidelines.

This CPG aims to articulate best practices and quality monitoring standards for suicide prevention. These guidelines reflect components of the **Zero Suicide Framework**:

1. **Lead** system-wide culture change committed to reducing suicides.
2. **Train** a competent, confident, and caring workforce.
3. **Identify** members with suicide risk via comprehensive screening and assessment.
4. **Engage** all members at risk of suicide using a suicide care management plan.
5. **Treat** suicidal thoughts and behaviors directly using evidence-based treatments.
6. **Transition** members through care with warm hand-offs and supportive contacts.
7. **Improve** policies and procedures through continuous quality improvement.

The guidelines include recommendations for specific screening tools, primarily the **Columbia Suicide Severity Rating scale (C-SSRS)** and the **Patient Health Questionnaire 9 (PHQ-9)**, and safety planning interventions, primarily the **Stanley Brown Safety Planning Intervention**.

Appendices acknowledge that potential approaches to certain populations (children/adolescents, peripartum, and geriatric) may require specialized care. CBH recognizes that there are other possible subgroups for which modifications to these guidelines can be clinically justified by evidence.

CBH expects providers to follow these guidelines in addition to all other relevant CBH, state, and federal regulations and standards, including the **CBH Provider Manual** and the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) **Practice Guidelines for Resiliency and Recovery-Oriented Treatment.**

CBH and DBHIDS encourage a biopsychosocial and recovery-based approach to treatment; in each case, these guidelines should be part of a multidisciplinary treatment approach that also involves collaboration between physical health and behavioral health providers and the inclusion of families and other supports whenever appropriate and possible.

3. PRACTICE GUIDELINES

3.1. Acute Crisis/Imminent Harm Response

Potential risk for suicide can be identified in any treatment or community setting at any time. If there is an imminent risk for harm to self or others, such as a member expressing current active suicidal ideation with plan and/or intent, or current suicidal behaviors, providers should arrange for emergency evaluation.

Please see the **CBH Member Handbook** and the **Provider Manual's Continua of Services document** (located under the "Authorizations" tab) for information on CBH crisis intervention services, which include:

- Crisis Walk-In at a corresponding **Crisis Response Center (CRC)**
- Community Mobile Crisis Response Teams (CMCRT)
- Crisis Intervention Response Teams (CIRT)
- Children's Mobile Crisis Teams (CMCT) (see **Appendix F** for more information)
- Children's Mobile Intervention Services (CMIS) (see **Appendix F** for more information)

For the most up-to-date listing of CBH Providers delivering these LOCs, visit the **CBH Provider Directory**.

The **National Suicide Prevention Lifeline (988)** provides 24/7, free, and confidential support to people across the U.S. in suicidal crisis or any emotional distress. While the old number (1-800-273-8255) remains operational, the shorter dialing code aims to improve access to the lifeline's network of trained counselors and over 200 crisis centers. The 988 number will connect local callers to Philadelphia Crisis Line operators. This line can also be reached directly (215-685-6440), though without opening call-routing for specific categories (e.g., Spanish language, Veteran). The City of Philadelphia also hosts information on this service at **healthymindsphilly.org**.

If a member is in an acute crisis, the provider should take steps to ensure the member's and staff's safety. Staff should seek immediate help/alert a supervisor, or use another emergency reporting system. Staff should stay with the member (or remain in contact by phone or other means) until additional help arrives. Staff should attempt to use de-escalation skills, such as a calming tone of voice, non-confrontational questioning, offering to make the member more comfortable, offering food/water, removing stressful stimuli, and using relaxation techniques. Staff should try to obtain relevant information such as member whereabouts, medical status, and emergency contact information.

If the member can engage in conversation and answer questions, with no immediate risk of harm, then the provider can implement suicide screening processes as outlined below.

3.2. Suicide Risk Screening and Identification

Adequate processes to identify and screen for suicide risks are a critical component of behavioral health care delivery. CBH requires the use of a standardized, structured, evidence-based tool to assess suicide risk. CBH strongly recommends the use of the Columbia Suicide Severity Rating Scale (C-SSRS) in all treatment settings. Other evidence-based suicide screening tools include the **Ask Suicide Questions (ASQ)** and the Suicide Prevention Resource Center (SPRC) **Patient Safety Screener (PSS-3)**. While other tools can be used to screen for suicide risk (e.g., PHQ-9, PHQ-3), these are more intended for use as depression screeners and do not provide sufficient information related to suicide risk screening.

There are **various versions of the C-SSRS** for different LOCs, care transitions, and treatment settings, as well as versions in multiple languages, self-administered versions, and versions for children or those with cognitive impairment. Providers are encouraged to choose the version most clinically appropriate for their LOC, treatment setting, and the specific population served.

CBH recommends that providers consider the use of both the Complete/Full C-SSRS as well as the screener version, with additional details below:

3.2.1. Complete/Full Suicide Risk Screening

The C-SSRS Full version includes questions about both recent (within the past 1 month) and historical (lifetime) suicidal ideation, intensity of the ideation, and suicidal behaviors, including the lethality of the behavior.

3.2.2. Basic Screening

C-SSRS has "Screener Basic Recent" or "Since last asked" versions that can be used for a quick, more limited screen. This assessment is designed to be completed by many community members (teachers, police, first responders, EMTs, etc.) and does not require mental health training. This version can be quickly administered and consists of 6 questions:

- Suicidal Ideation (questions 1-5): questions asked in a tiered style from least to most intense
- Suicidal Behaviors (question 6): question to assess for any history of suicidal behavior, including actual attempt, interrupted attempt, aborted attempt, preparatory behavior

3.2.2.1. Frequency of Screenings

Suicide risk screenings should be completed at the onset of treatment and on an ongoing basis. For members who screen negative (e.g., no positive response on the Columbia screener), CBH recommends ongoing screening at each treatment plan update (every 90 days). For members who screen positive, CBH recommends the screening be completed:

- Outpatient LOCs: screening should occur at every treatment session.
- Inpatient or residential LOC: At a minimum daily, but could be more often for those at high risk (e.g., every waking shift)

C-SSRS (or other screening tool) results should be integrated into the overall clinical assessment. When multiple clinicians see members, providers can review the results of a C-SSRS completed by a different team member, but should confirm the accuracy of the information. If discrepancies become apparent, the provider should try to clarify the results and/or document the reason for the discrepancy.

Providers should develop their own protocols for screening frequency, based on members' risk status and LOC. Other high-risk scenarios that warrant screening include, but are not limited to:

- Recent stressful life event (e.g., death of a loved one, a break-up, loss of employment/housing, etc.)
- Acute mental health decompensation or crisis (e.g., uncontrolled psychosis, severe depression, heightened anxiety/panic, etc.)
- Expressing recent suicidal thoughts or attempts, or preparatory acts or behaviors
- Lack of care or meeting basic needs for themself
- Report of an increase in non-suicidal self-injurious behavior (NSSIB)
- Collateral information source reports the member expressed or engaged in suicidal thoughts, acts, or other high-risk behaviors
- Recent release from incarceration (the highest risk is in the 30 days following release, with elevated risk continuing for at least one year)
- Recent discharge from psychiatric treatment in a higher LOC or other inpatient treatment setting (the highest risk is in the 30 days following discharge, with continued elevated risk through 90 days)
- Before a change in observation status or treatment setting (e.g., discontinuing 1:1 observation, discharge from inpatient setting, etc.)
- Recent changes in psychiatric medications (particularly if accompanied by side effects of agitation, insomnia, or akathisia/anxiety)
- Recent major medical diagnosis or event (e.g., cancer, severe injury, uncontrolled pain, etc.)
- For children/adolescents, also consider:
  - New foster care involvement or a change in foster care status
  - Recent reports of bullying/cyberbullying

Provider Requirement: CBH requires providers to screen all members receiving services for potential suicide risk using an evidenced-based screening tool. CBH strongly recommends use of the C-SSRS. Suicide risk screenings must be completed at the onset of treatment and on an ongoing basis. The policy should outline the frequency of screenings and staff responsible for completing and reviewing the screening results. All relevant staff must be provided with training/education on how to administer the screening tool and interpret the results. This education should be completed at the time of hire, and then at least annually.

3.2.3. Training Resources

- Prevent Suicide PA
  - **Introduction to Suicide Assessment in the Outpatient Primary Care Setting**
  - **Assessment and Clinical Management of Suicidal Youth**
- The Columbia Lighthouse Project
  - **C-SSRS Screener Training**
  - **C-SSRS Training**

3.3. Risk Assessment and Triage

3.3.1. Risk Assessment

CBH recommends that all members have a comprehensive suicide risk assessment at intake and after any new positive suicide screen. Risk stratification guidelines are embedded in many of the C-SSRS tools. For example, the **C-SSRS with SAFE-T-Protocol** is a version of the Columbia, which includes additional risk assessment factors, such as activating events, treatment history, clinical status, access to lethal methods, and identification of protective factors. The tool also includes recommended triage interventions and recommendations for clinical documentation.

Some risk assessments, such as the Comprehensive Suicide Risk Evaluation (CSRE) used by the VA[1], assess both acute (immediate, short-term, high-intensity crisis) and chronic risk (long-term, taking into account baseline susceptibility).

Studies consistently find multiple interacting risk factors present for individuals who die of suicide. These include biological, psychological, and social and environmental factors. The risk factors can range from

[1] *Saulnier KG, Bagge CL, Ganoczy D, Bahraini NH, Jagusch J, Hosanagar A, Ilgen MA, Pfeiffer PN.* ***Suicide Risk Evaluations and Suicide in the Veterans Health Administration***.

remote (chronic) to recent (acute), and can be static or dynamic. Adopted from **Stahl's Handbook on Suicide Prevention**, factors to consider and document in the risk assessment include:

- Results of the structured tool (C-SSRS)
- High risk symptomatology: hopelessness, insomnia, agitation, aggression, impulsivity, shame, burdensomeness
- History of self-harm or prior suicide attempts
- Severity of past attempts
- NSSIB
- Family history of completed suicide or suicide attempt
- Chronic, worsening, or uncontrolled pain
- Medical comorbidity
- History of traumatic brain injury (TBI)
- Substance use (particularly if use has increased, or a relapse has recently occurred)
- Comorbid psychiatric diagnoses (MDD, bipolar disorder, substance use, psychosis, BPD, PTSD, etc.)
- Recent changes in psychotropic medications (especially if the member is experiencing insomnia, agitation, or anxiety)
- Recent loss of a loved one
- Recent relationship conflict or breakup
- Bullying/Harassment
- Recent major life change resulting in instability (loss of job/housing/legal concerns/financial concerns)
- Recent traumatic event
- Recent exposure to suicide (suicide of a family member/peer/community member, or celebrity) This can be particularly true for children/adolescents, as research has shown they may be more susceptible to social contagion than adults, due to developmental factors like identity formation and peer importance, affecting behaviors like substance use, aggression, and mental health trends (depression, anxiety, suicidality)

- History of trauma (with attention to childhood sexual abuse, adverse childhood experiences (ACEs))
- Foster care or DHS involvement
- Cultural beliefs that hinder or deter from help-seeking and/or stigmatize mental health
- Access to, or new acquisition of, lethal means (firearms, potentially lethal medications, access to dangerous chemicals, bridges/buildings, cars, knives, ropes, belts)
- Members who identify as LGBTQ+
- Youth who have experienced rejection/ridicule/disownment from family networks, social groups, or other community groups
- Recent searching for or acquiring suicidal means, giving away of possessions, planning for suicide, or creating a will

A risk assessment should also consider protective factors. There is limited understanding of the degree to which protective factors impact a member's risk. Thus, protective factors should be considered individually, as part of a comprehensive risk assessment. Protective factors include:

- Family/other psychosocial supports
- Cultural beliefs that discourage suicide or encourage help-seeking
- Existing clinical supports (established care with specific providers or LOC)
    - Sense of connectedness to others or to roles/activities
    - Good physical health
- Psychological factors: flexible thinking, maintaining hope in the face of difficulty, optimism, finding meaning, resilience
    - For youth: healthy family dynamics, supportive school environment

3.3.2. Triage Monitoring Based on Risk

Provider policies should outline the workflows and protocols for members determined to be at various risk levels (e.g., imminent, high, moderate, low), and should consider both acute and chronic risk.

This can include, but is not limited to:

- **Imminent Risk:** The policy should be based on available resources and feasibility. Providers should utilize clinical interventions including, but not limited to, 1:1 observation or other heightened supervision to ensure an environment without access to lethal means. There should be protocols/procedures for emergency/crisis management and for referral to a higher LOC.

- For community-based providers, these interventions should include arrangements for immediate consultation with the supervisor/physician, referral to a higher LOC/mobile crisis/CRC, and/or petitioning for involuntary commitment.

- For inpatient/bed-based providers, these interventions should include protocols for responding to acute crises (calling code; alerting the physician; assessing the need for medical attention, 1:1 observation, medication, seclusion, restraint, etc.).

- **High Risk:** The policy should include clearly stated protocols and expectations for ongoing screening (including frequency), assessment of whether the member can independently maintain safety, whether there is need for higher LOC, safety planning intervention, frequency of clinical contacts/observation, referral for any needed behavioral health supports/services, protocols for information sharing with treatment team and other supports, mitigation of acute/chronic risk through enhancing protective factors and reducing modifiable risk factors, and use of evidence-based treatments.

  - Safety planning should be completed as a treatment intervention as soon as possible for members with suicidal intent, suicidal intent with a plan, or suicidal behaviors.

  - Safety planning may also be appropriate for other members (e.g., those with a recent suicidal crisis over one month ago) as assessed by the clinician.

- **Moderate Risk:** The policy should include clearly stated protocols and expectations for ongoing screening (including frequency), safety planning intervention (if applicable), frequency of clinical contacts (or observation if applicable), referral for any needed behavioral health supports/services, protocols for information sharing with treatment team and other supports, mitigation of acute/chronic risk through enhancing protective factors and reducing modifiable risk factors, and use of evidence-based treatments.

- **Minimal/Low Risk:** For members at minimal and/or low risk, management should include, at a minimum, ongoing routine screening.

Provider Requirements: Providers are required to update the High Risk Assessment Policy to include procedures and protocols for complete risk assessment and recommended management.

All providers must have a protocol for assessment of imminent risk, and a structured plan for how to ensure members at imminent risk are emergently referred to needed services and/or higher LOC.

Any member who screens positive should have complete risk assessment performed. If a provider is unable to complete a full risk assessment (such as peer services or case management) the member must be promptly referred to provider who can complete this.

Provider policy should include protocols for the expected management and follow up for members based on their individualized risk.

3.4. Safety Planning

The **Stanley-Brown Safety Planning Intervention** (SPI) and similarly structured protocols, such as Crisis Response Planning[2], are evidence-based brief interventions for members who have experienced recent acute risk for suicide. The purpose of a safety plan is to engage in a collaborative intervention with a member that results in a concrete plan to manage future acute suicidal crises. CBH recommends the use of a structured, evidence-based protocol, such as the Stanley-Brown SPI. The SPI is a collaborative clinical intervention that results in a prioritized list of warning signs, strategies, and external resources to use during a suicidal crisis.

Components of the SPI include:

- **Narrative interview:**
  This component invites the member to tell the story of a specific, recent suicidal crisis so they and the provider can develop a shared understanding of how the crisis began and escalated, what happened at its peak, and how it de-escalated.

- **Psychoeducation about the nature of acute suicidal crises and the rationale for an SPI:**
  With psychoeducation, the provider uses the member's narrative to illustrate that suicidal crises are time-limited and suicidal urges come and go. The provider explains that putting together an SPI for the member to use during a suicidal crisis reduces risk by allowing the crisis to pass with time without the member acting on their suicidal urges.

- **Recognizing warning signs/triggers:**
  These signs include specific thoughts, emotions, or behaviors that precede an acute suicidal crisis for the member.

- **Employing internal coping strategies:**
  These strategies include highly distracting activities that the member can do alone, without involving another person.

  - The best activities are simple and easy for the member to do. It is not sufficient to select strategies that are enjoyable or soothing; activities must be highly distracting. The activities should be specific and individualized, based on the member's specific situation and what they have access to.

- **Utilizing people and social settings that provide distraction:**
  These are friends/family supports that the member can call or seek out, and specific social settings they can go to be around people for distraction. It is not intended that the member disclose suicidal thoughts to people in this step. For teens, this person may be a peer.

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[2] *Bryan CJ, Mintz J, Clemans TA, Leeson B, Burch TS, Williams SR, Maney E, Rudd MD.* ***Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial.***

- **Utilizing family members, significant others, caregivers, or friends to help resolve the crisis:** These are trusted individuals to whom the member can disclose the suicidal crisis and ask for help. For children/adolescents, these should be trusted adults rather than peers.

- **Contacting mental health professionals, crisis services, or agencies:** These contacts include established clinicians, crisis hotlines (e.g., 988, Crisis Text Line, The Trevor Project), and emergency services (e.g., CRC, Mobile Crisis, Emergency Room).

- **Making the environment safer (reducing access to lethal means):** For every suicide method the member has considered (gathered during earlier comprehensive suicide risk assessment), identify a specific action plan that can be implemented to reduce access to these identified methods, including involving family/support people in lethal means reduction.

  This includes, but is not limited to, securing guns, firearms, weapons, ropes, belts, knives, chemicals, and medications that are dangerous in overdose. When possible or necessary, steps should be taken to contact family or support people to confirm that lethal means have been removed or secured. For inpatient and residential providers, lethal means reduction should also include assessment of the physical environment and consideration of removing anchor points (e.g., door hinges, hooks) and high-risk items (e.g., cords, bandages, strings, plastic bags, cleaning supplies), as well as adequate observation/supervision of the at-risk member.

  See Counseling on Access to Lethal Means (CALM), a practical intervention to increase the time and distance between members at risk of suicide and the most common and lethal methods of suicide.

The SPI results in a living document created in collaboration with the member. The member should be given a copy of this safety plan. With member consent, a copy should be shared with the member's supports (e.g., school, parent/family, friends, case managers). The plan should be easy to read and use the member's own words. It should be free of medical and clinical jargon.

When a member is identified as needing an SPI, the safety plan should be developed concurrently or within 24 hours. It is recommended to follow up within 72 hours to ensure the completion of actions related to lethal means reduction. The safety plan should be reviewed at the next treatment session, and then in an ongoing fashion (at a minimum every 90 days, but more often for those at heightened risk). This should include reviewing the various components of the safety plan and confirming that the information remains accurate and relevant.

There should be regular check-ins with the member as to whether they have needed to use their safety plan. If the member has used their plan, they should be asked about what worked and what did not. The safety plan should be collaboratively revised based on this conversation.

Provider Requirements: Providers are required to update their High-Risk Assessment Policies to include safety planning that must be completed as a treatment intervention as soon as possible for members with suicidal intent, suicidal intent with plan, or suicidal behaviors (i.e., corresponding to positive responses to items 4-6 on the C-SSRS screener). Safety planning can be completed for other members per the clinician's discretion. CBH recommends use of the

Stanley-Brown SPI safety plans must include a section for efforts taken to reduce access to lethal means. The safety plan should be reviewed and updated in an ongoing fashion (at minimum every 90 days, but more often for those at heightened risk). The policy should clarify who is responsible for completing and reviewing the safety plan. The provider must provide all relevant staff with education on how to complete safety plans. This education should be completed at the time of hire, and then at least annually.

3.4.1. Training on SPI

- **Stanley-Brown SPI Training Resources**
- SPRC: **Safety Planning for Youth Suicide Prevention**
- Penn Psychiatry: **Clinical Training in Suicide Prevention**
- Prevent Suicide PA: **Developing Effective Safety Plans for Suicidal Youth**

3.5. Health-Related Social Needs (HRSN)

Various factors have been known to increase the risk of suicidal ideation or suicide attempt. Much of this is covered above in sections on risk factors. Beginning in 2020, CBH and DBHIDS partnered with the **University of Pennsylvania Center for Mental Health** to conduct a review of the data related to suicide in Philadelphia in a project called *The Epidemiology of Suicide*. This project and additional data analysis are ongoing. It is important to note that some population sample sizes are small. Preliminary results reflect that, relative to the Philadelphia Medicaid population, suicide decedents were more likely to have a behavioral health claim (54.0% vs. 26.0%; adjusted risk ratio 3.03), a history of jail admission (18.2% vs. 5.6%; adjusted risk ratio 2.59), or a history of foster care (10.2% vs. 5.8%; adjusted risk ratio 2.57).

There were also differences when comparing the racial/ethnic composition of suicide decedents to the entire Medicaid population within age groups. Among some of the youngest age groups (ages 6 to 12 and 18 to 20), Black non-Hispanic individuals made up a disproportionately large share of suicide decedents relative to their share of the Medicaid population. Whereas among older age groups (ages 45 to 64 and 65+), White non-Hispanic individuals were overrepresented among suicide decedents. Hispanic individuals were underrepresented among suicide decedents across all age groups compared to their share of the Medicaid population. Again, it is important to note that some population sample sizes are small.

According to The Trevor Project's **2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People**, LGBTQ+ individuals are also at heightened risk of suicide. There is limited data available to assess suicide risk among LGBTQ+ CBH members specifically; however, the survey reported that 39% seriously considered attempting suicide. This rate rose to 46% for transgender and nonbinary young people. Approximately 12% of LGBTQ+ young people reported they had attempted suicide in the past year. LGBTQ+ youth who reported living in very accepting communities were 50% less likely to report having had a suicide attempt, highlighting the importance of community support. Access to care was also a concern, as only half of LGBTQ youth who wanted mental health care were able to get it.

There is widespread evidence to support screening for various aspects of social risk within clinical care. As part of assessment and recovery planning, providers should identify relevant health-related social needs (HRSN). Modifiable factors should be noted, and attempts should be made to support or connect members to resources to address them as part of a comprehensive recovery plan. Racial, cultural, social, linguistic, and other HRSN factors that may impact the member's therapeutic alliance should be considered in treatment. Efforts should be made to reduce barriers to engagement (e.g., transportation difficulties, childcare issues, financial instability) when feasible.

3.6. Diagnosis

Suicidal ideation/suicide risk is not a stand-alone diagnosis in the DSM-5; however, it does include "Suicidal Behavior Disorder" and "Non-suicidal Self-Injury" as conditions for future study with proposed criteria.

ICD-10 codes can be used to identify and track suicidal ideation, suicide attempt, and nonsuicidal self-harm. These codes are underutilized. These codes can be submitted on the claim in any position other than the primary diagnosis. The codes include:

ICD-10 Code	Title
R45851	Suicidal ideations
R4588	Nonsuicidal self-harm
T149XA	Suicide attempt, initial encounter
T149XD	Suicide attempt, subsequent encounter
T1491XS	Suicide attempt, sequela
Z9151	Personal history of suicidal behavior
Z9152	Personal history of nonsuicidal self-harm

Suicidal ideation and behavior are components and criteria for other diagnoses, specifically, major depressive disorder (MDD), bipolar disorder, borderline personality disorder (BPD), and post-traumatic stress disorder (PTSD). Suicidal ideation is also often comorbid with substance use disorders (SUDs) and psychotic illnesses. Members who are determined to have suicidal ideations or suicide risk should be fully evaluated for these conditions. CBH requires screening for depression with the PHQ-9 and postpartum depression with the Edinburgh Postnatal Depression Scale (EPDS). Additional information can be found on the CBH Screening Programs Webpage.

3.7. Management/Treatment

Management of members who are at risk for suicide is complex. Treatment should be multifaceted and incorporate biopsychosocial treatment modalities. All co-morbid conditions (MDD, anxiety disorders, substance use disorders, medical conditions, etc) should be addressed.

- Stanley-Brown SPI (see above section)

- Evidence-based psychotherapies:
  - **Cognitive Behavioral Therapies for Suicide Prevention (CBT-SP)**
    There is good evidence that manualized, individualized CBT designed specifically to address suicide risk can improve outcomes for suicidal members. The landmark study ***Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial*** found that CBT-SP led to a 50% reduction in subsequent suicide attempts when provided to patients presenting to the emergency department within 48 hours of a suicide attempt. **Another trial** adapted this protocol for military service members and found that brief CBT led to a 60% reduction in subsequent suicide attempts when provided to active duty army soldiers who were experiencing suicidal thoughts with a plan, or had a recent suicide attempt.
  - **Dialectical Behavioral Therapy (DBT)**
    DBT is an evidence-based, manualized therapy based on CBT that has been developed to treat suicidal ideation in members with BPD. According to ***Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder***, DBT has been shown to reduce suicide attempts by 50-70% when compared to control groups. Other findings included reduced hospitalization, lower emergency room utilization, lower medical risk, and improved treatment retention.
  - **Collaborative Assessment and Management of Suicidality (CAMS)**
    CAMS is a treatment that can be delivered in an outpatient setting in as few as six sessions. It has a very strong evidence base for reducing suicidal ideation and general distress, and increasing treatment acceptability and hope. There is also a program designed for youth and teens called ***CAMS-4Teens®***.
  - **Attachment-Based Family Therapy (ABFT)**
    ABFT is a family treatment that aims to reduce suicide risk among suicidal adolescents.
  - Problem-Solving Therapy for Suicide Prevention
  - Brief Interventions
  - Teachable Moments Brief Intervention (TMBI)
  - Crisis Response Planning (CRP)
  - Attempted Suicide Short Intervention Program (ASSIP)
- Medication considerations:
  - Comorbid conditions should receive appropriate evidence-based treatments.
  - Some medications (see below) have some evidence showing their efficacy to reduce suicidal ideation/behavior.

- **Lithium** has been shown to have efficacy for suicide prevention for both depressed and bipolar mood disorders. The suicide prevention effects are not "on demand or short-term," thus the medication should be used as part of a more long-term approach. It is also important to monitor for suicidal ideation, as this medication can be lethal in overdose. Its use requires laboratory monitoring studies (e.g., renal, thyroid, and other metabolic side effects). For times of heightened risk, the medication can be held by family or other support or given in small quantities.

- **Clozaril** is efficacious in reducing suicide risk for individuals with schizophrenia and schizoaffective disorder.

- **Ketamine infusion** is recommended by the VA/DoD clinical practice guidelines as an adjunctive treatment for short-term reduction of suicidal ideation in individuals with suicidal ideation and MDD.

- **Ketamine/Spravato® (esketamine) nasal spray** may be considered for adults with treatment-resistant depression or those with MDD with acute suicidal ideation, in conjunction with an oral antidepressant. While Spravato has shown promising efficacy in randomized trials, there are serious warnings and considerations, leading to strict monitoring of side effects and limited access through REMS-approved providers. For more information about Spravato prescribing and implementation within the CBH network, please see *Spravato® (Esketamine): Protocol and Procedures for Behavioral Health Provider Implementation of the Two-Hour Monitoring Period* on the **CBH Provider Manual webpage** under the Additional Documents tab.

- **Antidepressant medications (SSRI and SNRI)** are the gold standard for pharmacotherapy for depression.

  Providers should monitor for suicidal thoughts or behaviors when starting and titrating these medications, as there are black box warnings about those risks, particularly in younger populations.

➡ Other prevention strategies:

» Support groups for suicide attempt survivors

» Building community, sense of belonging/connection (see the SPRC webpage **Promote Social Connectedness and Support**)

» Multi-component community interventions, which may include training on mental/behavioral health topics and/or suicide risk factors; local networking and/or community facilitation; and providing mental/behavioral health and/or suicide prevention materials (see the **VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide – Provider Summary**)

3.8. Monitoring of Treatment

Careful and objective monitoring of treatment response is essential for guiding clinical care and maximizing the likelihood of achieving recovery. Monitoring should be conducted regularly to assess the response to psychotherapy, pharmacotherapy, or both. As above, there should be ongoing screenings based on individualized risk factors and clinical presentation (see additional information in the **Suicide Risk Screening and Identification** and **Risk Assessment and Triage** sections). A complete risk assessment should be completed for members who screen positive. Safety planning should be completed for those with suicidal intent, suicidal intent with a plan, or suicidal behaviors (this corresponds to positive responses to items 4-6 on the C-SSRS screener). Safety plans should be reviewed at the subsequent treatment session, and then periodically as needed.

Providers should follow their internal policies regarding the recommended treatment interventions for members based on their risk level. For members who are at moderate or high risk, this may include: interdisciplinary treatment team meeting, collaboration with other involved providers, medication adjustment, utilization of evidence-based psychotherapy, referral to a higher LOC, review of the safety plan, and collaboration with family or other identified supports (with consent). When a member is determined to be at imminent risk, the provider should follow internal policies to address this. These may include, but are not limited to, activating an emergency response system, calling 988 or 911, referring to a CRC, seeking voluntary or involuntary admission, etc. Providers should document the steps taken to address a member's suicide risk in the medical record.

When relevant, treatment plans should include individualized goals and interventions related to suicide prevention or reduction in risks of harm to self. Treatment planning is a collaborative process that involves the member. For members who are making progress, this should be reflected in the treatment plan, along with a notation of what has been effective for the member. For members who are not making progress, the treatment plan update should include steps taken to address the lack of progress or barriers to the member's success.

3.9. Coordination and Care/Linkages

Providers should have a structure in place that supports integrated care and collaboration with other treatment providers, including, but not limited to, physical health and mental health providers, case management services, family or other identified supports, housing services, justice system services, etc. Collaboration to coordinate care is expected among providers within an agency, as well as with external providers and entities that provide members' care. The purpose of this collaboration should be discussed with the member. The medical record should include documentation of this discussion and any attempts to coordinate care.

The member's safety plan should be shared with relevant providers/supports (with consent), including, but not limited to, family, social supports, case managers, schools, and other treatment providers. There should be documented efforts to collaborate during periods of heightened risk or when more severe symptoms are present. If a member declines collaboration, providers must assess risk and determine whether the clinical status warrants a break in confidentiality (such as when there is a concern that a member is at imminent risk of harm to themself or others). Providers should document their rationale for collaboration (or lack thereof) in these circumstances.

CBH requires evidence of real-time collaboration efforts in high-risk circumstances, including, but not limited to: suicide attempt, self-harm that requires medical attention, medical or psychiatric hospitalization, transitions in LOC, such as discharge from a hospital/residential setting, or significant change in the member's suicide risk status. Providers should be aware that they can call CBH to ask about services provided to members and to help find members' real-time locations, such as when a member is hospitalized.

3.10. Aftercare Planning/Discharge

Members should be involved in aftercare planning, and the plan should reflect their goals and preferences. Planning should include a clear, specific follow-up plan for the next recommended LOC. An appointment should be scheduled, and a warm handoff should be provided whenever feasible. Family, involved supports, and community-based providers (as well as schools for children/adolescents) should be involved in the discharge planning process. The safety plan should be reviewed and updated before discharge or step down in LOC. The updated safety plan should be shared with supports and other treatment providers (with consent). Care transitions also provide an opportunity to confirm that access to lethal means has been considered and that steps have been taken to mitigate risk as much as possible. For members at risk for suicide due to medication overdose, safety planning should address this. Options include ensuring that the family/support person holds/administers/secures medications (e.g., a lockbox) or providing a smaller supply of medications with more frequent refills.

Discharge documentation should be transmitted to the next LOC provider (giving copies to members does not comprise transmission). Copies of discharge medication plans should also be provided directly to members or caregivers. Providers should ensure that members have continued access to their medications during care transitions. For additional information about Discharge Medication Planning, please see the CBH website's **Pharmacy Resources for Providers page**.

The **Zero Suicide Framework** suggests that members may benefit from a follow-up contact within 24 to 48 hours post-discharge from inpatient care, and again at seven days post-discharge and/or until the member has attended one outpatient appointment. The follow-up contact should include "screening for suicide risk, and as needed, conduct full risk assessment and check in regarding safety plan and access to lethal means." In addition, the **VA/DoD Clinical Practice Guidelines** recommend "periodic caring communications," in the form of mail or text messages, in addition to usual care, for 12 months following a hospitalization related to suicide risk.

3.10.1. Structural Recommendations

CBH recommends that provider agencies consider additional interventions aimed at suicide prevention, which include:

- Creating a suicide prevention team (e.g., Zero Suicide Implementation Team)
- Inviting suicide attempt or suicide loss survivors to participate in the suicide prevention efforts of the organization (e.g., participating in policy decisions, assisting with employee training, participation in quality improvement, serving as "patient voice" in decision-making teams/boards)

4. MONITORING

CBH encourages its providers to maintain internal quality management programs to ensure treatment adheres to these and other applicable guidelines. CBH will continue to develop systematic strategies to support high-quality care within the network, including tracking valid quality-of-care metrics for various elements of treatment. In certain instances, CBH may request medical records to be reviewed for quality-of-care concerns. In addition, CBH will track the following performance metrics:

CMS MIPS 504: Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk: This measure assesses the percentage of adults aged 18 years and older who had suicidal ideation or behavior symptoms (based on results of a standardized assessment tool or screening tool) or increased suicide risk (based on the clinician's evaluation or clinician-rating tool) for whom a suicide safety plan is initiated, reviewed, and/or updated in collaboration between the patient and their clinician. It is calculated annually and includes two rates, as follows:

- Percentage of members 18 and older for whom a suicide safety plan is initiated, reviewed, or updated in collaboration between the patient and their clinician (concurrent or within 24 hours of the index clinical encounter)
- Percentage of members 18 and older for whom a suicide safety plan is initiated, reviewed, or updated in collaboration between the individual and their clinician at the time the suicidal ideation, behavior, or risk is identified (concurrent or within 24 hours of the index clinical encounter) AND reviewed and updated within 120 days after initiation

In addition, providers should maintain documentation of evaluations and interventions described in these guidelines, whether delivered by the provider or obtained from an outside practitioner. CBH will continue to monitor the treatment provided to ensure consistency.

APPENDIX A: REFERENCES

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- **Zero Suicide Organizational Self Study**, 2021, Suicide Prevention Resource Center and Education Development Center.

APPENDIX B: STRUCTURED TOOLS

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- SAMHSA Suicide Assessment Five Step Evaluation and Triage (SAFE-T)
- SAFE-T with C-SSRS (The SAMHSA SAFE-T risk assessment tool with C-SSRS questions embedded and triage categories)
- Ask Suicide-Screening Questions (ASQ) Toolkit
- Stanley-Brown Safety Planning Intervention (SPI)
- Patient Health Questionnaire (PHQ-9)
- SPRC Patient Safety Screener (PSS-3)
- Edinburgh Postnatal Depression Scale (EPDS)

APPENDIX C: CBH RESOURCES

- CBH Provider Directory
- EPIC Evidence-Based Practice (EBP) Program Designation
- Healthy Minds Philly Mental Health Screening Tools
- CBH Screening Programs
- CBH Clinical Practice Guidelines: Treatment of Adults with Major Depressive Disorder (MDD)
- DBHIDS Crisis Continuum Resources
- 988 Suicide & Crisis Lifeline

APPENDIX E: PERIPARTUM

A full discussion of suicide prevention in the peripartum period is beyond the scope of this CPG. Still, this appendix addresses some of the special considerations for this population and provides additional resources.

Though the suicide rate in pregnancy and the postpartum is very low (approximately 2 per 100,000 live births), it remains a leading cause of death among pregnant and postpartum women, accounting for approximately 20% of postpartum deaths. Suicidal ideation is also common in the postpartum period, with estimates from 5-14% of postpartum individuals. Perinatal suicide has a profound and long-lasting effect.

While some studies have shown pregnancy and parenthood to be protective against suicide, the association is not well established. Multiple studies have sought to identify potential risk factors for suicide in the postpartum period. These can include individuals who have a history of abuse or trauma (experienced recently or in the past), and those with peripartum depression or postpartum psychosis. Other risk factors include, but are not limited to, older age, individuals who are white or Native American, and those experiencing intimate partner conflict.

Peripartum depression is common. The most commonly used screening questionnaire for postpartum depression is the **Edinburgh Postnatal Depression Scale (EPDS)**. CBH requires providers to use the EPDS to screen for postpartum depression in any members who have given birth in the last 84 days. Screening results and any recommended follow-up steps should be discussed with the member. Members who score equal to or greater than 10 (positive screening) may have depression and should be referred for prompt follow-up at an appropriate LOC. Positive answers to item 10 on the EPDS may indicate suicidal thoughts. They should trigger additional screening and assessment for suicide risk with the completion of the **Columbia Suicide Severity Rating Scale (C-SSRS)**.

Risk assessments should include screening for any suicidal ideation, homicidal ideation (including thoughts to harm the child/children), and psychotic symptoms. Consideration should be given to the welfare of any children in the person's care.

Additional screening to identify bipolar disorder and/or psychotic symptoms among individuals experiencing mood symptoms during the peripartum period is critical, as this population is at an increased risk for the onset or relapse of bipolar disorder, with the highest risk occurring during the postpartum period. The use of a validated screening tool, such as the **Mood Disorder Questionnaire (MDQ)**, to identify mood disorders and/or psychotic symptoms is recommended to support appropriate treatment and prevent misdiagnosis.

For individuals who are pregnant or breastfeeding, informed consent discussions about medication are essential. They should highlight possible risks to the mother and unborn child, as well as benefits and alternatives. Also included in these discussions should be any risks associated with untreated depression. Providers should consider the reproductive status of the individuals that they treat and should aim to have these discussions before pregnancy if possible.

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Website Resources

- PubMed Drug and Lactation Database (Lactmed)
- CDC's Treating for Two
- womensmentalhealth.org
- ncrptraining.org

Patient Facing Resources

- mothertobaby.org
- postpartum.net

APPENDIX F: CHILDREN/ADOLESCENTS

A full discussion of suicide prevention in the peripartum period is beyond the scope of this CPG. Still, this appendix addresses some of the special considerations for this population and provides additional resources.

According to the **American Academy of Pediatrics (AAP)**, suicide is the second leading cause of death among individuals ages 10-24, accounting for over a quarter of all deaths, and rates have been rising for decades. Data from the **2023 Youth Risk Behavior Survey** indicated that among high school students, 20% reported "seriously considering suicide," and 9% attempted suicide within the past year. Rates of suicide attempts were higher among female than male students, and higher among LGBTQ+ than cisgender and heterosexual students.

Most children and adolescents who experience suicidal thoughts do not bring up the topic on their own. Therefore, screening can open the door to a potentially life-saving discussion and intervention. The AAP recommends screening all patients aged 12+ and targeted screening for youth aged 8-11 with behavioral health symptoms. They also recommend that those under the age of 8 should be assessed if a parent reports suicidal behavior, or the child presents with depressed mood, severe irritability, suicidal ideation, or a history of suicidal behaviors.

Providers treating children and adolescents should follow the same guidelines outlined above in the CPG related to screening for suicide risk, assessing and managing suicide risk, and safety planning. CBH recommends using the C-SSRS screening instrument for children and adolescents. The C-SSRS has a modified version for children ages 6-11. There are some special considerations for children and adolescents, as outlined below:

- As mentioned above, factors that have been associated with increased suicide risk in children/adolescents include DHS/foster care involvement, LGBTQ+ youth, bullying/cyberbullying, juvenile justice system involvement, and developmental disabilities.
- AAP guidelines note it is best to screen adolescents aged 12+ without their parent/caregiver in the room to encourage open and honest discussion.
- For children/adolescents determined to be at high risk for suicide after screening and assessment, immediate action should be taken to secure the child's safety. The provider should carefully, empathetically, and without rushing explain the need for precautions to ensure safety to them and their adult guardians.
- Collaboration within and between involved providers, school, agencies, and family/social supports is critical in this population.
- Safety planning can also include involving families to regularly monitor children/adolescents until safety has stabilized.
- Lethal means reduction is a critical part of safety planning in this population, as studies have shown that youth and young adults can impulsively act on suicidal thoughts/urges, with 24% of 13-34-year-olds reporting going from suicidal thinking to acting on their plan within five minutes.

- Lethal means reduction should include careful consideration of potential dangers in the child/adolescent's environment in all settings (i.e., home, school, caregivers).
- Attention should be given to medication access (including parents' medications). When a child/adolescent is experiencing suicidal thoughts, medications (both prescription and over-the-counter) should be locked away, and steps can be taken to reduce the quantity of medications in the home.
- As per AAP guidelines, firearms should be removed from the home when a child/adolescent is experiencing thoughts of suicide. If removal is not possible, firearms should be stored unloaded and locked, with ammunition stored separately and locked. Children/adolescents should not have access to the lock codes or keys.
- While clinicians can at times find it difficult to discuss firearm safety with the families they serve, this is an essential part of safety planning and suicide prevention.
- Additional information on firearm safety can be found in the APA's *Monitor on Psychology* article, **"Talking to patients about firearm safety."**
- Alcohol, drugs, household cleaners, weapons, and other dangerous products should be removed from the home or locked up.
- Cognitive Behavioral Therapy (CBT) is moderately effective for clients experiencing suicidality, specifically helping to decrease suicidal ideation and suicide attempts. A focused form of CBT called Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) has been developed to help adolescents experiencing suicidal thoughts.
- In addition to the psychotherapies mentioned above, Family therapy has some evidence to support its use. It should be considered if there is a perceived large component of family dynamics or family relationship stress.
- Suicidal children/adolescents who are prescribed medications should be closely monitored for clinical response and side effects.
- Although there is some concern that antidepressants may increase the risk of suicidality in pediatric patients, this remains an area of controversy, and the consensus among most mental health specialists is that the benefits of antidepressant therapy outweigh the risks (See ***Effect of antidepressants on suicide risk in children and adolescents***).
- CBH offers a continuum of crisis services for children and adolescents, including two Children's Crisis Response Centers (CRCs) and a Children's Mobile Crisis Team (CMCT). Providers can contact CBH with any questions about the available LOCs or accessing these services.

CBH Crisis Intervention Services for Children/Adolescents

Emergency Services

- Crisis Walk-in (Crisis Response Center/CRC)

- Crisis services are delivered at a CRC and include an emergency crisis evaluation to determine what service(s) may be most helpful.
- Current CRC information is available on the **Contact page** and in the **Provider Directory** at cbhphilly.org.

- Children's Mobile Crisis Team (CMCT)
  - CMCT services are provided in the community for up to 72 hours to children, youth, and young adults aged 21 and under experiencing behavioral health crises, to help stabilize the situation and reduce the immediate risk of harm.
  - Services are available 24 hours per day.
  - Services may include crisis assessment and safety planning, engagement with the member and family, and referral and linkages to behavioral health services.
  - Current CMCT provider information is available in the **Provider Directory** on cbhphilly.org.

Urgent Services

- Children's Mobile Intervention Services (CMIS)
  - CMIS are resolution-focused, short-term crisis management services provided in the home for children, youth, and young adults aged 21 and under following a CMCT assessment or discharge from a CRC.
  - CMIS teams include a master's level therapist, case manager, and a psychiatrist or certified nurse practitioner to provide the following services two or more times weekly:
    - Assessments and evaluations
    - Case management
    - Medication management
    - Family therapy
    - 24/7 on-call support
  - Current CMIS provider information is available in the **Provider Directory on cbhphilly.org**.

Screening Resources

- **C-SSRS for Children Ages 6-11**

- **Patient Health Questionnaire (PHQ-9) Modified for Teens**

Training Resources

- **Prevent Suicide PA: Trainings**
- **Prevent Suicide PA: Suicide Prevention Toolkits**
- **American Academy of Pediatrics (AAP): Adolescent Health Care Campaign Toolkit**
  has several videos related to caring for LGBTQ+ youth

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APPENDIX G: OLDER ADULTS

Special consideration should be given to suicide risk in the elderly population, who, according to 2022 data from the Centers for Disease Control and Prevention (CDC), accounted for nearly 21% of suicides in the U.S. (among people aged 65 years and older).

An increased focus should be placed on men aged 75 and older, who experience the highest overall rates of death by suicide, and according to 2022 CDC data, remain the demographic with the highest suicide rate in the United States.

Additionally, an age-related decline in cognitive abilities and control has been linked to higher suicide rates in older adults among population studies; however, further research is needed to determine the extent to which this is true. Dementia in older adults has also been linked to an almost-doubled risk of suicide, especially in the first year after diagnosis.

Factors that can place older adults at an increased risk of suicidality include, but are not limited to: experiences of loss, major life changes (such as retirement, financial changes, transition into care facilities), decreased relationships and social connections (living alone, increased isolation), feeling like a burden to loved ones, and the presence of chronic illness and pain.

Additionally, the older adult population is expected to grow substantially by 2030, with over 71 million Americans falling within the 65 years or older demographic, totaling approximately 20% of the U.S. population. This emphasizes the need for increased attention to the older adult population regarding suicide risk. Currently, older adults in Pennsylvania make up 20% of the state's population, yet account for 24% of all reported suicides; however, a significant portion of older adult suicides remain underreported (despite a high attempt-to-completion ratio).

The following considerations for this population should be taken into account when assessing populations aged 65 years and older:

- Suicide assessment through evidence-based screening tools remains a critical factor in the older adult population.
- Special consideration should be given to older men (especially those over 65), who have significantly higher suicide rates compared to older women. Older males die by suicide more often than females, as they use more lethal means when attempting suicide. Preventing access to lethal means such as guns or potentially dangerous medication can reduce the risk of suicide among this population.
- Social isolation is a common suicide risk factor among older adults. Attention should be given to interventions or resources that promote protective factors such as social connection, supportive therapeutic relationships, and adequate problem-solving skills. The involvement of positive family and social supports in treatment strategy and discussion can reduce risk and increase connectedness.

- Care must be taken to assess for comorbid or contributing medical problems or side effects of medications causing psychiatric/cognitive symptoms. Physical or somatic issues can manifest with depressive symptoms and vice versa. Cognitive symptoms of depression can lead to challenges with diagnosing formal cognitive disorders concurrently. Collaborative care is recommended, and providers should make any necessary referrals or connections to other required services.

- Older adults are more likely to have multiple comorbid conditions requiring treatment with chronic medications. Providers should be mindful to minimize polypharmacy. Psychotherapy may be a preferred alternative treatment to avoid medication interactions.

Resources

- SAMHSA: **Resources for Older Adults**
- SAMHSA: **Growing Older: Providing Integrated Care for an Aging Population**
- Suicide Prevention Alliance: **Resources: Older Adults**
- SPRC: **Resources: Older Adults**
- National Council on Aging (NCOA): **Preventing Suicide in Older Adults**
- Healthy Minds Philly: **Older Adult Resources**

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