EFFECTIVE SUICIDE ASSESSMENT IN PRIMARY CARE

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OBJECTIVES

1. Importance of suicide assessment in primary care
2. Evidence-supported suicide risk screening tools
    1. PHQ- 9. +. Columbia-Suicide Severity Rating Scale OR Ask Suicide Screening Quest.
3. Consistent, systematic response to elevated suicide risk
4. Guidance on effective communication with patients experiencing suicidal thoughts
5. Adult and pediatric considerations
6. Q &A

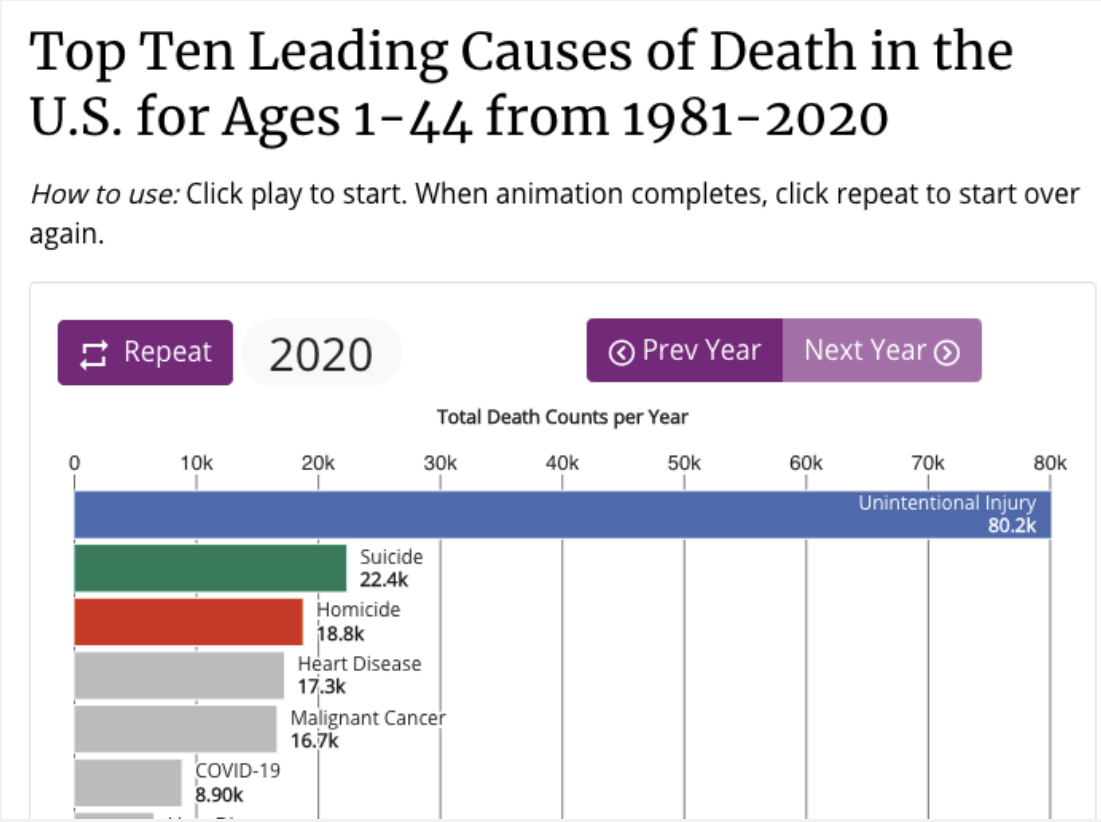
LANGUAGE

- Ideation
- Plan(s)
- Attempt Furtherance/ Preparation
- Desire

- Suicide Attempt
- Suicide Completion

SUICIDE FACTS

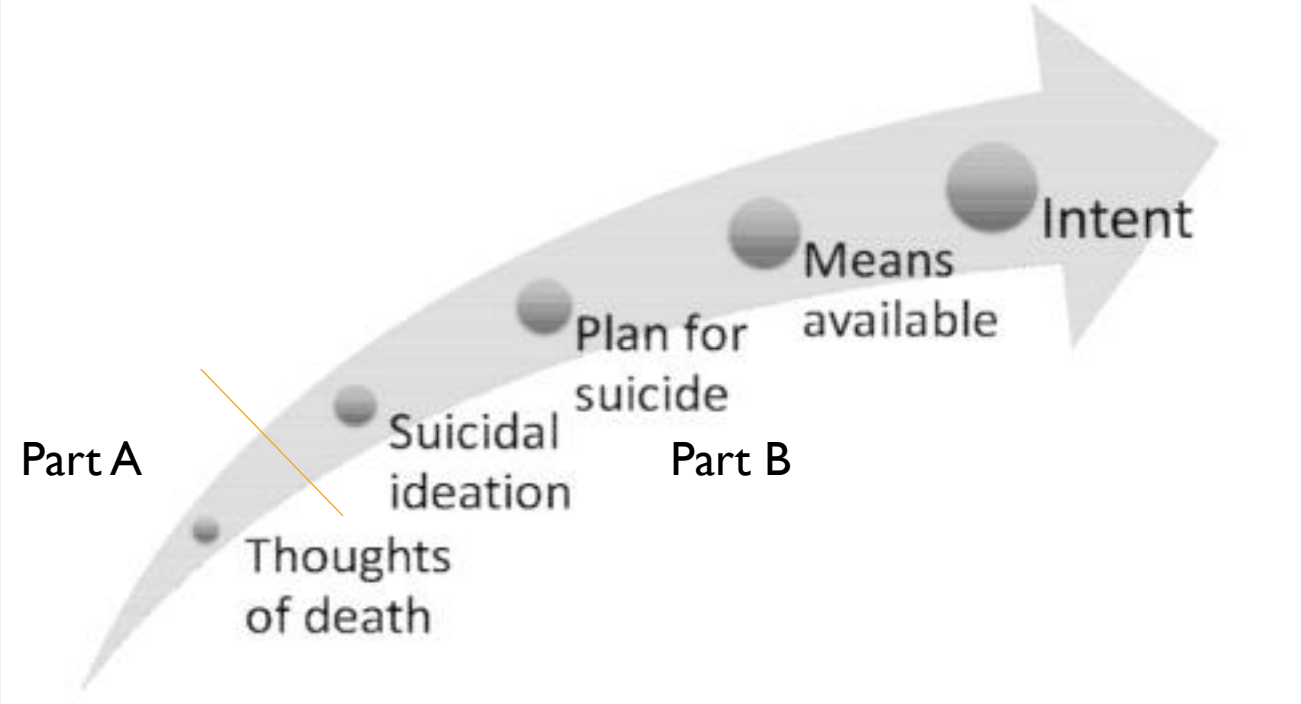
- Typically, Suicide is 8th leading cause of death in US, fell below top 10 in 2000 (1)
- Suicide is among second leading cause of teen/ young adult death (2,3)
- >50% of suicides are due to firearms (4)
- Thoughts about not living/ ending life are common
- 12.2 million Americans seriously contemplated suicide, 3.2 million reported making a plan to kill themselves, and 1.2 million attempted to end their life (5)
- 30% of suicide attempters re-attempt to end their life (6)



PRIMARY CARE AND SUICIDE

- 45% of people dying by suicide saw PCP **one month** before death; 20% saw MH clinician (7)
- One study showed only 36% of simulated patients receiving antidepressant medication were even asked about suicide by their PCP (8)
- 30-40% of patients who attempt suicide are acutely intoxicated (9)

ROADMAP FOR ASSESSMENT (10)



STEP 1- THOUGHTS OF DEATH

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: _____

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)

STEP 2- TRIGGERED RISK ASSESSMENT

- If a person answers positive on a PHQ for the suicide questions or reports any thoughts of suicide, ending life, or intrusive thoughts/voices about ending their life, further assessment is warranted

- Two Screeners are Recommended
- Columbia-Suicide Severity Rating Scale (11)
- Ask Suicide Screening Questionnaire (12)

C-SSRS

- The Columbia or C-SSRS was developed to quickly and effectively triage level of suicide risk
- Each level of suicidality warrants a different level of intervention, so this helps to develop an initial picture of risk and intervention
- Recommended for 11 years and older
- Can be completed by any health care team member with minimal training
- **KEY ADVICE:** Make sure non-verbal or question alterations don't happen (e.g., "You haven't had any thought about killing yourself, right?).

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
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 of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* e.g. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."*		
4) *Have you had these thoughts and had some intention of acting on them?* as opposed to *"I have the thoughts but I definitely will not do anything about them."*		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever 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, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Possible Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Referral
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Referral
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

ASK SUICIDE

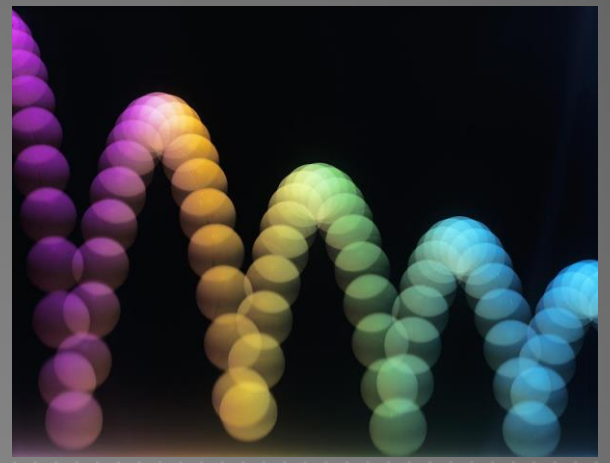
- An empirically validated tool for pediatric and adult populations to quickly and effectively screen risk
- Pediatric hospital implementation revealed: "During the first year of screening, 138,598 screens were completed, and 6.8% of screens were positive for elevated risk." (13)

STEP 3- TRIAGE & ASSIST

- For a positive C-SSRS or ASK Suicide, typically the next step is to refer to your co-located behavioral health / social work team member, if available

- The key duties are to respond relative to risk
  - **Functional Assessment---** How Frequent, How Intense, Duration, Triggers
    - Typically a Suicide Safety Assessment is conducted looking at protective/risk factors, access to means to kill self, and history of attempts
  - **Safety Plan**
  - **Mitigation Related to Risk Level**

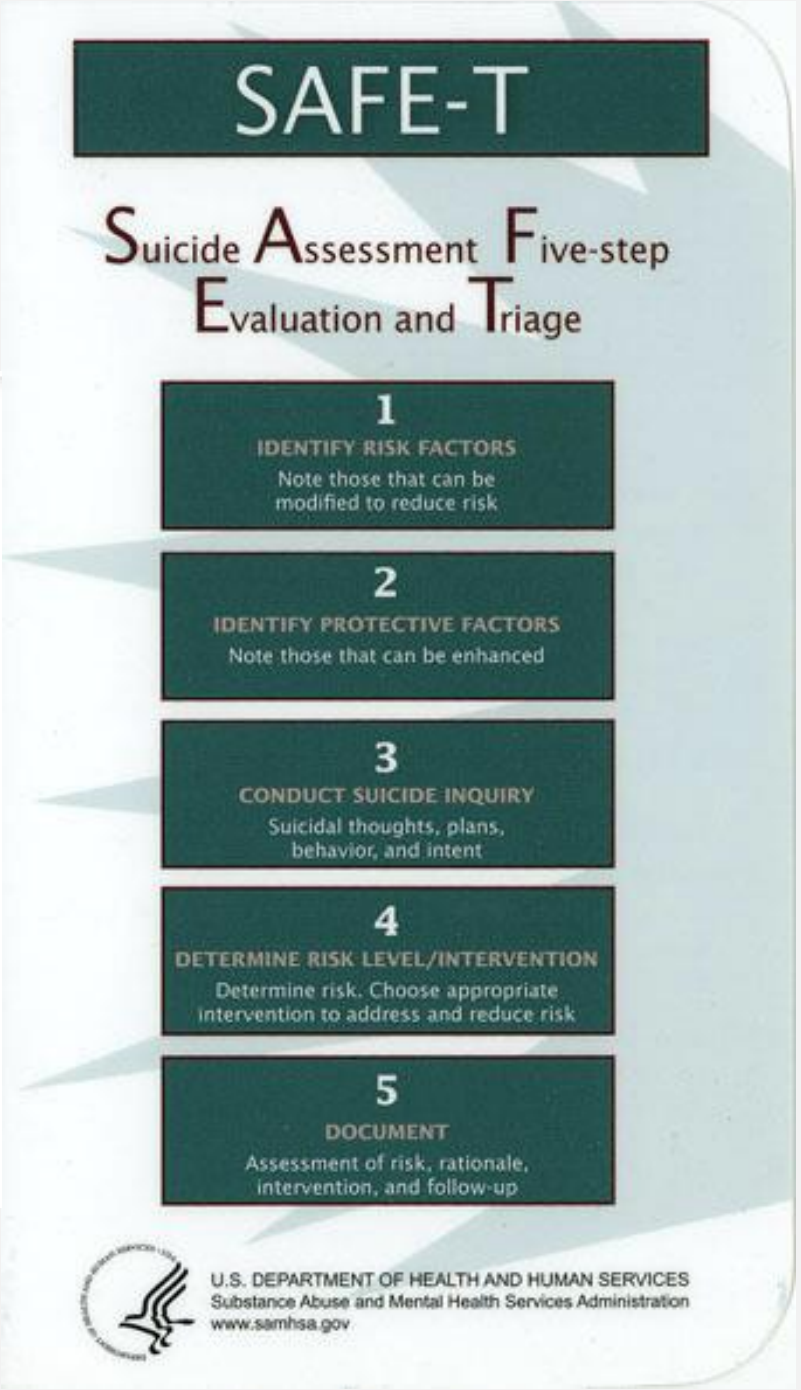
TALKING ABOUT SUICIDE



SUICIDE COMPREHENSIVE ASSESSMENT

How to Improve Suicide Screening at Your Organization

Address Uncertainty	Implement Change	Identify Risk Factors	Know Your Screening Tools
• Mistaken beliefs about suicide • Emotional weight of responsibility • Lack of skill and comfort • Perception of suicide validity	• Drive top-down support • Answer "what's in it for me?" • Add screenings to existing processes • Train staff • Offer telehealth services	• Prior attempts • Alcohol and drug abuse • Mood and anxiety disorders • History of trauma or loss • Serious illness or chronic pain • Social isolation • Access to lethal means	• Suicide • Depression/bipolar disorder • Trauma/anxiety • Drug abuse • Alcohol abuse



RISK LEVEL (14)

- Clinical Impression of Chronic Risk (long-term):
- ___ High Risk (Essential Features: Chronic psych conditions; hx of prior attempts; hx of substance abuse/dependence; chronic pain; chronic SI; chronic medical condition; limited coping skills; unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment); limited ability to identify reasons for living.
- ___ Intermediate Risk (Essential Features: Similar to above, but protective factors, coping skills, reasons for living, and relative psychosocial stability suggest a fairly enhanced ability to endure future crisis without resorting to SDV.
- ___ Low Risk (Essential Features: Can range from those having either no hx (or minor hx) of MH/SUD issues to persons with significant MH that is associated with abundant strengths/resources. Stressors have historically been endured without SI. The following factors will usually be missing: hx of SDV, chronic SI, tendency towards highly impulsive risky behaviors; severe, persistent mental illness; marginal psychosocial functions).

- https://dsamh.utah.gov/wp-content/uploads/2020/08/CSRE-Short-Form.pdf

TABLE 4 Level of Risk For Suicide

Risk for Suicide Attempt	Indicator for Suicide Risk	Contributing factors †
High Acute Risk	• Persistent suicidal **ideation** or thoughts • Strong **intention** to act or plan • Not able to control **impulse** OR • **Recent suicide attempt**	• Acute state of psychiatric disorder or acute psychiatric symptoms • Acute **precipitating** event(s) • Inadequate **protective factors**
Intermediate Acute Risk	• Current suicidal **ideation** or thoughts • **No intention** to act • Able to control the **impulse** • **No recent attempt** or **preparatory behavior** or rehearsal of act	• Existence of **warning signs or risk factors** †† AND • Limited **protective factor**
Low Acute Risk	• Recent suicidal **ideation** or thoughts • No **intention** to act or plan • Able to control the **impulse** • No planning or rehearsing a suicide act • No previous attempt	• Existence of **protective factors** AND • Limited **risk factors**
Undetermined Risk	Due to difficulty in determining the level of risk or provider concerns about the patient despite denial of ideation or intent. The patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.	

† *Modifiers that increase the level of risk for suicide of any defined level:*

- **Acute state of substance use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means:** (firearms, medications, toxins) may increase the risk for suicide act
- Existence of **multiple risk factors** or **warning signs** or lack of **protective factors**

SAFETY PLAN

- Evidence suggests providing a workable plan helps to reduce risk, in the present and going forward

- Suicide **contracts** are perceived by clients as "Forced" and "Covering yourself" not legally protective from malpractice cases, and don't focus on coping. They are not recommended

- **SAFETY PLAN/ COPING PLAN---** Developing a specific, well-detailed coping plan can be very helpful and is highly recommended

SAFETY PLAN

Step 1: Triggers, Risk Factors and Warning Signs

Step 2: Internal Coping Strategies

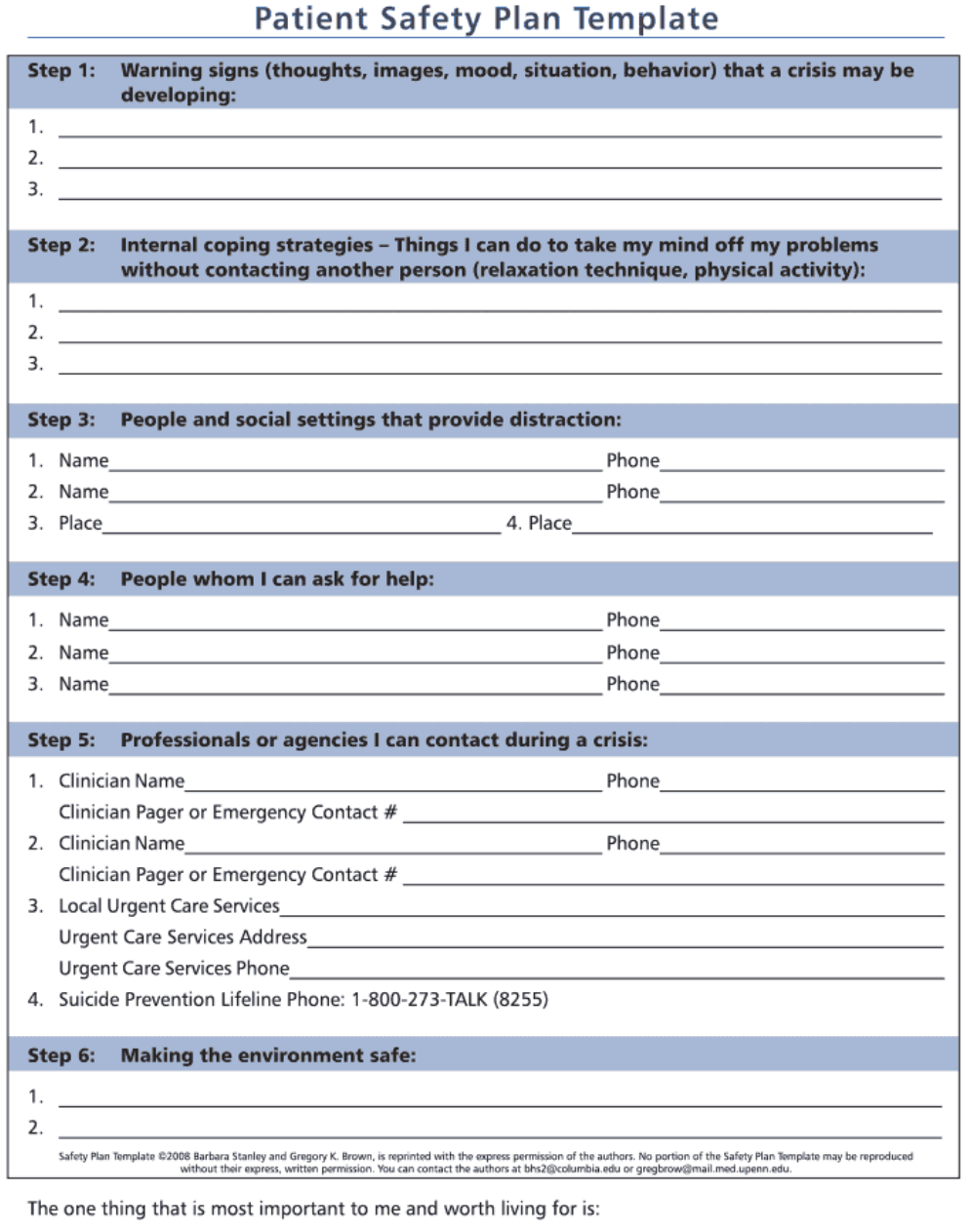
Step 3: Social Contacts Who May Distract from the Crisis

Step 4: Family Members or Friends Who May Offer Help

Step 5: Professionals and Agencies to Contact for Help

Step 6: Making the Environment Safe

- Provide a copy, or two have a person take a picture of it, hang it somewhere they can see it, put it in wallet/purse
- Involve a family member



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:

_____

TREATMENT OPTIONS

- Follow-up on use of safety plan and reassessment
- Involve family, supports, or others, with patient permission
- Address risk factors and monitor response and suicidality
- Connect to behavioral health services
- Voluntary inpatient admission evaluation
- Involuntary inpatient admission evaluation (302)

SPECIAL POPULATIONS- ADULTS

- Growing rates of suicidality are being seen in Black, Indigenous, & Persons of Colour.
  - Particularly high risk in teens/ young adults; older adults; recently separated/ divorced/ widowed
- Suicide in one's immediate support network increases odds of suicide: "implicit permission"; "greater option"
- Suicide is a hallway with just one window--- people are eager for other doors and options
- Risk can be scarier with shades of grey, especially with social isolation, inconsistent treatment attendance, physical limitations, substance use

SPECIAL POPULATION- CHILDREN/ TEENS

- Risk level can be more variable, as a function of impulsivity
- Power of moment in teens, hard to see past moment neurodevelopmentally
  - Key on present moment– relationship challenges, personal setbacks, losses
- Realistic concerns of social contagion with suicide
- COVID-19 and community violence can be traumatizing and isolating--- enhanced risk???
- Importance of expanding network, how to add in social supports/ peers, and family
- Bullying, parental separation, substance use, poor sleep ACES, increased risk with sexual abuse
- Consider familial "expressed emotion" –enhanced criticism, close monitoring, and loss of privacy

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