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

now matters now

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. (Petterson 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.

Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909 -

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.”

Joint Commission Sentinel Event Alert 56

Sentinel Event Alert

EMBARGOED UNTIL FEB. 24

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[8] and continues to be high especially within the first year[8,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). 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.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Baerum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

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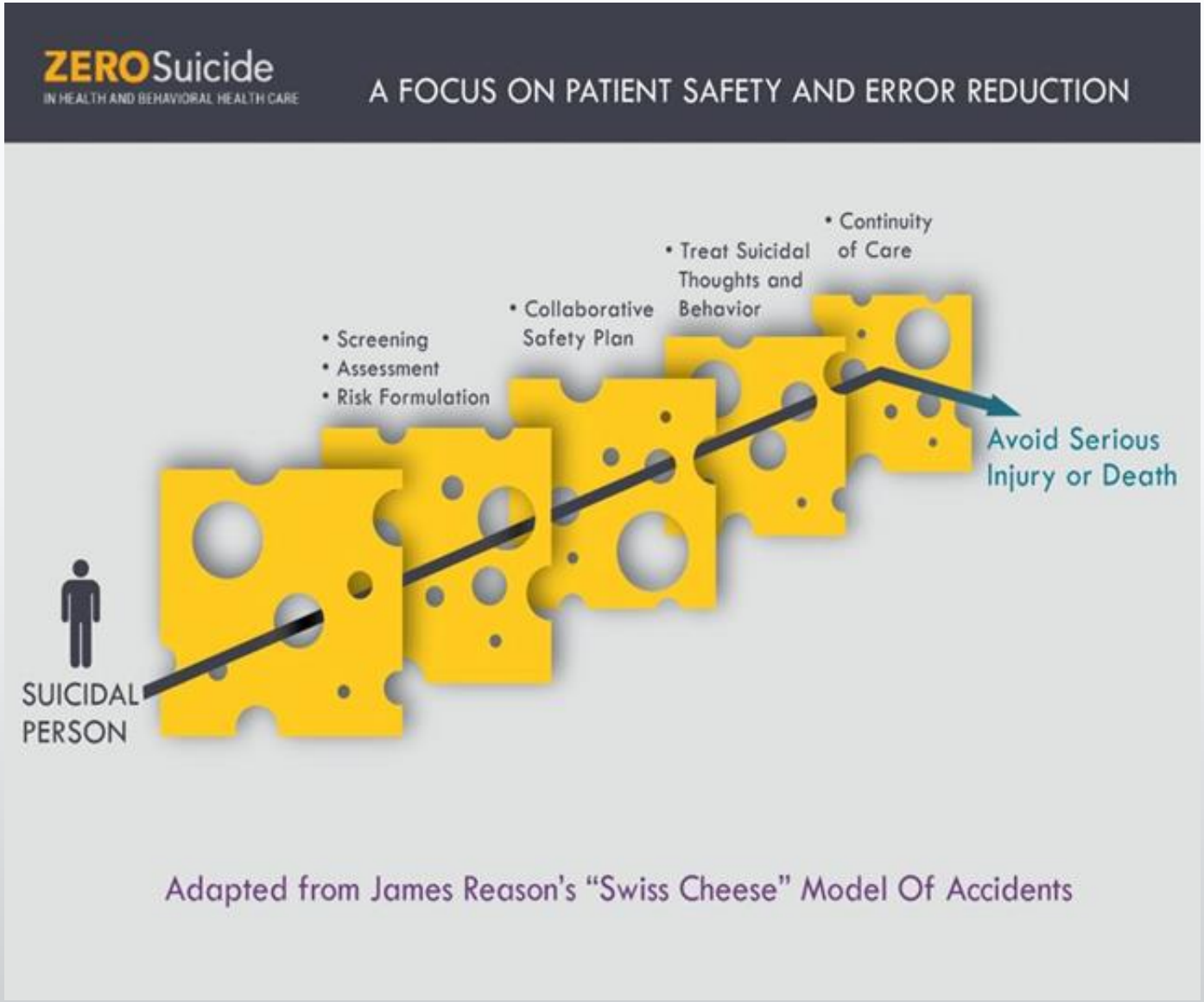
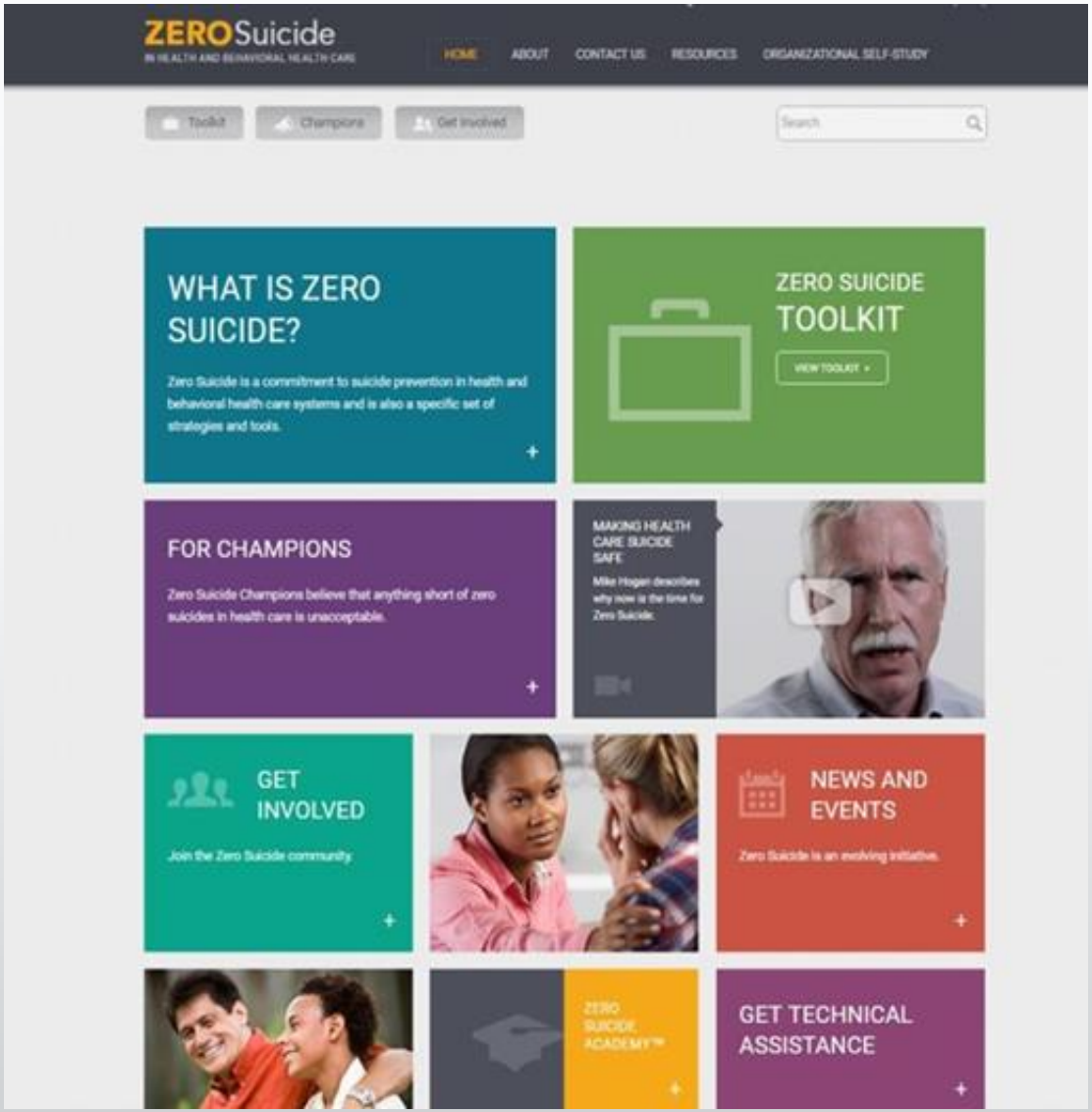
Patient Safety and Error Reduction



Zero Suicide



Access at:

www.zerosuicide.com

The Minimum How (to do it)

3 things that suicidal people want

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

The Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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
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

"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

Behaviors

Ask questions that are in bold.

Ask Questions 1 and 2	Past Month YES	Past Month NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual 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 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 someintention 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.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Response Protocol

Ask questions that are in bold.

Ask Questions 1 and 2	Past Month: YES	Past Month: NO
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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")

NowMattersNow.org Works

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. (V 18.05.27)

ON FIRE

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.

IN A FIRE

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

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

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_____ 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:

_____

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

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Caring Contact

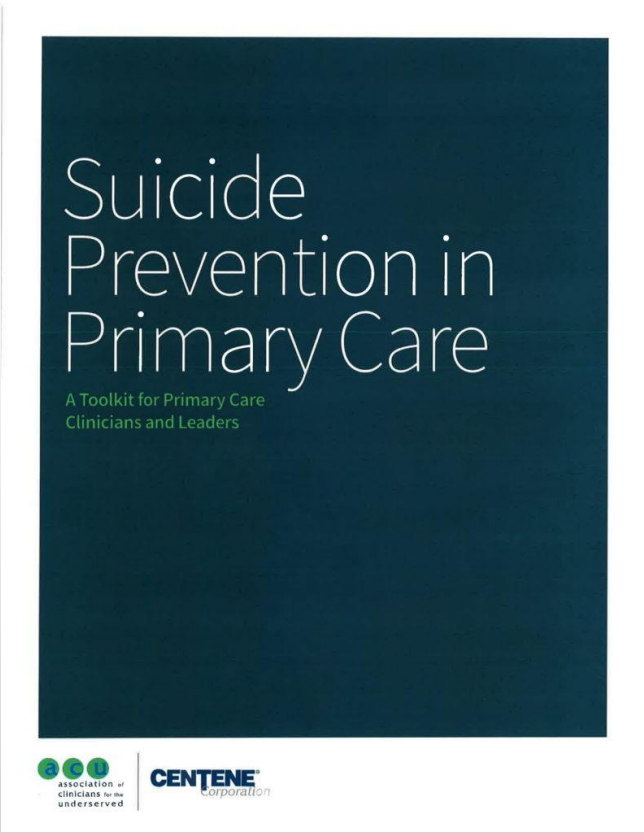
Henry,
I don't know you well yet, I am glad that you told me a little more about your life. I have lots of hope for you – you've been through a lot. I hope you'll remember that and come back to see us. With care, -Nurse Matt

Caring Messages

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!