Suicide Screening and Prevention Using an Integrated Behavioral Health Approach

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SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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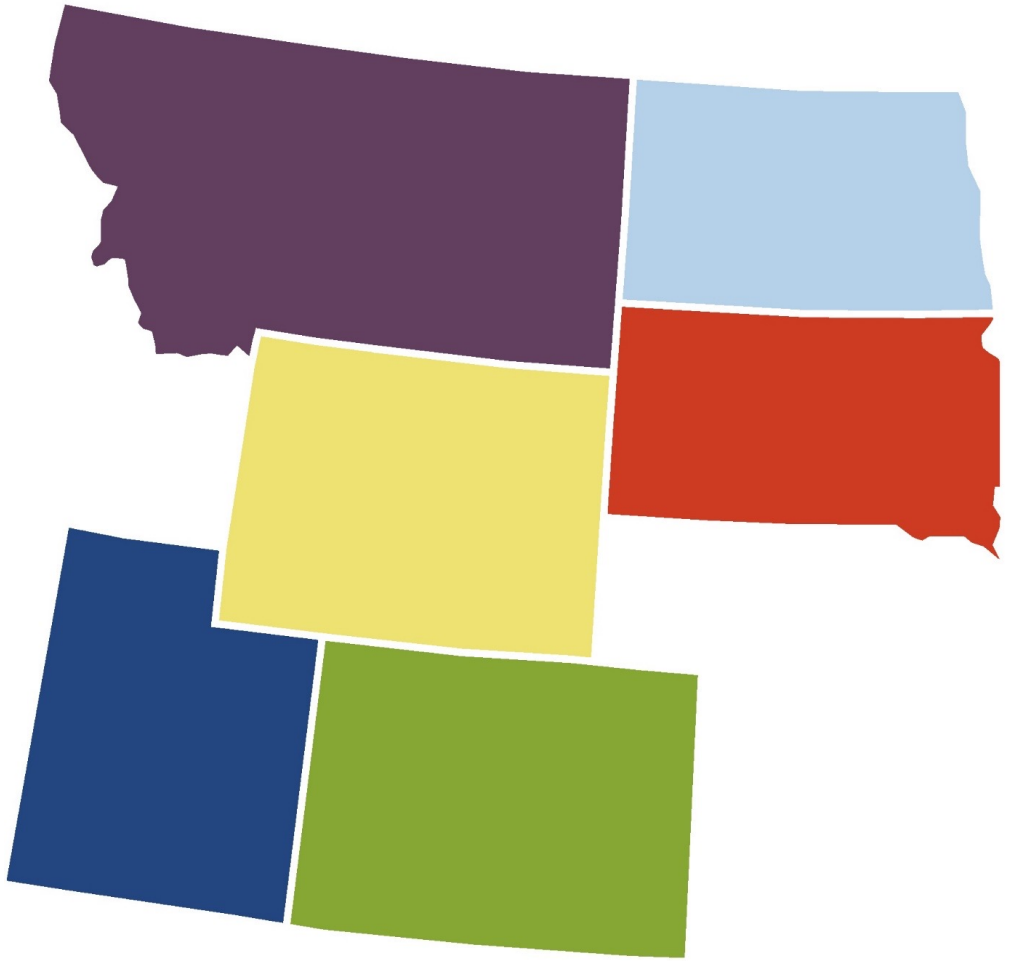
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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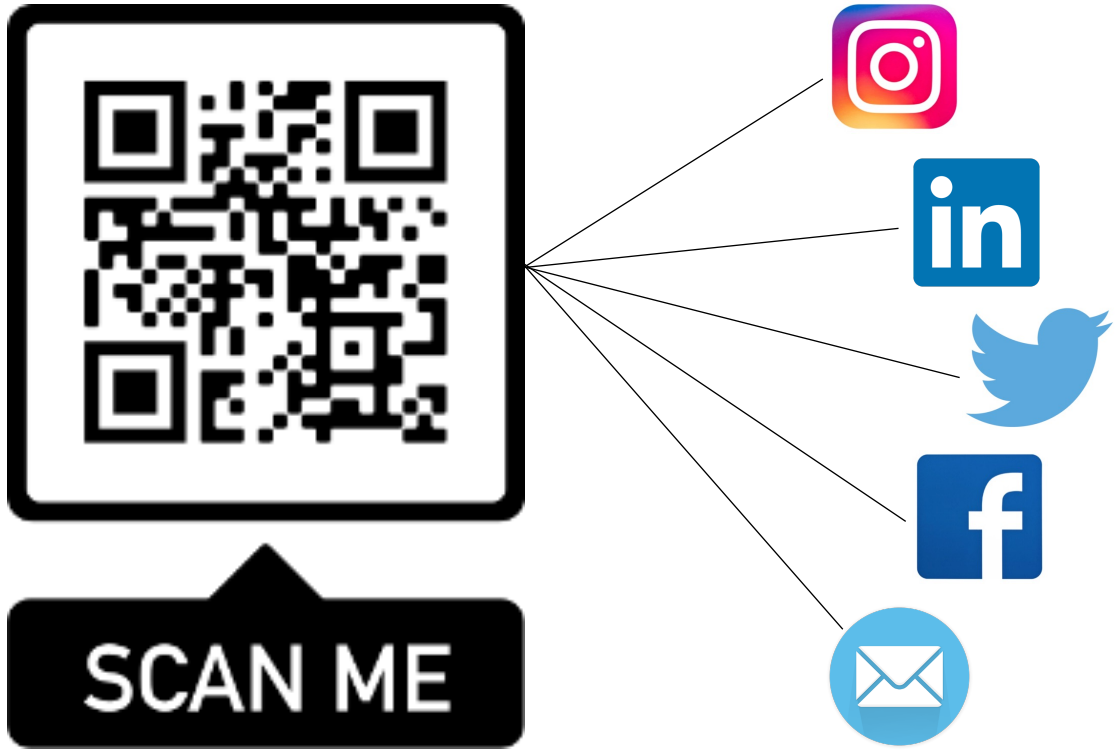
Scan this QR code to follow us on Instagram, LinkedIn, Twitter, and Facebook. You can also join our e-mail newsletter!



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MHTTC

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Objectives

- Following the presentation, the participant should:

1. Be able to explain why suicide prevention strategies are necessary in primary care
2. Practice SBIRT related to suicide prevention
3. Know the components of a suicide risk assessment
4. Know some possible interventions
5. Obtain ideas for policies and procedures including referrals

How serious is this problem?

- Suicide is the second leading cause of death in children ages 10-14.
- The third leading cause of death for children and young adults 15-24.
- And the fourth leading cause of death for adults ages 35-44.
- In 2020, there were twice as many suicides in the U.S. than homicides.
- Up to 45% of people who died by suicide visited their primary care provider a month prior to their death.

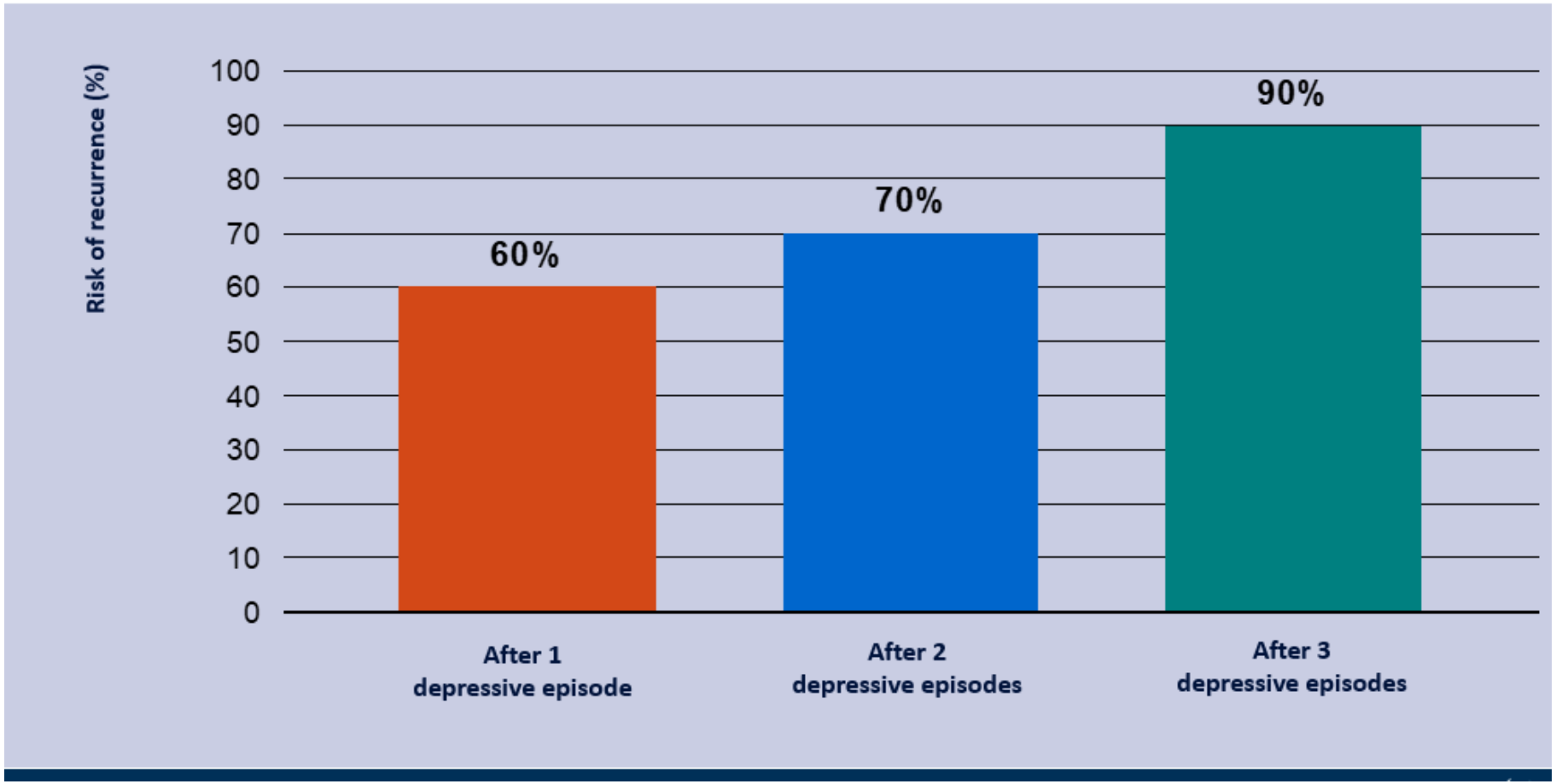
National Institute of Mental Health
https://www.nimh.nih.gov/health/statistics/suicidewithin a month prior to their death.

Who is a "high-risk" patient in a primary care clinic?

- While there are many conditions which may alert a provider to potential high-risk, Depression is the most condition associated with suicide, or can lead to an inability of someone to care for self.

- Other conditions/situations associated with depression: Irritable bowel syndrome, **sleep disturbances**, epilepsy, weight changes, fatigue, memory or cognitive complaints, eating disorders, relationship changes.. (COMORBIDITY IS THE RULE!!)

Depression is a highly recurrent disorder



Under-recognition of bipolar disorder in primary care

- Bipolar disorder is common effecting approximately 2.3 million people in the U.S.
- Estimated that 30% of patients seen in PC for depression actually have bipolar disorder
- Bipolar depression phase is the most dangerous time for suicide
- Remember, comorbidity is the rule
- Consider the Mood Disorder Questionnaire (MDQ)

Lewis, F. (2004). Bipolar Depression in Primary Care: A Hidden Threat. *Journal of Osteopathic Medicine*, *104*(s6), 9-14. https://doi.org/10.7556/jaoa.2004.20018

Screening Brief Intervention Referral for Treatment (SBIRT)

What is SBIRT?

- Screening
- Universal, quick assessment
- Occurs in a variety of settings (e.g., public health, primary care settings, community social services)
- Brief Intervention
- Brief motivation and awareness-raising
- Short conversations
- Referral to Treatment
- Further evaluation for specialty care

Depression Scales

- PHQ-9 (PHQ-A for adolescents), PHQ-2 brief
- Geriatric Depression Scale (GDS)
- Hamilton Depression Scale (HAM-D)
- Edinburgh Postnatal Depression Scale (EPDS)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

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

Interpretation/PHQ-9 scoring

- Use clinical judgment, treat the patient, not the score….

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

PHQ-9 modified for Adolescents (PHQ-A)

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

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

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

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

☐Yes ☐No

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

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

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

☐Yes ☐No

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

☐Yes ☐No

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

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

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

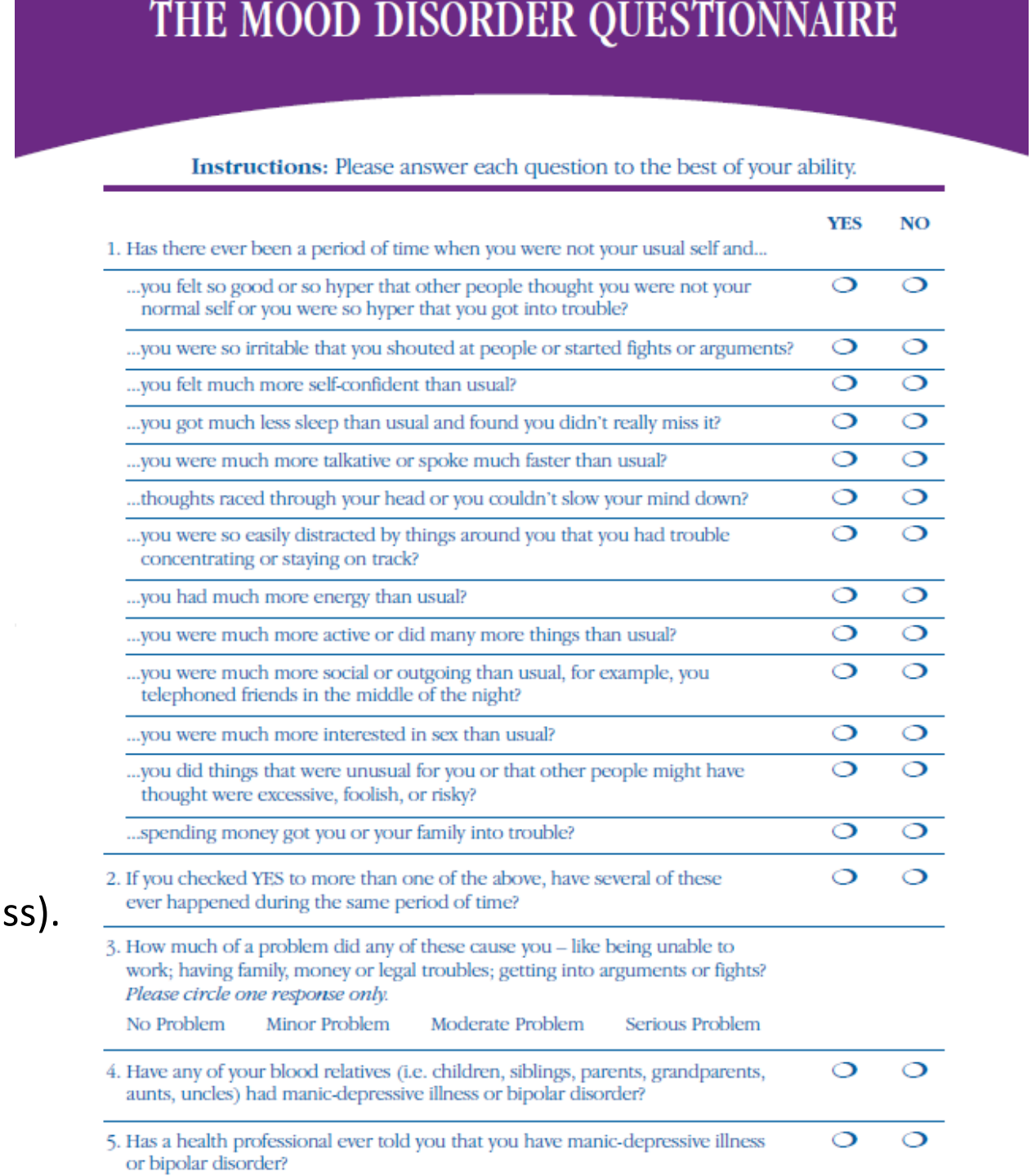
A “positive screen” is when:

--“Yes” to 7 or more questions in section 1

--“Yes” to section 2

--“Moderate” or “Serious” to section 3

Fair at sensitivity (+ when those have the illness),
Better at specificity (- when those don’t have the illness).



THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

Twelve Core Principles of Suicide Risk Assessment

Suicide risk assessment…

-Each person is unique.
-Is complex and challenging.
-Is an ongoing process.
-Errs on the side of caution.
-Is collaborative and corroborative.
-Relies on clinical judgment.
-Takes all threats, warning signs, and risk factors seriously.
-Asks the tough questions.
-Is treatment.
-Tries to uncover the underlying message.
-Is done in a cultural context.
-Is documented.

Granello, D. H. (2010). The Process of Suicide Risk Assessment: Twelve Core Principles. *Journal of Counseling & Development , 88*, 363-370.

C-SSRS

	Past 1 Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

Columbia-Suicide Severity Rating Scale

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Higher Risk Patients

Associations with suicide particularly when activity is reduced

- Back Pain (chronic pain in general)
- COPD
- HIV/AIDS
- Sleep Disorders
- Cancer
- Traumatic Brain Injury
- Epilepsy
- Migraine
- Renal Disease
- Heart Failure
- Multimorbidity

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 (e.g., 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 (e.g., setting, medication, psychotherapy, 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.

Means Matter

Part of the tough questions in Suicide Risk Assessments..

- Suicide crisis is usually brief.
- Some methods may have as low as a 1% lethality rate, versus 85-90% with some others, such as firearms.
- Up to 90% of people who survive even an almost lethal suicide attempt will not go on to die by suicide later.
- Controlling for means does work. The Sri Lanka example.

From *Lincoln's Melancholy*, A.W. Shenk, Houghton, Mifflin, Co. 2005

… when, as a young man, Abraham Lincoln was depressed and suicidal, a friend said of him, "Lincoln told me that he felt like committing suicide often."

It was said that when he again became depressed later in life he "dared not carry even a pocket knife… "

Seeing suicide warning signs, Lincoln's neighbors mobilized to keep him safe, watching over him, and removing his knives and pistol.

Means Matter

Three specific steps:

- Tell the individual and/or the family directly that you believe that they are at risk for suicide (and why you have made this determination)
- Explain that they can **reduce** the risk of suicide by reducing their access to lethal means, particularly firearms.
- Discuss specific steps they can take to remove or at least reduce access to firearms and other lethal means

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The Three 'I's (Chiles, J. & Strosahl, K. (2005).

- Intolerable – "This pain is too great to bear."
- Interminable - "This pain will never end."
- Inescapable – "There is no way out."

*Watch/listen for verbal, situational, and behavioral cues

Potential Interventions

- Brief intervention – psychoeducation about depression (worsening symptoms), provide resources
- Biweekly Assessment Tool (PHQ-9)
- Suicide prevention strategies (safety plan, contacting a family member, counseling on access to lethal means)
- PCP may choose to start a medication
- A referral to specialty mental health may be appropriate
- Placed on the registry for monthly check-in to monitor for worsening of symptoms. Use of assessment tool. If patient moves to high risk, hospitalization may be necessary
- Case management if available
- Depression relapse plan

Interventions

Depression: Recognizing Signs of Recurrence and What to Do About It

Signs of Relapse:

1. HALT (Hungry, Angry, Lonely, Tired). This is an addiction recovery idea, but it applies with depression, also. If we have physically unmet needs, such as hunger or we are not sleeping well, and/or our moods are extreme in any direction, this may indicate depression or a serious change in our mood.

2. Major life events, even some that may be positive, can cause stress and can lead to a depression. Some negative events could be death of a family member, loss of a job, getting diagnosed with a serious illness, or divorce. Positive changes, such as getting a new job and moving, may still cause significant stress and worry, which could then lead to feeling overwhelmed and perhaps depressed.

**Best advice: When you experience something major, try to be mindful of how your body and mind are responding. Get help sooner rather than later if you feel something is off.

3. Try to identify and avoid things that can trigger depression. This could include: Limiting time with negative people, monitoring alcohol use, avoiding taking on too many responsibilities, and avoid eating while feeling down.

Stages of Symptoms

Early Warning

You may notice subtle changes in your sleep, feelings, behaviors, and thoughts. Perhaps you are starting to avoid others or think negatively about yourself or others. Think about what your depression looked like before. If you think problems may be starting, you can try these things:

- Check to see that your daily exercise regimen has not lapsed. If it has, get back on your schedule.
- Check to see that your diet and sleep cycles are normal.
- Monitor your moods for a few weeks on a daily basis using a 0-10 scale, with 10 being severely depressed. Where are you falling on a daily basis? Expect small fluctuation.
- Make an appointment with your therapist. Discuss any significant stressors, such as domestic conflicts, problems at work, health challenges or financial worries.
- Nurture yourself (take the day off, spend time in nature, get a loving massage, hang out with a good friend).

Beginning of a Crisis

- Call your psychiatrist or prescriber so that your medication can be evaluated and possibly adjusted.
- Call your therapist/counselor for an emergency session.
- Call your support team to let them know you are in crisis.
- Try to take some time off from responsibilities.
- If you are open to prayer, call one of the telephone prayer ministries listed on this web site.
- Do something nurturing for your physical body, such as going on a long walk, practicing yoga, or taking a bath.
- Monitor your thoughts. If you are beginning to catastrophize, tell yourself that with the right support, you can make it through this period.

Crisis

Sometimes, despite your best efforts, a major depressive episode can occur. At this time, you may experience serious thoughts of suicide, suffer from severe depressed mood, and other symptoms.

If you have not contacted your support system and a mental health provider by now, this is the time. If you are feeling suicidal, call 911 or another appropriate hotline for help. Do anything from the previous section that you believe may be helpful.

Patient Safety Plan Template

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. _____

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

_____

Policies and procedures for suicide crisis

- **Policy should include**
  - In-Person or Over the Phone
  - Mention of an assigned designated person
  - Who to call for help/further assessment
  - Transportation
  - Willing vs. Unwilling client
  - Emergency and Non-Emergency Procedures (Referrals)
- **Designate the person responsible during shifts** (charge nurse, supervisor)
  - Where is the client now?
  - Assuring someone is present
  - Knows policies about contacting help/transport
  - Awareness of staff well-being / Back-up for them
  - After the crisis

Referrals

- Know who provides emergency care in your area. Have this information on something you can send with the patient.
- Promote 988 and other crisis lines through signage
- Speak with your community partners about your roles in suicide prevention and how you can work together.
- Referrals for needs related to social determinants of health

Resources

Suicide Prevention Resources

Be a lifesaver

Visit
Your Primary Care Provider
Mental Health Professional
Walk-in Clinic
Emergency Department
Urgent Care Center

Find a mental health provider
findtreatment.samhsa.gov
mentalhealthamerica.net/finding-help

CrisisChat.org

Suicide Prevention Lifeline
1-800-273-TALK (8255)
Veterans: Press 1

Text TALK to 741741
Text with a trained crisis counselor from the Crisis Text Line for free, 24/7

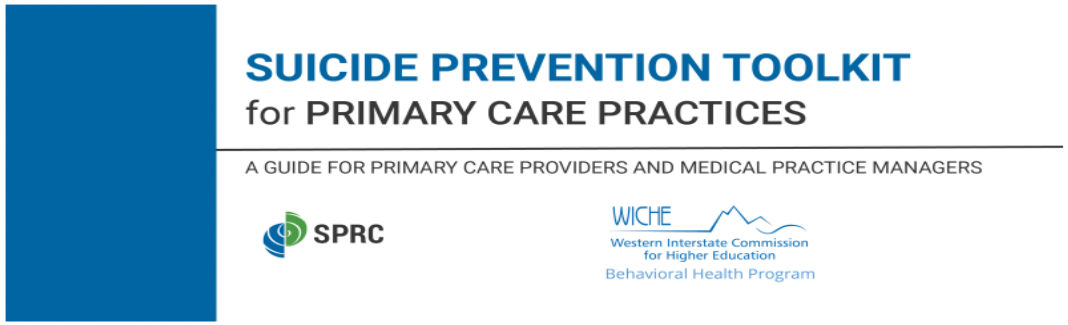
911 Call 911 for emergencies

American Foundation for Suicide Prevention

afsp.org/resources

988 SUICIDE & CRISIS LIFELINE

Suicide Prevention Toolkit for Primary Care Practices



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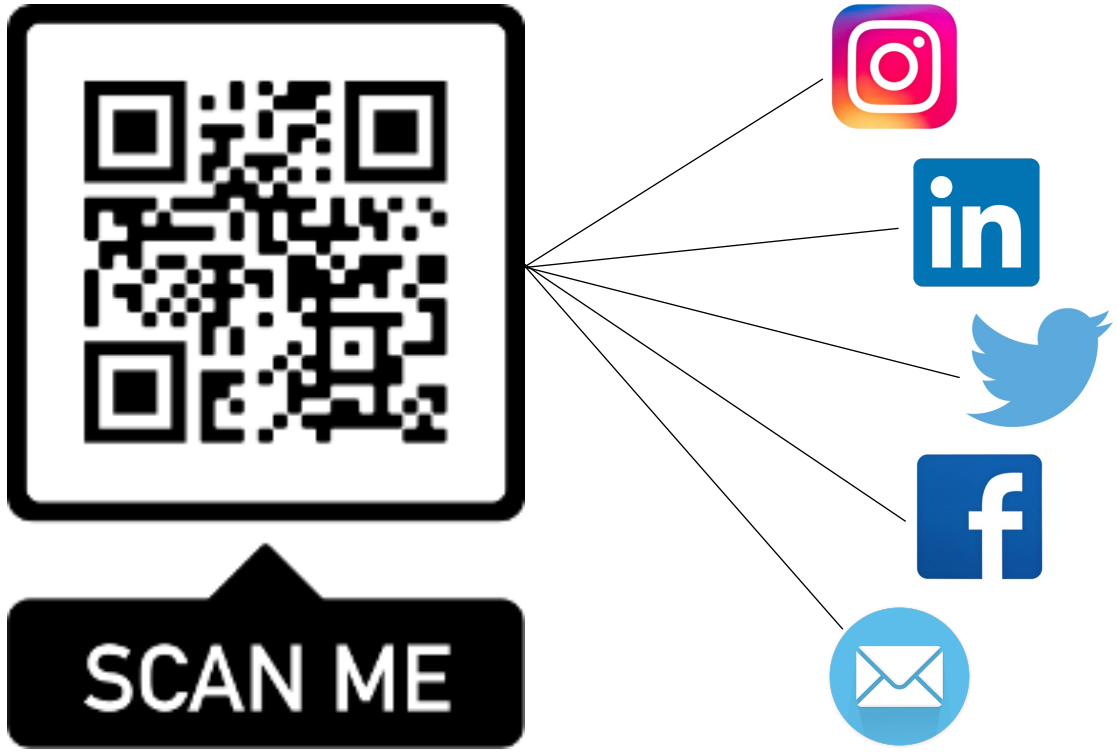

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THANK YOU!

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