Identifying and Caring for Patients at Risk for Suicide during the COVID-19 Pandemic

April 29, 2020
About the Association of Clinicians for the Underserved

ACU is a nonprofit, transdisciplinary organization of clinicians, advocates, and health care organizations united in a common mission to improve the health of America’s underserved populations and to enhance the development and support of the health care clinicians serving these populations.
Housekeeping

• We are recording.
• Everyone is muted.
• Use the Q&A box to ask questions.
• If you are having any technical difficulties, please use the chat box and direct your message to Mariah Blake.
Poll 1

What type of organization are you representing?

- Hospital
- Federally Qualified Health Center
- Public Health Department
- Rural Health Clinic
- Centene network provider
- Other (please list)
Poll 2

Since COVID-19, are you aware of any increases in suicidal behavior or actions by patients?

• I’m not sure; that’s why I’m here.

• We have seen an increase in suicidal behavior or actions, not resulting in death (that I am aware of).

• We have seen an increase in patients who have died by suicide.
Meet your presenter

Virna Little, PsyD, LCSW-r, SAP, CCM
Concert Health
@virnalittle
Suicide Experiences are NOT Uncommon

Each year, approximately 10 million Americans adults think seriously about killing themselves, 3 million make suicide plans, and 1 million make a suicide attempt.

Substance Abuse and Mental Health Services Administration.
HHS Publication No. (SMA) 13-4795 2013
Language Matters
Choosing Compassionate & Accurate Language

Died of/by Suicide vs Committed Suicide
Suicide vs Successful Attempt
Suicide Attempt vs Unsuccessful Attempt
Describe Behavior vs Manipulative/Attention-Seeking
Describe Behavior vs Suicidal Gesture/Cry for Help
Diagnosed with vs they're Borderline/Schizophrenic
Working with vs Dealing with Suicidal Patients
Discussion for Workshop

- Primary Care Providers Role in Suicide Safe Care
- Identifying Patients at Risk for Suicide
- Assessing Patients at Risk for Suicide
- Safety Planning
- Office-Based Interventions for Primary Care Providers
A Call to Action for Primary Care Providers

THE OPPORTUNITY

Americans visited primary care physicians 462 million times in 2008, a number that is expected to increase to 565 million by 2025. While the primary reason for this increase is due to population growth, it is also attributed to an aging population and expanded access to insurance. Both older adults and those who previously did not have access to care are historically underserved populations who have had difficulty accessing quality care, especially mental health care. (Peterson et al, 2012)

Primary care patients who are at risk of suicide often do not tell their provider that they are experiencing thoughts of killing themselves, and too often, providers do not ask. One study found that 45 percent of people who have died by suicide visited their primary care physician within a month of their death, with older adults having higher rates of contact with primary care providers within one month of suicide than younger adults. In one of the highest risk groups—adults suffering from a major depressive episode—60.7 percent received treatment from a primary care provider. (Ahmedani et al, 2014)

Most primary care providers are starting to screen for substance abuse; which is a significant risk factor for suicide, especially alcohol. Adults aged 18 or older with past year illicit drug or alcohol dependence or abuse were more likely than those without dependence or abuse to have had serious thoughts about suicide in the past year (12.2 vs. 3.0 percent). Adults with substance dependence or abuse also were more likely to make suicide plans compared with adults without dependence or abuse (3.1 vs. 0.9 percent) and were more likely to attempt suicide compared with adults without dependence or abuse (1.7 vs. 0.4 percent).” (SAMHSA, 2010)
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.

What We Hear Sometimes...

• “I refer all of my patients to mental health.” (patients at risk for suicide have diabetes)

• “I don’t have the knowledge to assess or intervene.”

• “With such a short amount of time, I don’t have time to ask or address suicide risk.”

• “We have so many other initiatives.”
The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.”
Patient Safety and Error Reduction

[Image: Diagram adapted from James Reason’s “Swiss Cheese” Model Of Accidents]

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

Avoid Serious Injury or Death
Zero Suicide

Access at:

www.zerosuicide.com
The Minimum How (to do it)

In Your Office

• Do not panic.

• Be present listen carefully and reflect)

• Provide some hope
  Ex. “You have been through a lot, I see that strength”

LANGUAGE MATTERS!
Identification

• Many offices are screening for depression

• Ask patients directly (ask what you want to know)

• Social determinants play a role

• Many patients don’t have depression

• Substance and alcohol use play a role

• Transitions are a time of risk

Do you know how many patients in your practice are at risk?
### 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

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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
"I just always run into the issue where as soon as things start becoming difficult, they just immediately suggest that I go to the mental hospital and I just cannot stress enough that it was not a good environment for me. And, they still suggest that I go back, when it’ll just make things worse... It just seems like that’s one of their first options when it should be a last resort (P168)."
Assessing Risk

- Can and does happen in primary care settings
- Helpful to know: Speak the same language and understand the assessment process
- This is the primary care visit...
What is the Columbia Suicide Severity Rating Scale (CSSRS)

• The CSSRS supports the assessment through a series of simple, plain-language questions that anyone can ask.

• Identifies whether someone is at risk for suicide.

• Assesses the severity and immediacy of that risk.

• Gauges the level of support that the person needs.
Why Use the CSSRS?

• Simple: Ask the questions in a few moments or minutes — with no mental health training required to ask them.

• Efficient: Use of the C-SSRS redirects resources to where they’re needed most (only those who need to go to the ER, go to ER)

• Effective: Real-world experience and data show that the scale has helped prevent suicide.

• Universal: The C-SSRS is suitable for all ages and special populations in different settings and is available in more than 100 country-specific languages.
Why Use the CSSRS? (continued)

- Evidence-supported: An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the C-SSRS to assess suicide risk, making it the most evidence-based tool of its kind.

- Free: The scale and the training on how to use it are available free of charge for use in community and healthcare settings, as well as in federally funded or nonprofit research.

- Consistent: Provides consistency of language and classification within and across settings.

- Non-judgmental: Avoids use of stigmatizing language.
CSSRS Screener for Primary Care

1 to 5 scale of suicidal ideation

<table>
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<tr>
<th>Ask Questions 1 and 2</th>
<th>Past Month</th>
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<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>NO</td>
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<tr>
<td>2. Have you had any actual thoughts of killing yourself?</td>
<td>YES</td>
</tr>
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</table>

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 may 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 to question 6, ask: **Was this in the past 3 months?**
# Response Protocol

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| 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? | Lifetime | Past 3 Months |

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<th>6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?</th>
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<td>NO</td>
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If YES to question 6, ask: **Was this in the past 3 months?**

- **Schedule follow-up**
- **Address Lethal Means, Safety Planning, Schedule Follow-up**
- **Evaluate Hospitalization, Address Lethal Means, Safety Planning, Schedule Follow-up**
CSSR Trainings

Links and trainings can be found at:  
http://cssrs.columbia.edu/training/training-options/
What is Safety Planning?

Safety Planning Intervention consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.
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”)
Website visits are associated with decreased intensity of suicidal thoughts and negative emotions. This includes people whose rated their thoughts as “completely overwhelming”
# 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>On Fire</th>
<th>In A Fire</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Visit NowMattersNow.org (guided strategies)</td>
<td></td>
</tr>
<tr>
<td>□ Paced Breathing (make exhale longer than inhale)</td>
<td></td>
</tr>
<tr>
<td>□ Call/Text Crisis Line or A-Team Member (see below)</td>
<td></td>
</tr>
<tr>
<td>□ “This makes sense: I’m stressed and/or in pain”</td>
<td></td>
</tr>
<tr>
<td>□ “I want to feel better, not suicide or use opioids”</td>
<td></td>
</tr>
<tr>
<td>□ Opposite Action (act exactly opposite to an urge)</td>
<td></td>
</tr>
<tr>
<td>□ Mindfulness (choose what to pay attention to)</td>
<td></td>
</tr>
<tr>
<td>□ Mindfulness of Current Emotion (feel emotions in body)</td>
<td></td>
</tr>
<tr>
<td>□ “I can manage this pain for this moment”</td>
<td></td>
</tr>
<tr>
<td>□ Notice thoughts, but don’t get in bed with them</td>
<td></td>
</tr>
<tr>
<td>□ Distraction:</td>
<td></td>
</tr>
</tbody>
</table>
## 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 | Place
4. Place | 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 # | Phone
2. Clinician Name | Phone
   Clinician Pager or Emergency Contact # | Phone
3. Local Urgent Care Services
   Urgent Care Services Address | 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:
Safety Planning

- Program Lifeline or hotline into phone and call “I am going to step out to see my next patient………”

- Call someone from the patients team “Sarah and I would like to speak with you, she has listed you on her suicide safety plan.”

- Be creative – Walmart!

- Pictures
Lethal Means Counseling

Preferred method is important.
Lethal Means Restriction

• Temporary

• Matter of Fact

• Standard Practice

• Safety Approach (Public Health!)
Lethal Means

• How much medication is in your home? (neighbors, family)

• Medication boxes, family, bubble wrap

• Gun locks, boxes, family or surrender for holding
Lethal Means

• How much medication is in your home? (neighbors, family)

• Medication boxes, family, bubble wrap

• Gun locks, boxes, family or surrender for holding
Henry,
I don’t know you well yet, I am glad that you told me a little more about your life. I have lots of hope for you – you’ve been through a lot. I hope you’ll remember that and come back to see us. With care, -Nurse Matt
Caring Messages

We asked over 1000 people. Here are the top results. Please use and adapt these any way you like for those you care about.

Dear you. Yes you! Remember that one time you felt connected to the universe. No one can take that away from you. It's yours.
— Ursula Whiteside

You may feel you don't matter but you do and see no future. Yet it is there - please let it evolve because the world needs you and your contribution.
— Kristine Leaminen

If I could fill the world with more people who feel the world, I would. Understanding suffering is a heavy burden to carry at times for sure - but you are never a burden for feeling it.
— Nina Smith

You're a human being, not a human doing. Your worth is intrinsic, and your strength is likely greater than you think it is.
— John Brown

Live. If only at times, because it is an act of radical defiance.
— Ursula Whiteside

Your story doesn't have to end in this storm. Please stay for the calm after the storm. The possibly a rainbow. Maybe not tomorrow or next week, but you can weather this.
— Breanna Laughlin

This is part of a poem from Jane Hirschfield. “The world asks of us only the strength we have and we give it. Then it asks more, and we give it.”
— Sara Smucker Barnwell

I've been there - that place where you'd do anything to stop the pain. It's a dark, suffocating birth canal to a better place...Life changes can suck; but nothing ever changing sucks more.
— Kathleen Bartholomew

Please don’t stop fighting. You are being prepared for something far greater than this moment.
— Breanna Laughlin

Just like winter, the long dark days slowly get shorter until there is more light than dark. Please believe this while you wait to see the light.
— Debbie Reisert

Things can be completely dark for some of us sometimes. I don't know where you are at today, or if this message can shine through, but I'm here sending you a tiny bit of light - a light beam.
— Ursula Whiteside

I was trapped in the Dark Place. Drowning in it. Lost in the fog. Sinking in the quicksand. Unable to get out. Slowly, slowly, slowly. I am. You might be able to too. Just get through today.
— Amy Dietz

This is a favorite line of mine from Desiderata: “You are a child of the universe, no less than the trees and the stars; you have a right to be here.”
— Andy Bogart

Wanting to be rid of pain is the most human of impulses. You are brave to hold that. You are worth so much. Because you exist. And breathe air. Contingent on nothing else.
— Sara Smucker Barnwell

I've found this Franklin D. Roosevelt quote helpful. "A smooth sea never made a skilled sailor.” We'll be prepared for something bigger.
— Ursula Whiteside

now matters now
Association of Clinicians for the Underserved
Suicide Prevention in Primary Care Webpage
http://clinicians.org/suicide-prevention-in-primary-care/

- Request a training
- Access the Suicide Prevention in Primary Care Toolkit
Questions?
Thank you!