MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Suicide Safe Care for Patients

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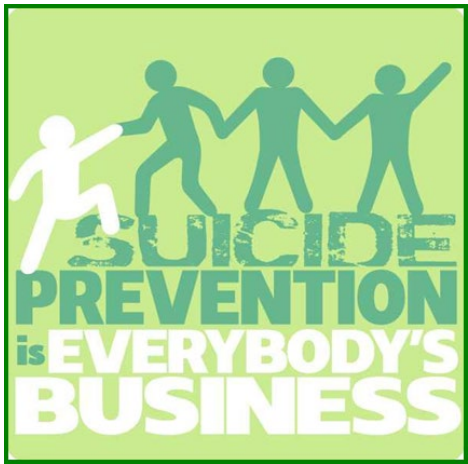


June, 2021

Suicide in Montana

Data Source: AAS (12/20), Montana DPHHS (1/21)

- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past forty years.

- According to the most recent numbers released by the National Vital Statistics Report for **2019**, **Montana has the 3rd highest rate of suicide in the United States (289 suicides for a rate of 27).**

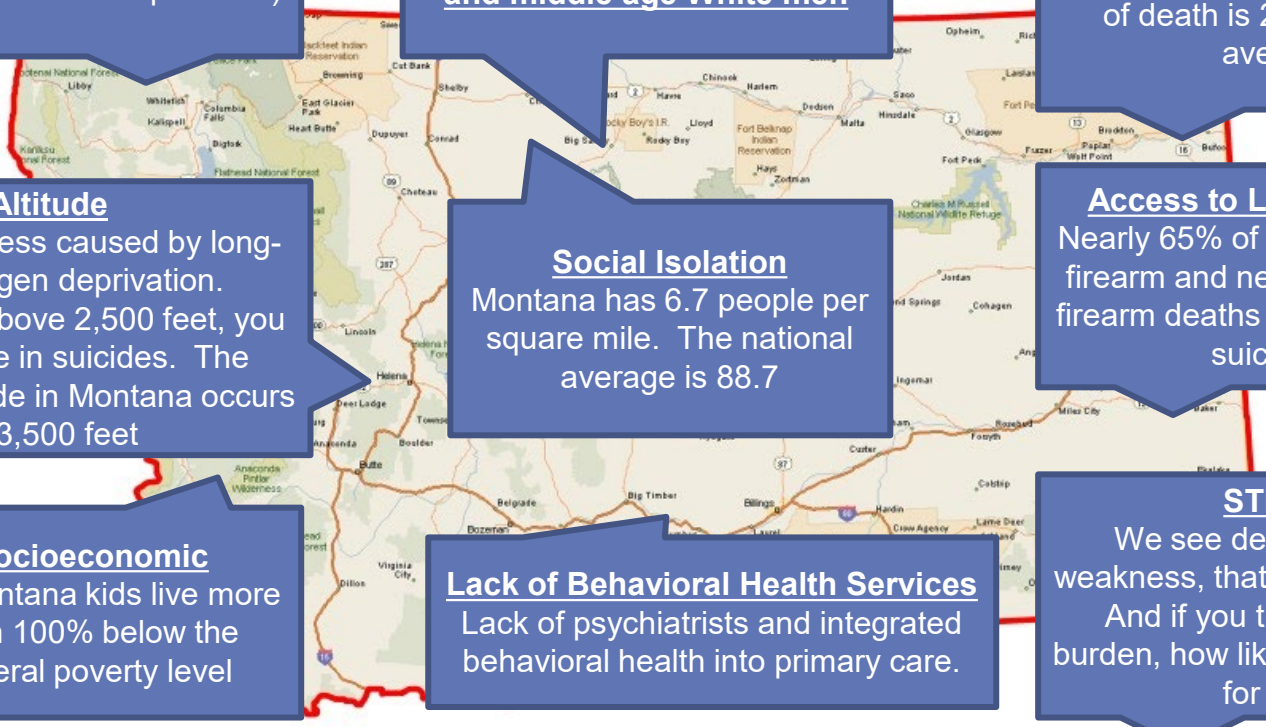
Why does Montana have such a high rate of suicide?

It's not one factor, but rather multiple factors all occurring at the same time. It is a cultural issue.

Vitamin D Deficiency (correlated with increased risk of depression)

High concentration of Veterans, American Indians, and middle age White men

Alcohol as a coping strategy (alcohol in the blood at the time of death is 2x the national average)



Altitude
Metabolic stress caused by long-term oxygen deprivation. Worldwide, above 2,500 feet, you see a spike in suicides. The average suicide in Montana occurs at 3,500 feet

Social Isolation
Montana has 6.7 people per square mile. The national average is 88.7

Access to Lethal Means
Nearly 65% of suicides are by firearm and nearly 90% of all firearm deaths in Montana are suicides

Socioeconomic
1/5 Montana kids live more than 100% below the federal poverty level

Lack of Behavioral Health Services
Lack of psychiatrists and integrated behavioral health into primary care.

STIGMA
We see depression as a weakness, that we are a burden. And if you think you are a burden, how likely are you to ask for help?

Suicide and Primary Care

- Up to **45%** of individuals who die by suicide visit their primary care provider for presenting physical health problems within **a month** of their death, with **20%** of those having visited their primary care provider within **24 hours** of their death

- Elders who complete suicide:
  - **73%** have contact with primary care physician within a **month** of their suicide, with **nearly half** visiting in the preceding week.

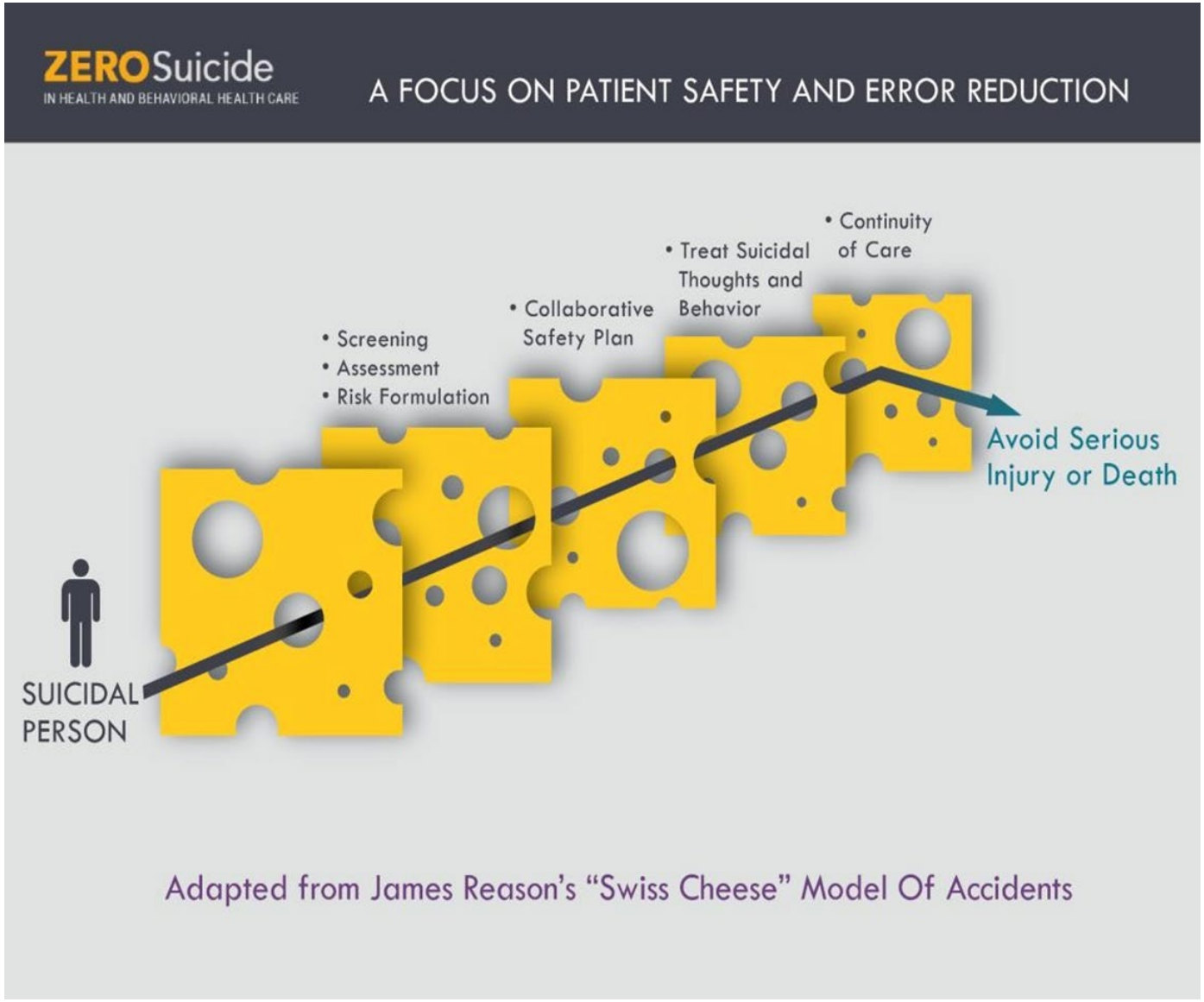
- There is a strong correlation between chronic pain and suicide
  - **20-30%** of those who die by suicide have issues of chronic illness or pain.
  - A person with chronic pain is **3 times** the risk of suicide

Keys things to remember in assessing the degree of risk

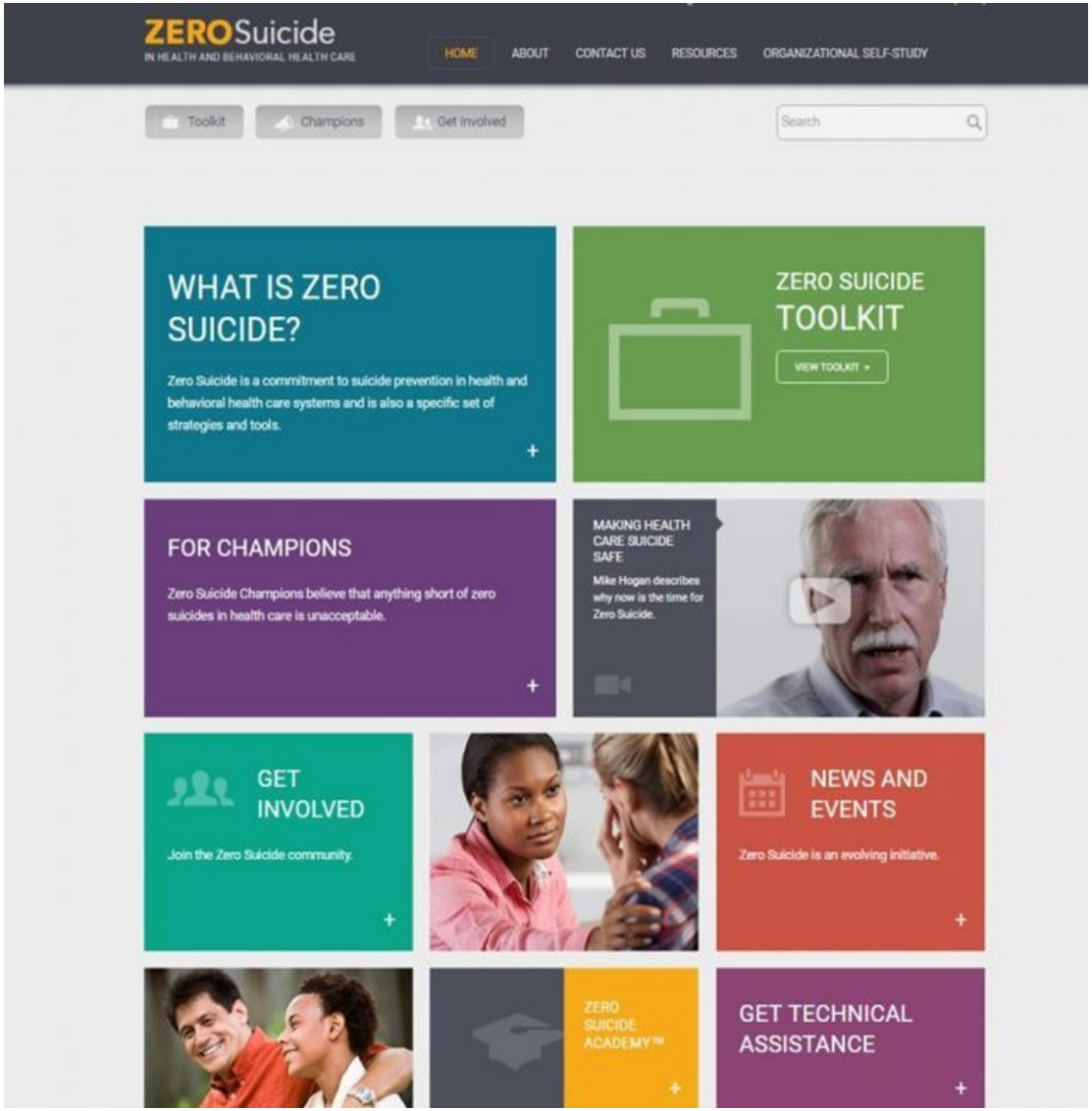
Don’t hesitate to bring up the word “suicide”

- Many fear that asking them if they are suicidal will plant the idea in their mind. This is a myth! There is no research to support this. Being direct validates their pain and gives them the opportunity to talk.

Patient Safety and Error Reduction



Zero Suicide



Access at:

www.zerosuicide.com

Shaded response to question #9 indicates 10x the risk of suicide.

A POSITIVE RESPONSE TO QUESTION #9 OR MULTIPLE POSITIVE RESPONSES SHOULD RESULT IN A FORMAL SUICIDE RISK ASSESSMENT BEING COMPLETED.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

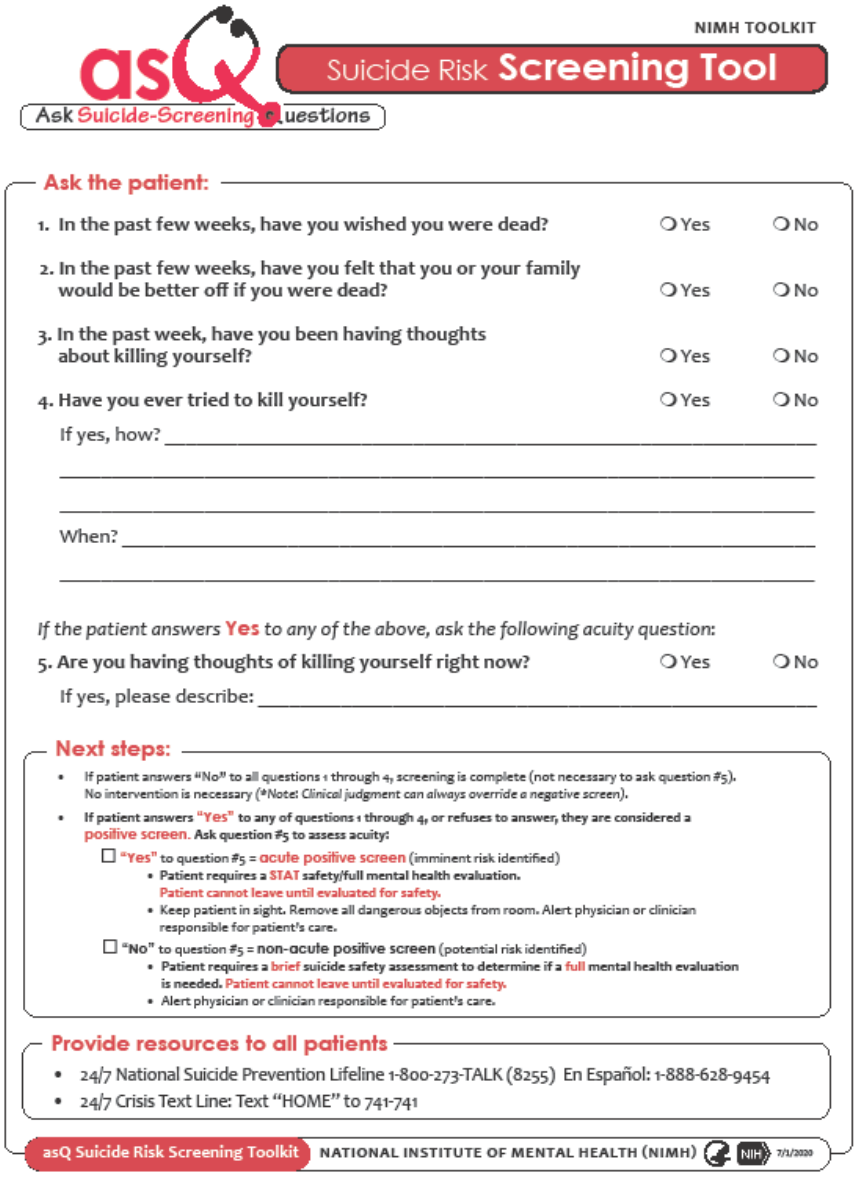
Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble 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 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
add columns:		+	+	
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 _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

The ASQ is a set of four screening questions that takes 20 seconds to administer and is designed for screening youth ages 10-24

- 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



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

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/full 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 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

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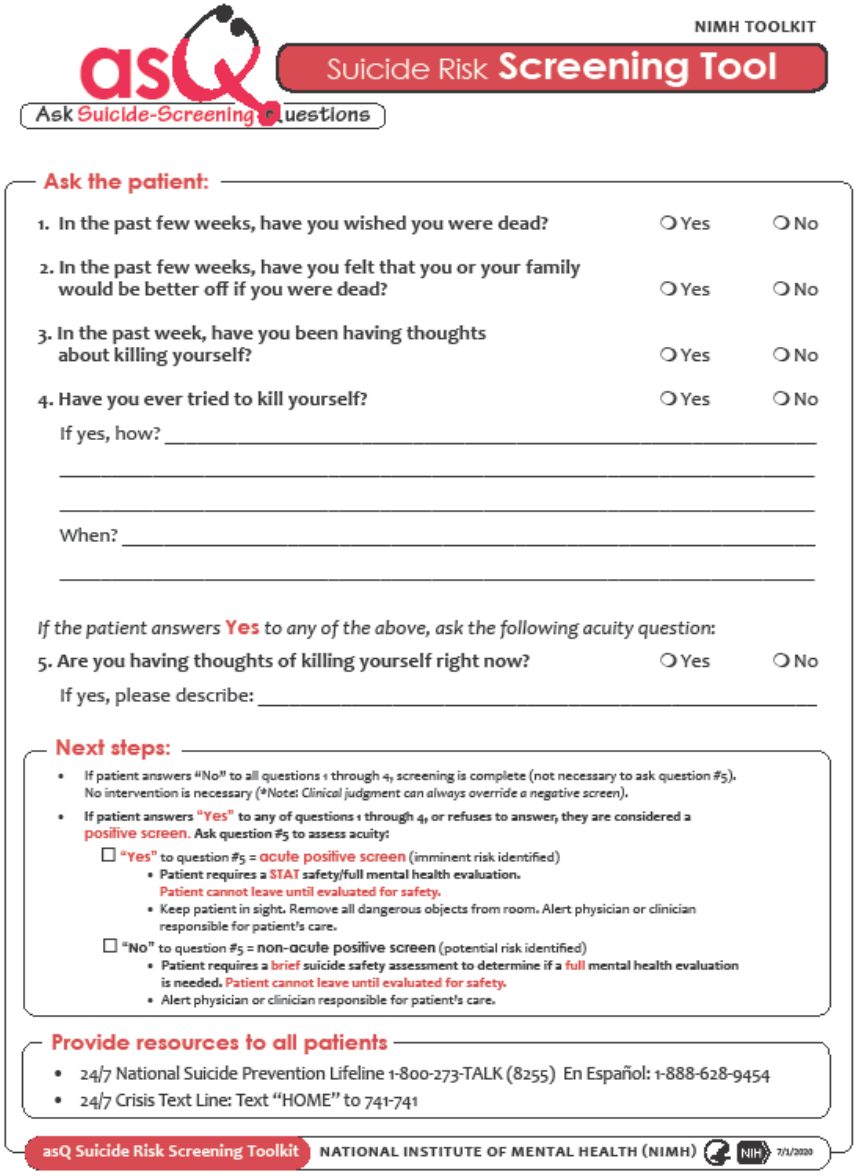

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4. Have you ever tried to kill yourself? ❍ Yes ❍ No

If yes, how? _____

When? _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

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If yes, please describe: _____

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    - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. **Patient cannot leave until evaluated for safety.**
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asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

asQ Ask Suicide-Screening Questions

Script for nursing staff

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."

asQ Ask Suicide-Screening Questions

Parent/guardian flyer

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.

Columbia Suicide Severity Rating Scale (C-SSRS)

Ask the first 2 questions by saying, "**in the past month**…

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you had any thoughts about killing yourself?

If "NO" to #2, go directly to question 6 and say "in the past 3 months…"

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

If YES to #2, answer questions 3, 4, 5, and 6

3. Have you thought about how you might do this?
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them.
5. Have you started to work out the details of how to kill yourself? Do you intend to carry out the plan?

RESPONSE PROTOCOL TO C-SSRS SCREENING

COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**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 might 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.	**Lifetime**	
	Past 3 Months	
If YES, ask: ***Was this within the past 3 months?***		

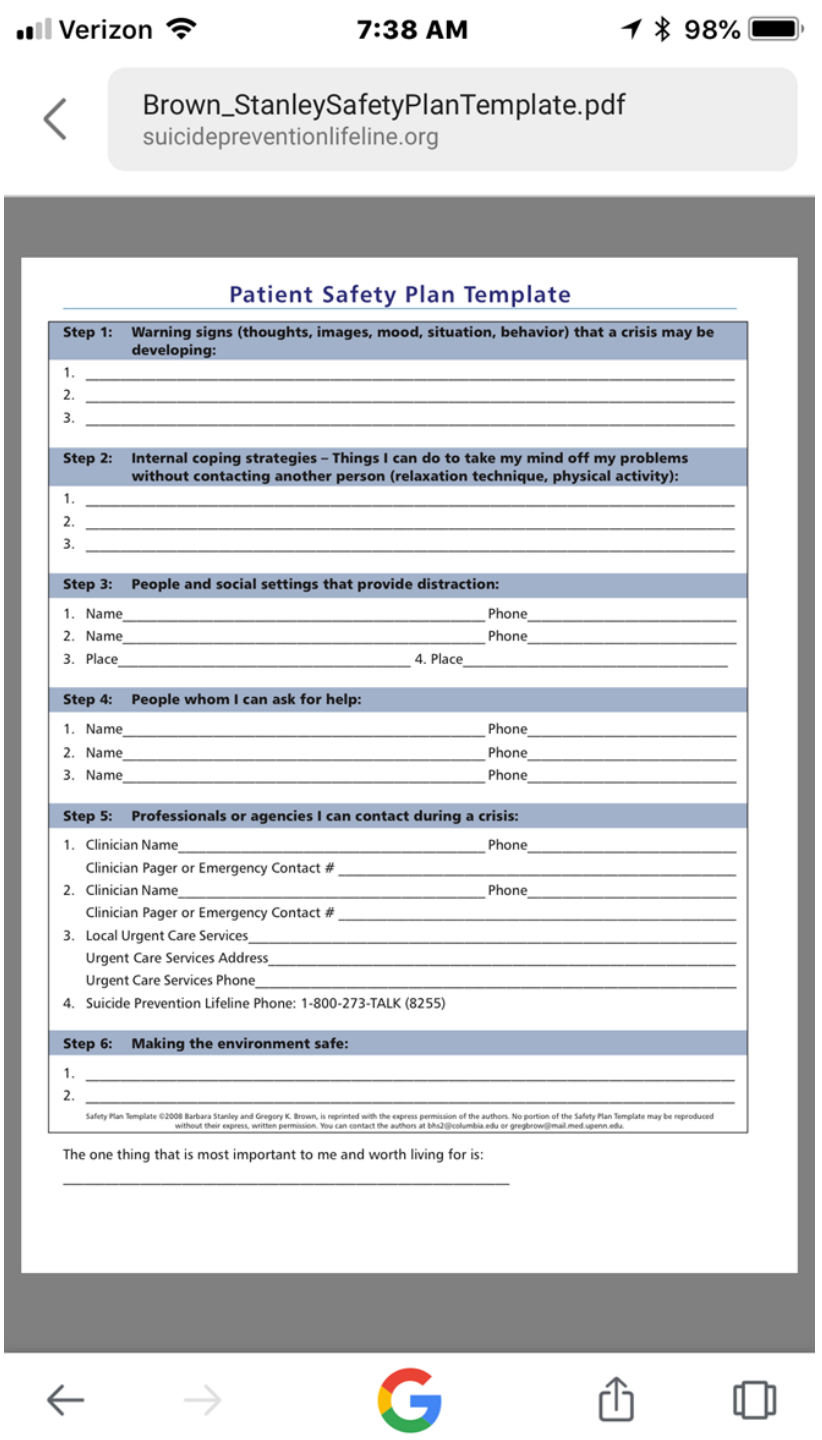
Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Safety Planning Intervention

Taken from a webinar from the National Action Alliance for Suicide Prevention entitled, “Safety Planning and Means Reduction in Large Health Care Organizations”, on December 16, 2014.

Stanley B, Brown GK. A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*. May 2012;19(2):256-264



Target Population for Safety Planning Intervention

- Individuals at increased risk but not requiring immediate rescue
- Patients who have…
  - ❖ Made a suicide attempt
  - ❖ Suicide ideation
  - ❖ Psychiatric disorders that increase suicide risk
  - ❖ Otherwise been determined to be at risk for suicide

"Theoretical" Approaches Underlying SPI

- Suicide risk fluctuates over time (eg, Diathesis-Stress Model of Suicidal Behavior)
- Problem solving capacity diminishes during crises—over-practicing and a specific template enhances coping (e.g., Stop-Drop-Roll)
- Cognitive behavioral approaches to reducing impulsive behaviors (e.g., Distraction)

Mann JJ, et al. *American Journal of Psychiatry*. 1999;156:181-189.

Safety Planning Intervention: Overview

Prioritized written list of coping strategies and resources for use during a suicidal crisis

- Helps provide a sense of control
- Can be used as single-session intervention or incorporated into ongoing treatment

Safety Plan Intervention: What It Is Not

- It does not substitute for treatment
- It does not help if the individual is in imminent danger of death by suicide
- Safety plans are **not** “no-suicide contracts”
  - ❖ No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive .

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Step 1: Recognizing Warning Signs

- Clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis
- Ask: “How will you know when the safety plan should be used?” Be specific!
- Ask: “What do you experience when you start to think about suicide or feel extremely distressed?”
- Thoughts, images, thinking processes, mood, and/or behaviors

Step 2: Using Internal Coping Strategies

- List activities individual can do without contacting another person
- ***Activities function as way to help individual take their minds off their problems and promote meaning in their life***
- Coping strategies prevent suicide ideation from escalating
- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not act on your thoughts or urges?”

Step 2: Internal Coping Strategies	**N (%)**
• Watching TV or Movie	34 (34%)
• Taking a Walk	33 (33%)
• Listening to Music	33 (33%)
• Exercising	29 (29%)
• Playing Video Games or Computer Activities	28 (28%)
• Reading or Schoolwork	23 (23%)
• Praying, Meditating, Deep Breathing	23 (23%)
• House Chores	20 (20%)
• Creative Pursuits	19 (19%)
• Self-care or Self-soothing Activities	13 (13%)
• Looking at Photos of Loved Ones	9 (9%)
• Taking a Time Out, Distracting, Walking Away	8 (8%)
• Spending Time with a Pet or Animals	7 (7%)

Step 3: Socializing with Family Members or Others

- Ask: “Who helps you take your mind off your problems—at least for a little while?”
- Ask: “Who do you enjoy socializing with?”
- Ask individuals to list several people, in case they cannot reach the first person on the list

Step 3: Healthy Social Settings

- Ask: “Where do you think you could go that is a healthy environment to have some social interaction?”
- Ask: “Are there places or groups that you can go to that can help take your mind off your problems…even for a little while?”
- Ask individuals to list several social settings

Step 3: Social Settings	**N (%)**
• Library or Bookstore	17 (17%)
• Outdoors (park, city streets, etc.)	15 (15%)
• Place of Worship or Community Center	12 (12%)
• Theater	10 (10%)
• Shopping at a Store or Mall	9 (9%)
• Restaurant or Coffee Shop	9 (9%)
• Someone Else's Home	9 (9%)
• Go to the Gym	8 (8%)
• NA/AA Meeting or Support Group	8 (8%)
• Other	7 (7%)

Step 4: Contacting Family Members or Friends

- Ask: “How likely would you be willing to contact these individuals?”
- Identify potential obstacles and problem-solve ways to overcome them
- Ask if the safety plan can be shared with family members

Step 5: Contacting Professionals and Agencies

- Ask: “Which clinicians (if any) should be on your safety plan?”
- Identify potential obstacles and develop ways to overcome them

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
  - Clinicians
  - Local ED or other emergency services
  - Suicide Prevention Lifeline: **800-273-TALK (8255) or text "mt" to 741741.**

- May need to contact other providers, especially if listed on the safety plan

Step 6: Reducing the Potential for Use of Lethal Means

- Ask individuals what means they would consider using during a suicidal crisis
- **Regardless, the counselor should always ask whether individuals have access to a firearm**
- Rationale for placement at the end of the safety plan: if individuals have a sense of alternatives to suicidal behavior, they are more likely to engage in discussion of means restriction

Lethal Means Counseling

Following is a summary of the steps, goals, and things to consider when talking with clients about reducing access to lethal means

CALM- **C**ounseling about **A**ccess to **L**ethal **M**eans

1. Raise the issue.

Behavioral Goal: ***Motivate the family to reduce access to lethal means at home.***

Sample Language:

- *"When someone is struggling in the ways that you are, sometimes suicidal feelings can emerge and escalate rapidly. There are a few steps we routinely recommend for the home to make things safer."*

Behavioral Goal: ***Assess how guns and medications are currently stored at home.***

Sample Language:

- *"What some gun owners in your situation do is temporarily store their guns away from home. If you have guns at home, I'd like to talk over storage options like that with you."*

- *"Let's also talk over what types of medications are in your home and how they're stored."*

2. Develop a plan

Behavioral Goal: *Safely store firearms until the client recovers.*

Considerations:

- Storing firearms away from the home temporarily is the safest choice. Here are some options:
  - Relative or friend, Self-storage rental unit, Gun shop or shooting range, Pawn shop, Law enforcement.
- Quick and easy access to a loaded firearm during a suicidal crisis adds a lot of risk. Here are some additional safety considerations:
  - A locked gun is safer than an unlocked gun.
  - An unloaded gun is a lower suicide risk than a loaded gun, especially if the ammunition is stored separately or away from the home.
  - Hiding guns is not recommended. Family members, especially children and teens, often know or can find the hiding places someone else uses.
  - If a loaded gun is needed for self-defense, discuss with the client and family the short-term comparative risk of suicide versus a home invasion.

3. Document and Follow Up

Behavioral Goal: ***Agree on roles and timetable*.**

Sample Language:

- *"Let's review who's doing what and when: Dad will take the guns to his brother's house this weekend and in the meantime, he will put them in the gun safe. Mom will put a week's worth of [client's name] antidepressants in the pill sorter and lock up the rest.*

Behavioral Goal: ***Document the plan and next steps*.**

Sample Language:

- *"I've written down the plan here for you to take with you. We'll give you a call in a few days to see how things are going."*

Behavioral Goal: ***Confirm that the plan was implemented*.**

Sample Language:

- *"Hi! I wanted to check in and see how [client's name] is doing and also ask how the plan is going that we talked about for gun and medication storage."*

“Caring Contacts” Intervention

Taken from a webinar by the American Association of Suicidology entitled, “Post Treatment Caring Contacts for Suicide Prevention” by David D. Luxton, PhD., M.S., on January 15, 2015

Caring Contact is a suicide prevention intervention that entails the sending of brief messages that espouse caring concern to patients following discharge from treatment.

- Simple, non-demanding, expressions of care that...
  - With multiple contacts, may contribute to a sense of belongingness (via a caring connection)
  - Reminders of treatment availability may provide route to seek help
  - May help patients to feel better about treatment and therefore motivate them to adhere to treatment.
  - It can be done using various modalities such as phone, text, email, and should be done within 24 hours of being seen.

Depression is Treatable
Suicide is Preventable

If you are in crisis
and want help,
call the
Montana Suicide Prevention Lifeline,
24/7, at
1-800-273-TALK
(1-800-273-8255)
Or text "**MT**" to **741 741**

www.dphhs.mt.gov/suicideprevention