Suicide Prevention in Healthcare
Change is possible ..........
Public Health Problems

• 2018 deaths among all ages

  • Influenza and pneumonia: ~55,000 deaths a year = 150 per day
    • Among 10 to 24-year-olds: ~241 deaths a year = 4 per week

  • Motor vehicle accidents: ~39,000 deaths = 108 deaths a day
    • Among 10 to 24-year-olds: ~7,000 deaths = 19 deaths a day

  • Suicide: ~48,000 deaths = 132 deaths a day
    • Among 10 to 24-year-olds: ~6,800 deaths = 18 deaths a day

Zero Suicide | zerosuicide.edc.org

CDC, 2018
Systemic Support for Healthcare Settings

- Support broad screening practices in all settings
- Training for all levels of staff
- Systemic approaches to suicide safer care across the organization
- Reimbursement for screenings, assessments and safety planning
Why Focus on Health Care Settings?

- 84% of those who die by suicide have a health care visit in the year before their death.
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.
- Almost 40% of individuals who died by suicide had an ED visit, but not a mental health diagnosis.

Patient Safety and Error Reduction

A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
The Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Over the past 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not At all</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Column Totals: ____ + ____ + ____

Add Totals Together: __________

10. If you checked off any problems, how difficult have those 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
# PHQ-9 modified for Adolescents (PHQ-A)

**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.

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

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)
**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/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.

**Provide resources to all patients**

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741741

**NIMH Suicide Risk Screening Tool**

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
Say to parent/guardian:
“National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child’s safety, we will let you know.”

Once parent steps out, say to patient:
“Now I’m going to ask you a few more questions.”
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
“I’m so glad you spoke up about this. I’m going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you.”

If patient screens positive, say to parent/guardian:
“We have some concerns about your child’s safety that we would like to further evaluate. It’s really important that he/she spoke up about this. I’m going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child.”
Your child’s health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today’s visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child’s safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that asking kids questions about suicide is safe, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and does not put thoughts or ideas into their heads.

Please feel free to ask your child’s doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.
Assessing Risk

Can and does happen in primary care settings-appropriate level of care
Helpful to speak the same language and understand the assessment process
The primary care visit focus becomes the risk for suicide
## Response Protocol

Ask questions that are in bold.

<table>
<thead>
<tr>
<th>Ask Questions 1 and 2</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>2. Have you had any actual thoughts of killing yourself?</strong></td>
<td>YES</td>
</tr>
<tr>
<td>If <strong>YES</strong> to 2, ask questions 3, 4, 5 and 6. If <strong>NO</strong> to 2, go directly to question 6</td>
<td></td>
</tr>
<tr>
<td><strong>3. Have you been thinking about how you may do this?</strong></td>
<td>YES</td>
</tr>
<tr>
<td>e.g. &quot;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.&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>4. Have you had these thoughts and had some intention of acting on them?</strong></td>
<td>YES</td>
</tr>
<tr>
<td>as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
</tr>
<tr>
<td><strong>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?</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?</strong></td>
<td>Lifetime</td>
</tr>
<tr>
<td>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.</td>
<td>Past 3 Months</td>
</tr>
<tr>
<td>If <strong>YES</strong> to question 6, ask: <strong>Was this in the past 3 months?</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Schedule follow-up**

**Address Lethal Means, Safety Planning, Schedule Follow-up**

**Evaluate Hospitalization, Address Lethal Means, Safety Planning, Schedule Follow-up**
The Minimum WHAT (to do)

BEFORE THEY LEAVE YOUR OFFICE

• Suicide Prevention Lifeline or Crisis Text Line in their phone
  – 1-800-273-8255 and text the word “Hello” to 741741
• Address guns in the home and preferred method of suicide
• Give them a caring message (NowMattersNow.org ➔ “More”)
## Safety Plan

**NowMattersNow.org Emotional Fire Safety Plan**

Select boxes that fit for you. Add your own. Form is based on research and advice from those who have been there. Visit nowmattersnow.org/safety-plan for instructions (coming soon). Do not distribute. ©2018 All Rights Reserved (V 18.05.27)

Direct advice for overwhelming urges to kill self or use opioids

- **Shut it down** —
  - Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

- **No Important Decisions** —
  - Especially deciding to die. Do not panic. Ignore thoughts that you don’t care if you die. Stop drugs and alcohol.

- **Make Eye Contact** —
  - A difficult but powerful pain reliever. Look in their eyes and say “Can you help me get out of my head?” Try video chat. Keep trying until you find someone.

### Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Visit NowMattersNow.org (guided strategies)</td>
<td>□ Opposite Action (act exactly opposite to an urge)</td>
</tr>
<tr>
<td>□ Paced Breathing (make exhale longer than inhale)</td>
<td>□ Mindfulness (choose what to pay attention to)</td>
</tr>
<tr>
<td>□ Call/Text Crisis Line or A-Team Member (see below)</td>
<td>□ Mindfulness of Current Emotion (feel emotions in body)</td>
</tr>
<tr>
<td>□ “This makes sense: I’m stressed and/or in pain”</td>
<td>□ “I can manage this pain for this moment”</td>
</tr>
<tr>
<td>□ “I want to feel better, not suicide or use opioids”</td>
<td>□ Notice thoughts, but don’t get in bed with them</td>
</tr>
<tr>
<td>□ Distraction:</td>
<td>□</td>
</tr>
</tbody>
</table>

NowMattersNow.org ©2018 All Rights Reserved
# Patient Safety Plan

## 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 __________________ Phone __________________

### 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: ____________________________
Questions?

Virna Little

Virna@concerthealth.io