Suicide Screening

PAIGE GOLDADE, RN-BC

AVERA BEHAVIORAL HEALTH

Importance of Screening for depression

- Depression is frequently co-morbid with other medical complications
- Each year, about 25 million Americans will experience an episode of clinical depression
- Depression is estimated to be the 2nd largest disability by 2020
- When untreated, it leaves other illnesses more difficult to treat and increases health care utilization

Fighting this disease

- Depression is hard to treat.
  - Can't be seen.
  - Even those with depression have stigma often times.
  - Cancel appointments, stop taking medications, use drugs or alcohol to cope.
  - This all leads to more hospital stays and increased healthcare utilization.

Suicide

- Suicide is a growing epidemic.
- It is the 2nd leading cause of death for those 10-24 worldwide!
- Early detection is critical to prevent suicide.

- QUESTION – Is it more or less likely for someone to commit suicide within months of seeing their care provider?

Screening

- Screening for suicide is vitally important.
- Asking the questions can be hard and uncomfortable.
- One must become comfortable with this.
- Asking the questions does not give a person more ideas.
- Increase identification of those struggling giving them the opportunity to get further assessment and care.

Risk Factors for Suicide

- Characteristics of a person or his environment that increases likelihood that he will die by suicide.
  - Prior suicide attempt
  - Misuse and abuse of alcohol or other drugs
  - Mental disorders, particularly depression or other mood disorders
  - Access to lethal means
  - Knowing someone who died by suicide, particularly a family member
  - Social isolation
  - Chronic disease and disability
  - Lack of access to behavioral health care

Protective Factors

- Personal or environmental characteristics that protect people from suicide
  - Currently receiving behavioral health care
  - Connectedness to individuals, family, community
  - Self esteem and a sense of purpose or meaning in life
  - Cultural, religious, personal beliefs that discourage suicide
  - Life skills (problem solving and coping skills)
    - Can help them build upon, many lack
    - Think back to when they were well

Biggest Risk

- Ligature risk is our greatest suicide risk in the hospital.
- The bathroom is where the most attempts occur.
- For this reason when not in use bathrooms should remain locked.
- Door handles, sinks, and toilets should be free from protrusions. Shower curtains should be break away.
- Superficial scratching/cutting
- Overdose, cheeking

Contraband

- No strings, belts, hoods, shoelaces, bracelets, sandals with metal, nylons, jewelry with chains, piercings.
- No glass make up, nmirrors, aerosol, scarves, shower poofs, pumps, hair clips, headbands, straps, floss, nail clippers, tweezers, no alcohol in 1st 3 ingredients, ponly tail with metal, personal toothbrushes, scissors, eyelash curlers
- No knitted, tied blankets, vases, picture frames, hangers, bags, cords
- No electronic games, personal markers, spiral notebooks, fabric book marker longer than 6 in, pens, mechanical pencils, erasers with metal, stapes, paperclips, razors
- No purses, wallets, knives or weapons, lighters
- Drink containers unless provided by hospital, no mugs

Safety Measures for the Adult Programs

- 1. Rounds are made regularly to appropriate level of observation
- 2. Staff will be alert to a change in the patient's behavior and report to assigned RN.
- 3. Room checks are done daily 2-4 times depending on unit acuity.
- 4. All doors not in immediate use are to remain locked.
- 5. Patient's rooms are to remain unlocked unless indicated otherwise by physician order.
- 6. No access to shoelaces.
- 7. Contraband items will be sent home with family or secured.
- 8. Straight edge razors not allowed.
- 9. Suitcases will be stored in intake room.
- 10. Visitors will be identified before allowing them on unit.
- 11. Packages given to patients will be opened in presence of staff, including outside food.
- 12. Staff will be familiar with use of pendant alarm, how to alert security.
- 13. Staff will not be alone in seclusion room.
- 14. Patient will not be left alone in group room.

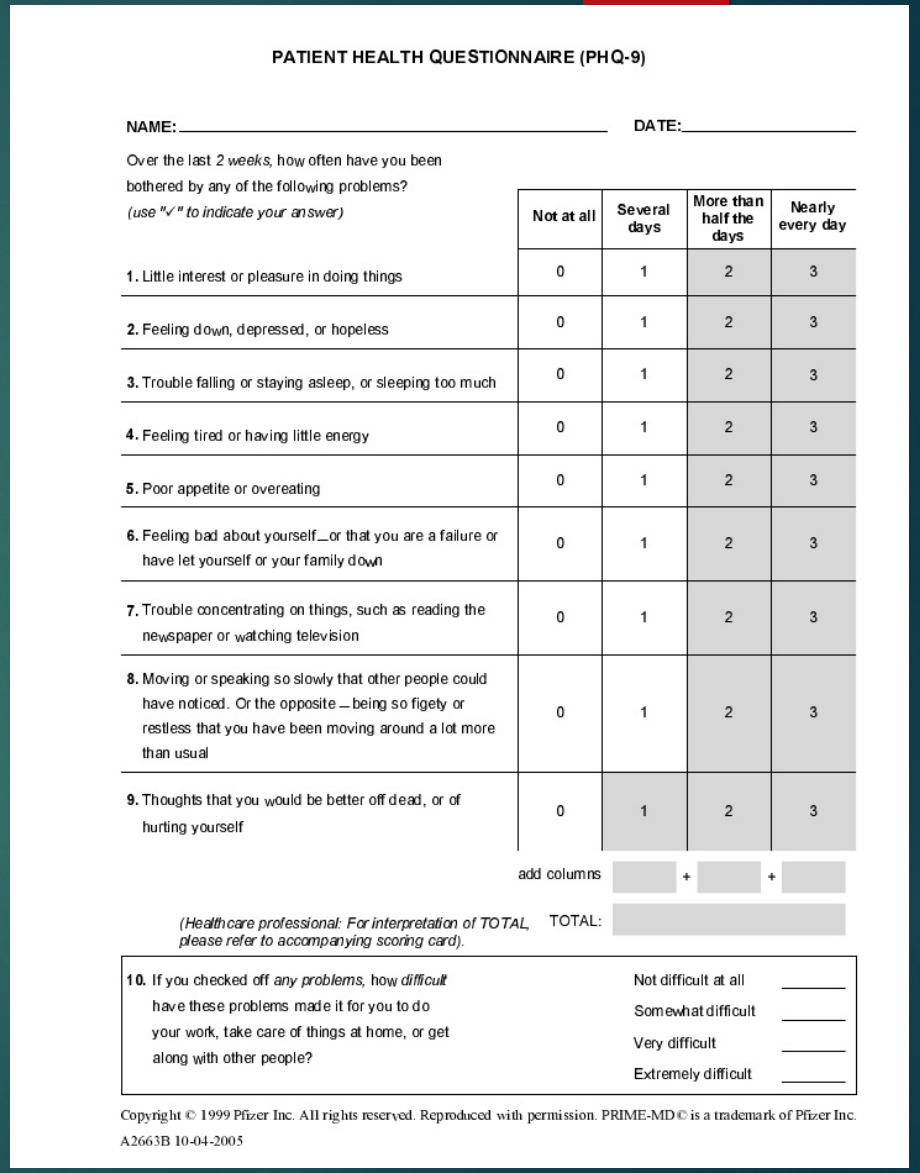
Zero Suicide Initiative

- PHQ9-PHQA scores
- Columbia
- Means Safety Planning
- Crisis Response Planning

PHQ9

- Screening tool for diagnostic assessment for depression
- Evaluates 9 core symptoms of depression
- Question 9 screens for presence and duration of suicidal ideation

- At behavioral health if a patient scores greater than 20 on PHQ9 / PHQA and 2+ on question 9 they are on increased observation status.
- Check with your policy to see what your hospital follows.



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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 figety 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	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. 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 _____

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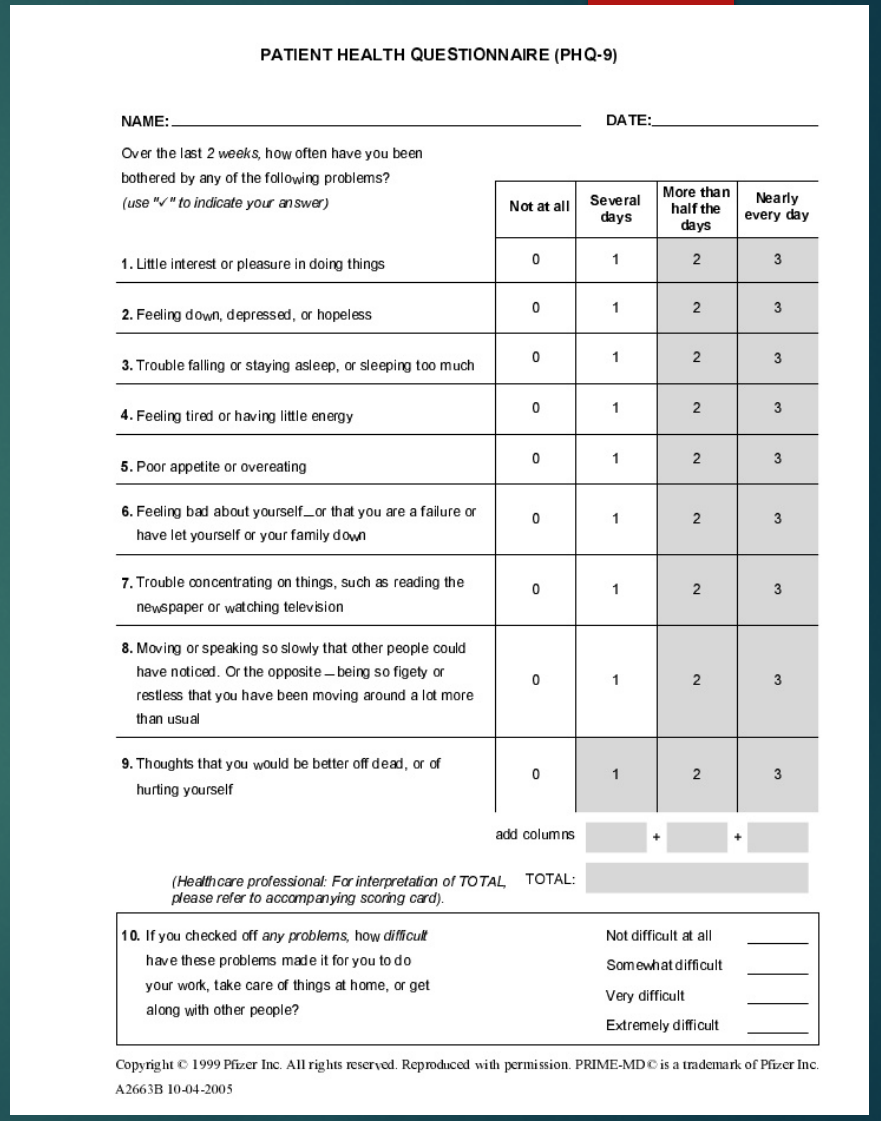
Who receives screening?

- All patients in acute hospital
- Patients admitted to ambulatory with behavior health problem
- Any patient can be screened or rescreened based on concern
- This data inputted electronically

- QUESTION – Can I reword a question to better fit my patient? It might make them uncomfortable the way it is worded.



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Columbia

Past month – Admission and Discharge

- 1. Wish to be dead “Have you wished you were dead or wished you could go to sleep and not wake up?”
- 2. Non-specific Active Suicidal Thoughts “Have you actually had any thoughts of killing yourself?”
- 3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act “Have you been thinking about how you might do this?”
- 4. Active suicidal Ideation with Some Intent to Act, without Specific Plan “Have you had these thoughts and had some intention of acting on them?”
- 5. Active Suicidal Ideation with Specific Plan and Intent “Have you started to work out or worked out the details of how to kill yourself? Do you intent to carry out this plan?”

Past 3 months

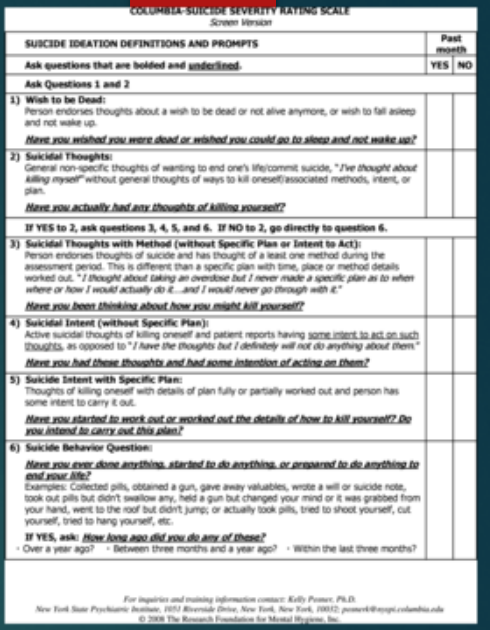
- 6. “Have you done anything, started to do anything, or prepared to do anything to end your life?”

We ask these questions daily and upon discharge

- QUESTION – What do I do if the patient is still feeling suicidal upon discharge?

- QUESTION – What risk factors are characteristic of a person/environment that may increase the likelihood someone will die by suicide?

Columbia Daily Screening



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	YES	NO
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. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***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) 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.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
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. ***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) Suicide Behavior Question: ***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:** ***How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

- Suicidal Thoughts -Yes or No
  - 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
  - Daily/Shift – Ask questions like this: Since you were last asked, have you actually had thoughts about killing yourself?
- Suicidal Thoughts with Method (w/o Specific Plan/Intent) – Yes or No
  - Person endorses thoughts of suicide and has thought of at 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."
  - Daily/Shift – Ask Question like this: Have you been thinking about how you might do this?
- Suicidal Intent w/o Specific Plan - Yes or No
  - Active suicidal thoughts of killing oneself and patient reports having intent to act on such thoughts as opposed to "I have the thoughts but definitely will not do anything about them.
  - Daily/Shift – Ask question like this: Have you had these thoughts and had some intention of acting on them?

Means Safety Counseling Fidelity Monitoring

- Explain rationale for means safety
- Discussed impulsivity, cognitive confusion, and poor problem solving when highly distressed
- Identified potential methods for means safety
- Asked about access to firearms
- Collaboratively engaged patient in discussion about means safety
- Elicited feedback and input from patient regarding preferred options for securing means

Crisis Response Plan Fidelity Monitoring

- A collaborative partnership with patients
  - Introduce Crisis Response Plan
  - Identify Personal Warning Signs
  - Identify Self-Management Strategies
  - Identify Reasons for Living
  - Identify Social Supports
  - List of Professional Supports
  - On a Scale of 0-10 how likely are you to use the CRP?
  - Problem solve with patient if not at a 10

Case Study 1

- Johnny is a 22 year old patient who has just entered the clinic for symptoms of a cold persisting for 3 weeks. He is with his father. Upon assessment it is noted that his mother recently passed away from cancer.
- Johnny seems guarded and doesn't have good eye contact. His father mentions to his nurse that even though Johnny has a lot of friends and he is doing well in school, he really isn't doing well.
- The nurse asks to speak with Johnny alone. He reluctantly admits to his nurse that he has considered taking some of his fathers prescription medications and states "I just can't take it anymore, I don't want to live. I am lonely."

- 1. What would you say to him?
- 2. What else would you do or say to help?

Question

- Listen, validate, communicate hope.
- Question the suicide ideation, intent. Get more information
- Listen to problem, they won't agree to get help if they don't feel they can trust you.

- Question directly – "are you thinking about hurting yourself?"
- NOT "You're not thinking about suicide are you?"

Persuade

- Ask for agreement, commitment for them to get help, insist, get commitment for them to live.
- Instill hope

Refer

- Go with them, help make arrangements, call and follow-up
- “I want you to get help”
- “Let’s go talk to someone who can help you.”
- Don’t invalidate their feelings.

Case Study 2

- Marisa is a 30 year old mother of 3 who enters the ED with complaints of chest pain. She is short of breath, diaphoretic and hypertensive. All cardiac workups are coming back normal.
- The physician has diagnosed her with an anxiety attack. The nurse assigned to her is doing the suicide screening form. Although Marisa is preparing for discharge and is now calm she admits she is overwhelmed at home. She tells the nurse, “I just can’t do this anymore, I have no help and I am so tired. My anxiety is out of control.”
-
- 1. What is your next step?
- 2. What else would you do or say to help?

Question

- Listen, validate, communicate hope.
- Question the suicide ideation, intent. Get more information
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Case Study 3

- Jim comes to your ED with complaints of chronic back pain. He has been seen at this ED 10 times in the past 10 months for the same thing. He is irritable and guarded with staff. When the physician refuses to prescribe him with narcotics Jim become irate. He states, “I can’t live with this pain anymore! No one believes me! I am going to go home and kill myself! You don’t care about me.”

- 1. What is your next step?
- 2. What else would you do or say to help?

Question

- Listen, validate, communicate hope.
- Question the suicide ideation, intent. Get more information
- Listen to problem, they won't agree to get help if they don't feel they can trust you.

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Case Study 4

- A patient was brought to the emergency department (ED) via ambulance after being found unresponsive at home from an alcohol and drug overdose. The patient was given Narcan by the EMS prior to arrival and was able to participate during triage.
- Upon the patient's arrival to the ED, a nurse performed a suicide screening using questions adapted for the organization's electronic medical record (EMR). Though the patient shared that he had recently lost his job and was having relationship issues, he assured the nurse that the overdose was an attempt to relax and sleep, and he denied suicidal ideation. The suicide screening was determined to be negative. While the patient's social stressors were documented in the nursing notes, they were not directly communicated to the ED physician.
- The ED physician assessed the patient, noting a decrease in oxygen saturation, and consulted with the hospitalist. They decided to admit the patient to the medical floor for suspicion of aspiration pneumonia. This was the third overdose patient that shift for the ED physician, and after seeing the suicide screen as negative and hearing the patient's explanation, the physician believed the patient to have accidentally overdosed, so the physician focused on the medical aspects. Psychosocial factors were not communicated to the admitting hospitalist. Later, it was found that eight months prior, the patient had been admitted to a sister hospital for an overdose after a suicide attempt. This information was not accessed by either physician.
- The patient was transferred to the medical-surgical unit. A hand-off between the ED and the receiving unit did not occur. An admission assessment and history/ physical was conducted by the medical-surgical nurse. Although a repeat suicide risk screening and assessment was required per policy, it was not performed.
- The patient improved medically throughout the day with more energy and positive presentation, though he continued to casually verbalize stress over the loss of his job and relationship issues to various staff (nursing, substance abuse services consult), remarking that he was "tired of dealing with it all" and wished he could "just sleep and it'll be over." The comments were documented in the EMR, but were not communicated to anyone
- Later in the afternoon, the patient had a visitor. Some time after, a nurse performing hourly rounds entered the patient's room to find the patient hanging from his belt, which was wrapped around his neck and tied to the bed. A code blue was called, and the code team arrived to revive the patient, but he was unable to be resuscitated.

Case Review

- The suicide screen was developed by the organization and was not evidence-based.
- The suicide screening process was driven by the EMR and did not trigger consideration for other at-risk behaviors or events. The process had become rote.
- Previous admissions are cumbersome to access in the EMR.
- The verbal report/hand-off with the receiving med-surg nurse was not conducted because of a high-volume of cases in the ED.
- Each discipline's notes are separate, and there is no efficient means to see the "big picture" for each patient. To do that, staff must go in and out of each discipline's notes.
- Concerned statements by the patient were not followed up on or interrogated further, as there was no education as to high-risk triggers or actions to take to mitigate risk.
- It was a busy time for the ED, limiting opportunity for verbal communication.
- The inpatient suicide risk screening/assessment is accessed by a tab that the nurse must click to open and complete. As the suicide screen was negative in the ED, there was no other apparent information or prompt, so the additional suicide screening/assessment was overlooked.
- https://www.jointcommission.org/assets/1/6/Case_Example_3.pdf

Why is this hard?

- It can be uncomfortable to talk about suicide.
- These tools are great to use to guide your conversation and help you to become at ease with this topic.
- This is important work, every life we save is a precious life.
- Open communication, developing trust through good rapport, & having a nonjudgmental presence can help patient's open up.

How to Safeguard Your Home

If your child is experiencing a mental health problem or life crisis, these simple steps can help protect your family and possibly save your child's life.

STORE FIREARMS OFFSITE

- Ask a trusted friend or family member to keep them temporarily until the situation improves.
- Call your local police precinct, gun range, or shooting club to see if they will offer temporary storage.
- If you can't store the firearms away from the home, store them unloaded and locked in a gun safe or lock box. You can also lock them using a cable or trigger lock. Locking devices using combinations are safer than those using keys.

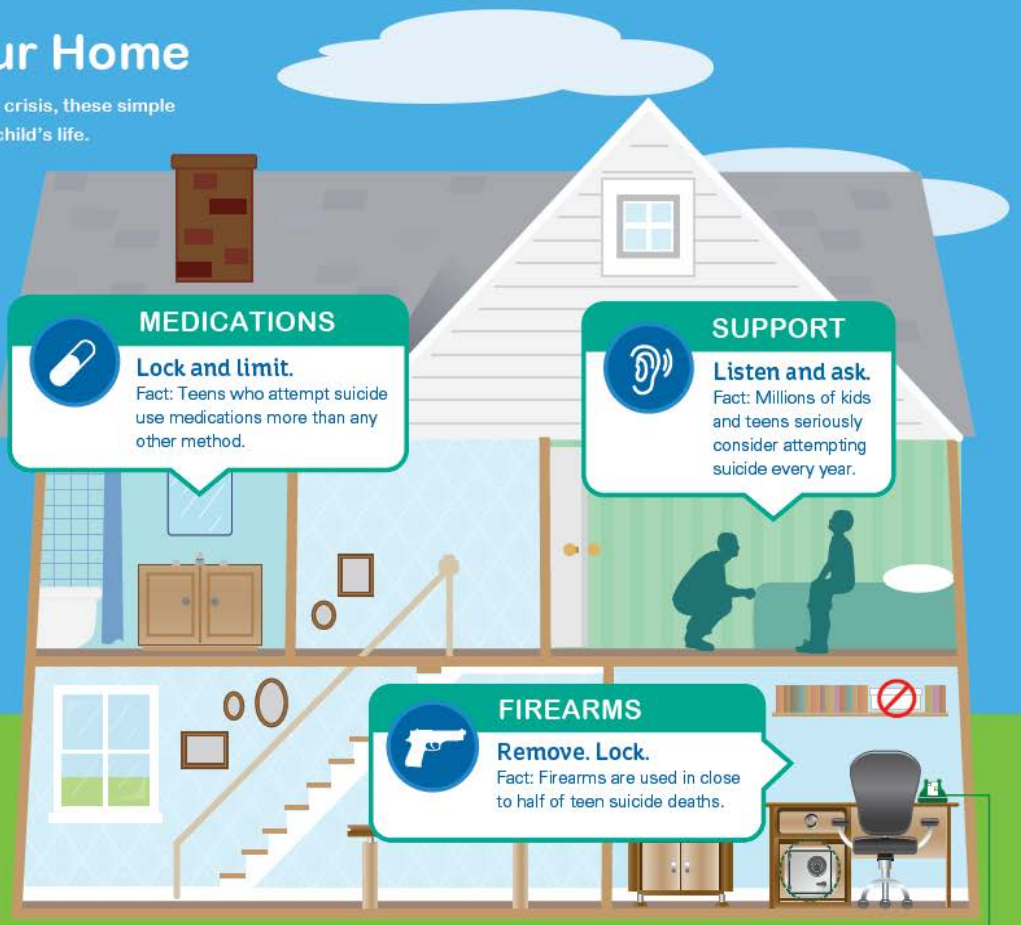
LOCK UP MEDICATIONS

- Store all medications in a lock box or locked medicine cabinet.
- To dispose of unused medications, locate a medicine take-back program in your community or follow the FDA guidance: Mix the medicines with kitty litter or used coffee grounds in a sealable bag. Then throw away the mixture in the trash.

PROVIDE SUPPORT

- Pay attention to your child's moods and behavior.
- If you notice significant changes, ask them if they're thinking about suicide.
- If you think your child is in crisis, call 911 or go to the nearest emergency room.
- Make sure your child knows how to access the suicide prevention lifeline.

For crisis support or information call the Helpline Center. (605) 339-4357.



HELP IS AVAILABLE
if you're concerned that someone you care about is at risk of suicide.

Visit sdsuicideprevention.org

helpline center
24/7 free and confidential.
1·800·273·8255

IN CASE OF EMERGENCY:
Call 911 or visit your local emergency room.

Resources

- Avera Behavioral Health Assessment Program, Sioux Falls, SD: 1-800-691-4336 The assessment team is available 24/7 to help you or your loved one find appropriate help for mental health issues. They provide free, confidential mental health screenings with a counselor to determine the necessary level of care.
- National Suicide Crisis Line: 1-800-273-TALK (8255)
- National Crisis Text Line: Text HOME to 741741 for free 24/7 crisis support in the US.
- NAMI (National Alliance of Mental Illness): Dedicated to improving the lives of individuals and families affected by mental illness. www.nami.org Free Family-To-Family, a free peed education program (605-610-5485) as well as a support group for those affected by mental illness. Website is www.namisiouxfalls.org 605-610-7226.
- HELP! Line Center (South Dakota) 211 in the 605 area code. www.helplinecenter.org The Helpline is an invaluable resource that can give information on everything from childcare in the community, to rent and housing assistance, to volunteer opportunities. They also have information specific to mental health including information and resources for prevention training and other tools for school and community.
- www.MinnesotaHelp.info: 211 in Minnesota
- www.211iowa.org: 211 in Iowa and Nebraska
- Family Crisis Intervention: Volunteers of America, Sioux Falls, SD: 1-800-365-8336
- Many CD resources as well.
- Please contact Whitney Flanagan if you want more information on these resources