

Screening and Safety Planning for People at Risk of Suicide

Presented by Jeanne Bereiter M.D. and Laura Rombach M.A.

University of New Mexico

Department of Psychiatry and Behavioral Sciences

Division of Community Behavioral Health

Learning Objectives

- Describe the use of the Columbia Suicide Severity Rating Scale in assessment of suicide risk
- Demonstrate how risk factors and protective factors relate to safety planning with a client.
- Describe the 6 components of a safety plan

Disclaimer

- Dr. Bereiter and Laura Rombach have no financial relationship to this program

Suicide Prevention Webinar Series

The Suicide Prevention Webinar Series is presented through the National Strategy of Suicide Prevention in New Mexico grant

In collaboration with the University of New Mexico, State of New Mexico, Human Services Department, Behavioral Health Services Division and Indian Health Services

SCREENING

What do we screen for?

Why?

What do we do with the information we obtain?

What Do We Screen For and Why?

- Depression
- Alcohol use
- Drug use
- Other mental health conditions
- SUICIDALITY

Polling Question

I have the skills I need to screen and assess a patient/client's suicide risk.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Depression Screening

- Depression is the psychiatric disorder most commonly associated with suicidality
- Depression is a common mental health problem and causes problems other than suicidality
- Recommended: screen all patients who are seen in healthcare and behavioral health care
- Different standardized assessment instruments available
- PHQ-2 and PHQ-9 very commonly used

PHQ2 and PHQ9

- PHQ-9 is a 9 question screen for depression
 - the 9th question is about suicidality
- Validated for use in primary care and other busy clinical settings
- IHS recommends for use in Native American populations (IHS 2011)
- Already in use at all SBIRT sites and other sites in NM
- PHQ-2 is a briefer (2 question) screen which can be followed up by PHQ-9
- To better assess suicidality PHQ-2 plus 9th question can be used = PHQ-3

PHQ-2

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Total point score: _____

Score interpretation:

<i>PHQ-2 score</i>	<i>Probability of major depressive disorder (%)</i>	<i>Probability of any depressive disorder (%)</i>
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Figure 1. Patient Health Questionnaire-2 (PHQ-2). This questionnaire is used as the initial screening test for major depressive episode.

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care* 2003; 41:1284-92.

PHQ-9

- 9 question self-administered scale designed to assess depressive symptoms within the past 2 weeks
- Designed to screen for depression, assess severity of depression, measure response to treatment
- 9th question addresses suicidal ideation:
 - “Thinking that you would be better off dead or that you want to hurt yourself in some way.”
 - Note that this is a broad screening question and will pick up non-suicidal self injurious behavior as well as lower risk suicidal ideation

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 D	Somewhat difficult D	Very difficult D	Extremely difficult D
---------------------------	-------------------------	---------------------	--------------------------

Scoring the PHQ-9

Interpretation of Total Score

Total

Score Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

PHQ9 Copyright © Pfizer Inc. All rights reserved.

Screening for Alcohol and Drug Use

- Alcohol and drug use can increase impulsivity
- Many suicide attempts and suicides are impulsive, not planned
- Alcohol and drug use commonly co-occur with mental health problems
- Many screens exist, we recommend AUDIT-C (alcohol) and DAST-10 (drug)

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:

a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.³
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Scoring and Interpretation – For the DAST-10, score 1 point for each question answered, “YES”, except for question (3) for which a “NO” answer receives 1 point and (0) for a “YES”. Add up the points and interpretations are as followed:

<u>DAST-10 Score</u>	<u>Degree of Problem Related to Drug Abuse</u>	<u>Suggested Action</u>
0	No problems reported	None at this time.
1 – 2	Low Level	Monitor, reassess at a later date.
3 – 5	Moderate Level	Further investigation is required.
6 – 8	Substantial Level	Assessment required.
9 – 10	Severe Level	Assessment required.

ASSESSMENT

Polling Question

If we assess suicidal risk in every patient presenting to primary care we will:

- Greatly increase referrals to behavioral health
- Increase referrals to behavioral health
- Have no effect on referrals to behavioral health
- Decrease referrals to behavioral health
- Greatly decrease referrals to behavioral health

Why Assess Suicide Risk?

- Increases awareness
- Provides a common language about suicide
- Provides guidance for developing an action plan
- Helps to ensure that all staff are following a standardized, evidence based protocol to identify individuals at risk of suicide
- Evidence exists that screening actually
 - DECREASES referrals to behavioral health
 - Provides behavioral health resources to those who truly need them, not to those who weren't actually at high risk
 - May actually save lives

Polling Question

I know the difference between a suicide attempt, an interrupted suicide attempt, and non-suicidal self-injurious behavior

- Strongly agree
- Agree
- Disagree
- Strongly disagree

What is a Suicide Attempt?

- A self-injurious act committed with at least some intent to die as a result of the act
- People often have mixed motives/ambivalence
- Ask “Did any part of you want to kill yourself?”
- Client doesn’t need to verbalize that it was a suicide attempt

Non-Suicidal Self-Injurious Behavior

- Action done 100% for reasons other than to kill themselves
- Done to feel better, relieve pain, get attention, get a bed in a hospital
- Is a risk factor for suicide

Other Suicidal Behaviors

- Interrupted Attempt
 - Someone else stops the person
- Aborted or Self-Interrupted Attempt
 - Person stops him or herself
- Preparatory Acts or Behavior
 - Writing a suicide note
 - Buying a gun, collecting pills

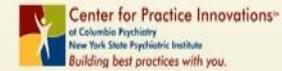
Terms Not to Use

- Suicide gesture
- Suicide threat
- Parasuicide

**COLUMBIA SUICIDE
SEVERITY RATING SCALE
(CSSRS)**

A semi-structured
interview used to assess
suicide risk

Suicide Risk Identification and Triage Using the Columbia Suicide Severity Rating Scale



CSSRS

- Don't need mental health training
- Comes in multiple formats
 - Screener version appropriate for First Responders, gatekeepers, peer counselors
 - Full version appropriate for behavioral health clinicians
 - Versions for children, intellectually disabled
 - Available in 100+ languages
 - Versions to assess lifetime/recent/since last visit
 - Used for research, and clinically
- Flexible format, don't need to ask all the questions if not necessary
- Integrate information given by collateral sources (family, caregivers)

CSSRS– Full Version

- It is a clinical interview using a written instrument
- For clinicians- provides information to aid decision making
 - 6-16 questions
 - Ideation severity
 - Ideation intensity
 - Behaviors
 - Lethality of attempts

CSSRS-Screening Version

- Appropriate for 1st responders, crisis lines
- 3-6 questions
 - Severity of ideation
 - 1 question about behaviors
- Divided into 2 sections:
 - Suicidal ideation
 - Suicidal behavior

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening Version - Recent

If 1 and 2 are no, ideation section is done.

Columbia Suicide Severity Rating Scale Screening Version

Minimum of 3 Questions

	Past Month	
	YES	NO
Ask questions that are bold and underlined		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan." <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "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." <u>Have you been thinking about how you might kill yourself?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>		
	Past 3 Months	
	YES	NO
6) Suicide Behavior <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u> 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.		

When to Refer?

- Ideation: 4 or 5 in the past month
- Behaviors: any behavior in the past 3 months
- Score of 4 indicate some suicidal intent
- Risk doubles from 3 to 4

SAFETY PLANNING

Polling Question

If a person is serious about suicide, there is little that can be done to prevent it.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Reasons for Safety Planning

- Suicide risk fluctuates over time
- Problem solving capacity is lower during times of crisis so it helps to plan ahead
- Cognitive behavioral approaches reduce impulsive behaviors
- Learning to cope with suicidal crises without hospitalization helps increase a person's self-efficacy and self confidence
- Safety planning helps to instill hope!

Who is Appropriate for Safety Planning & What Does it Do?

- Patients at increased risk for suicide who do not require immediate hospitalization
- Fills the gap between hospital or ED discharge and follow-up
- Provides an alternative for those who don't want or don't receive outpatient care

However...

- Hospitalization can always be part of a safety plan if other measures are ineffective

Risk Factors

- Past suicidal behavior
- Current/past psychiatric disorders
- Key symptoms
- Family history
- Current stressors
- Change in treatment/level of care
- Access to firearms

Protective Factors –Internal

- Problem-solving skills
- Good frustration tolerance
- Ability to cope with stress
- Religious beliefs

Protective Factors-External

- Responsibility to others
- Effective mental health care
 - Including CBT, DBT
- Connectedness
 - Between individuals, families, community, social institutions
- Contacts with Caregivers
 - Including postcards, letters from ED

What Is a Safety Plan?

- A written list (or on an App) of coping strategies and resources to use during a suicidal crisis
- Is NOT a “no suicide contract”
- A “no suicide contract” asks patients to promise to stay alive but doesn’t give them tools to help them do so, apart from asking them to call you if feeling suicidal

Elements of Safety Planning

- Means restriction
 - Guns, pills, alcohol and drugs
- Teach brief problem solving & coping skills
- Increase social support and identify emergency contacts
- Motivational enhancement for further treatment

Components of a Safety Plan

1. Recognizing warning signs
2. Internal coping strategies
3. Socializing with others to provide distraction & support
4. Contacting family or friends who patient can ask for help
5. Contacting professionals /agencies to ask for help
6. Making the environment safe/reducing access to lethal means

1. Warning Signs: When To Use the Safety Plan?

- Person needs to be able to recognize warning signs/triggers
 - Write them down (thoughts, mood, behavior)
- Clinician can go through the events leading up to/during/after the last suicidal crisis
- Help patient to identify when they should use their safety plan

2. Internal Coping Strategies

- Activities a person can do on their own
- Usually these are meaningful activities that distract person and make them feel better (not alternate self harm or unhealthy activities)
- If person is able to cope on own even briefly this increases self-efficacy, self control
- Examine “road blocks” to using these strategies and problem solve ways around them
- Not wanting to help self can be a road block

3. Using Socialization for Distraction & Support

- If Step 2 doesn't resolve the crisis, patient moves to step 3
- Socialization is for distraction/meaning
- Go to a “healthy” social setting e.g., library, not bar
- Seek support from family, friends, acquaintances
- List more than 1 person as 1st person might not be available

4. Contacting Family or Friends to Ask for Help

- Use Step 4 if Step 3 doesn't resolve the crisis
- Help patient to list people she or he would be likely to contact
- Problem solve obstacles to contacting these people
- Discuss whether safety plan can be shared with these people (a good idea to do so if possible)

5. Contacting Professionals/Agencies to Ask for Help

- Use Step 5 if Step 4 doesn't resolve the crisis
- Identify which clinicians should be on the safety plan
- Identify which agencies should be on the safety plan
- List address, phone numbers, location of:
 - Local Crisis lines
 - Suicide Prevention Lifeline: **800-273-TALK (8255)**
 - Emergency rooms, crisis centers

6. Reducing the Potential for Use of Lethal Means

- Ask about reduction to lethal means at the end of safety planning not the beginning
 - patients are more likely to discuss this if they have ideas about alternatives to suicide!
- Ask what means they might use during a suicidal crisis
- Even if they don't mention firearms, always ask if they have access to a firearm

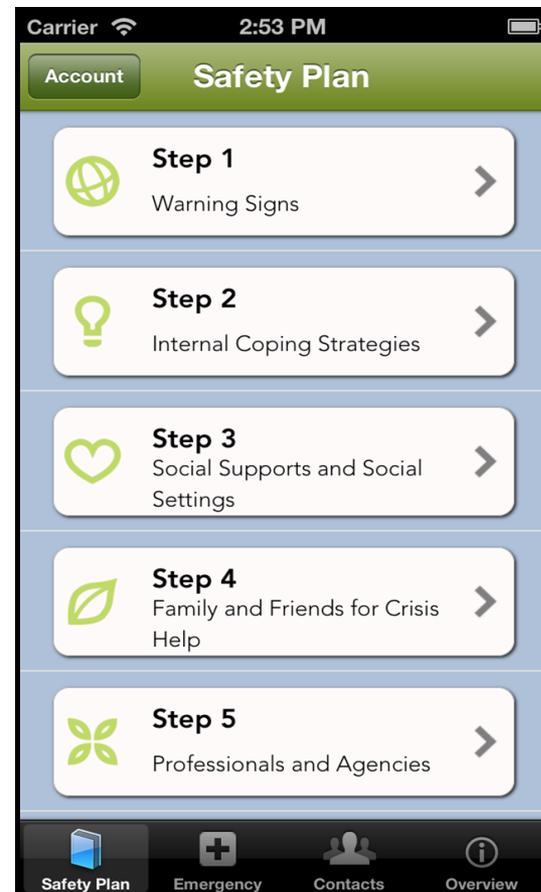
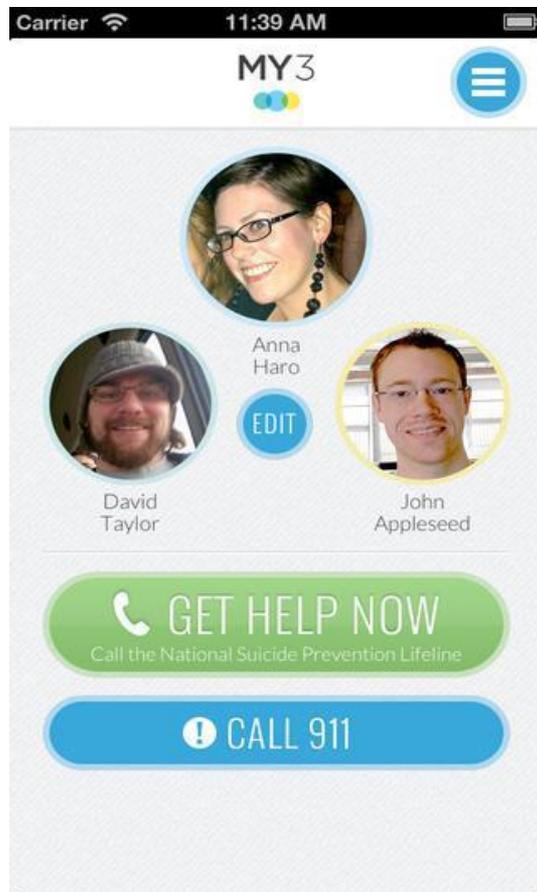
7. Reducing the Potential for Use of Lethal Means-Continued

- For low lethality means, ask patients to remove these themselves
- For high lethality means, identify a person who can help to secure firearms, etc.
- Discuss reduced access to alcohol/drugs

Safety Planning Apps

- Safety Plan by Two Penguins Studios LLC
- My 3
- Both available in apple app store and Google Play

My3 and Safety Plan Apps



Implementation of A Safety Plan

- Discuss where patient will keep the safety plan
- Safety Plan Apps might be a good alternative to paper that can get lost
- Discuss how patient will remember that she or he has a safety plan
- Discuss how confident patient is that she or he will use the safety plan
- Discuss barriers to use, and ways to overcome these

Caveats

- Safety planning needs to be collaborative not coerced
- Needs to include items that have meaning to the individual and which she or he is likely to use
- When involving family/friends, the patient needs to have control over how/when they are told
- Safety plans change over time as people change/social support systems change
- Important to instill hope

Resources

- Free, e-learning workshop from Columbia, NY OMH: Safety Planning Intervention for Suicidal Individuals
www.zerosuicide.com
- Safety planning: A quick guide for clinicians
<http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf>
- Safety Plan template, manual and other resources:
www.suicidesafetyplan.com
- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf

Further Resources for Behavioral Health Clinicians

- Counseling on Access to Lethal Means (CALM)
- Free online course to explain purpose of means reduction & how to assess for lethal means and provide necessary intervention
- <http://training.sprc.org/course/description.php#course3>