NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

Suicide Risk Assessment and Safety Planning in Integrated Primary Care Settings

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Webinar Tips for Attendees

Please review our webinar guidelines for frequently asked questions:
www.nationalregister.org/webinar-tips/

1 CE Credit, Instructional Level: Intermediate
1 Contact Hour (New York Board of Psychology)

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Aubrey Dueweke, Ph.D.

Dr. Aubrey Dueweke is a clinical psychologist and Assistant Professor in the Department of Psychology at East Tennessee State University. Dr. Dueweke's research focuses on using nontraditional service delivery models, like primary care behavioral health integration, telehealth, and community outreach, to increase access to mental health care for underserved populations. She has clinical expertise working with individuals experiencing posttraumatic stress and suicidal ideation.

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Disclosures/Conflicts of Interest

- I have no conflicts of interest to disclose

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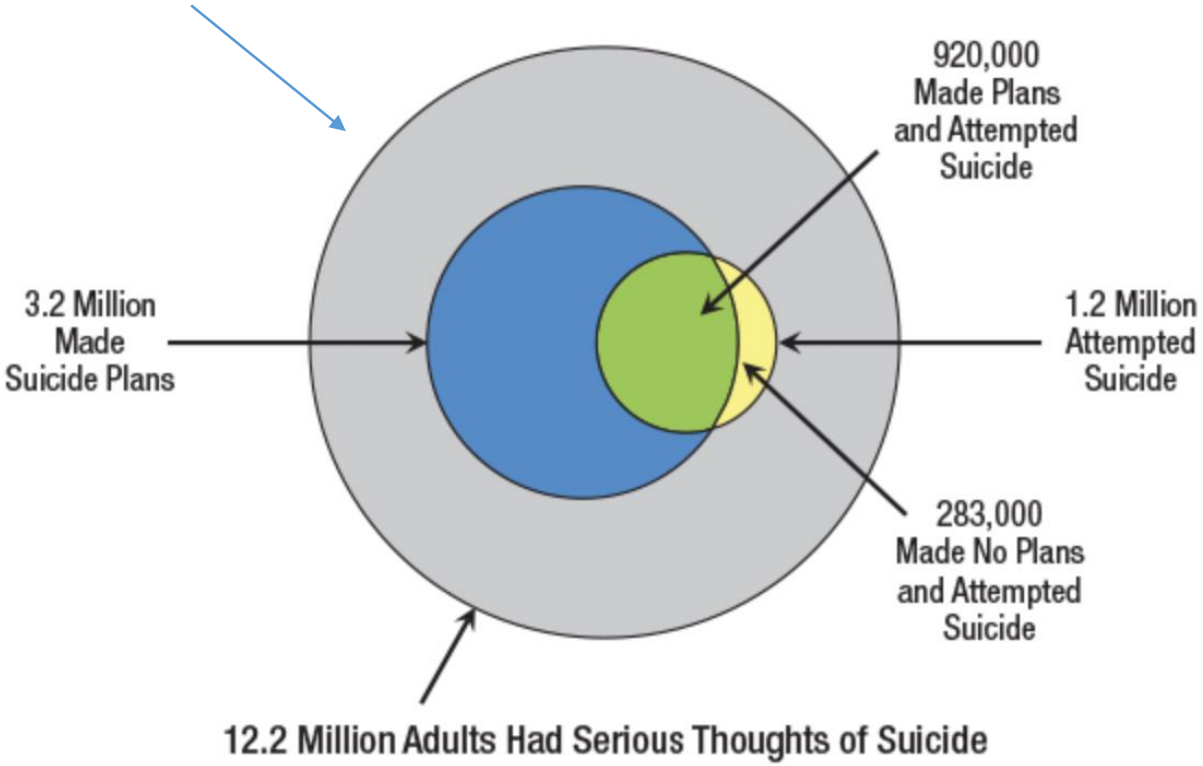
Learning Objectives

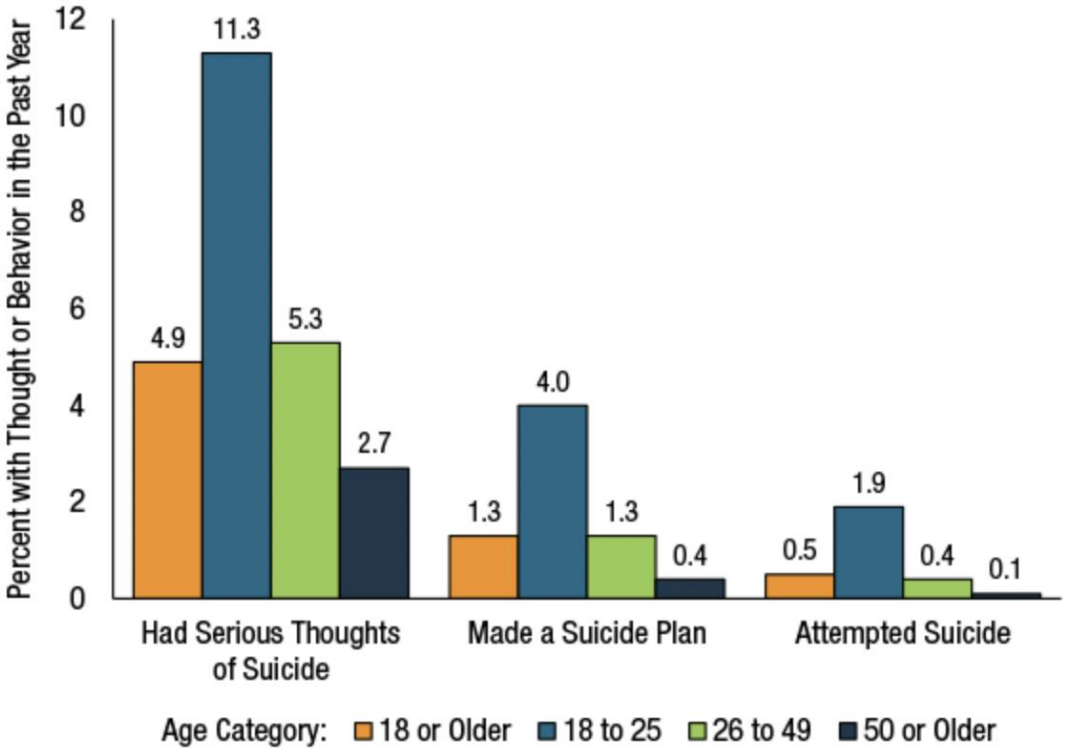
1. List key considerations for how to act when assessing and managing suicide risk.
2. Explain elements of a comprehensive suicide risk assessment.
3. Describe components of safety planning in primary care.

Prevalence of Suicidal Ideation, Plans, Attempts and Deaths in the U.S.

Almost 5% of the population!



Results from the 2020 National Survey on Drug Use and Health



https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR102121.htm#suicadult

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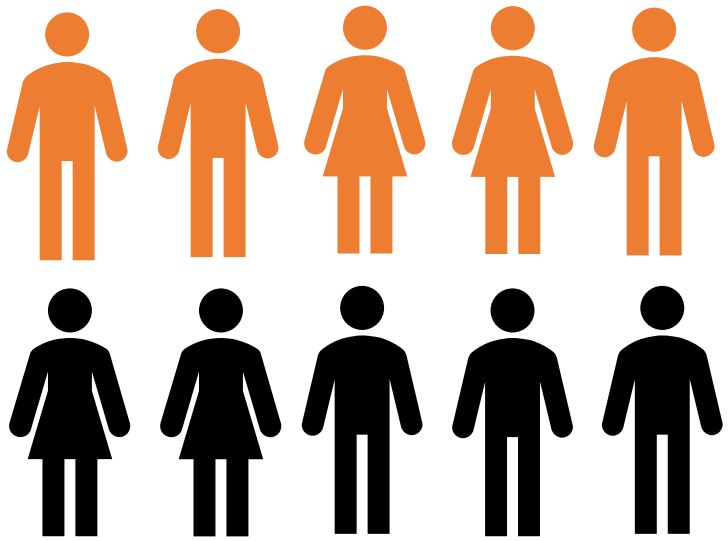
In the month prior to an attempt…

Half of people who ultimately die by suicide visit their primary care provider (PCP)



While only 20% visit specialty mental health care

However, there are few developed protocols for management of suicide risk in primary care

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,* 909-916.

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Review of Suicide Interventions in Primary Care

Educating practitioners

Screening for suicide risk and/or mood disturbance

Managing depressive symptoms

Assessing and managing suicide risk

Necessary but not sufficient

Multidisciplinary teams can help

Dueweke, A. R., & Bridges, A. J. (2018). Suicide interventions in primary care: A selective review of the evidence. *Families, Systems, and Health, 36,* 289-302.

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Primary Care Behavioral Health (PCBH) Integration

- Mental health professionals work alongside the primary care team under one roof and are available to see patients the moment mental health needs are identified
- Shorter visits (i.e., 20-30 minutes) and fewer visits overall (i.e.,1-4)
- Focus on improving functioning, rather than ameliorating symptoms completely
- Visits occur in medical exam rooms
- “Warm handoff” from PCP facilitates rapport and follow-through

[1]Robinson & Reiter, 2016

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Evidence Supporting the PCBH Model

- Frees up time PCPs can devote to other patients[1]
- Reduces service utilization barriers for patients[2, 3]
- Effective way of addressing a variety of mental health concerns, particularly depression and anxiety[4, 5, 6]
- Therapeutic alliance can be easily formed in PCBH despite the setting and rapid pace of treatment[7]

[1]Robinson & Reiter, 2016; [2]Bridges et al., 2014; [3]Bridges et al., 2017; [4]Bridges et al., 2015; [5]Bryan et al., 2012
[6]Ray-Sannerud et al., 2012 [7]Corso et al., 2012

Clinical and Ethical Challenges

- Provider discomfort in managing elevated suicide risk[1, 2]
  - Anxiety about possibility of losing a patient to suicide
  - Concerns about malpractice liability
- Issues around competence[1]
  - Informed consent
  - Inadequate risk assessment
  - Use of outdated and unhelpful interventions (i.e., no-suicide contracts)[3]
- Over-reliance on hospitalization, despite little supporting evidence[1,4]

[1]Jobes et al., 2008; [2]Leavey et al., 2017; [3]Rudd, Mandrusiak, & Joiner, 2006; [4]Chung et al., 2017

Informed Consent

- Review confidentiality (and limits) at the beginning of each visit
  - Even though patients likely have signed a consent form, it is good practice to review expectations verbally at the start of visits
  - Limits to confidentiality:
    - **Risk of harm to self or others**
    - Child or elder abuse
    - Subpoenaed by a judge

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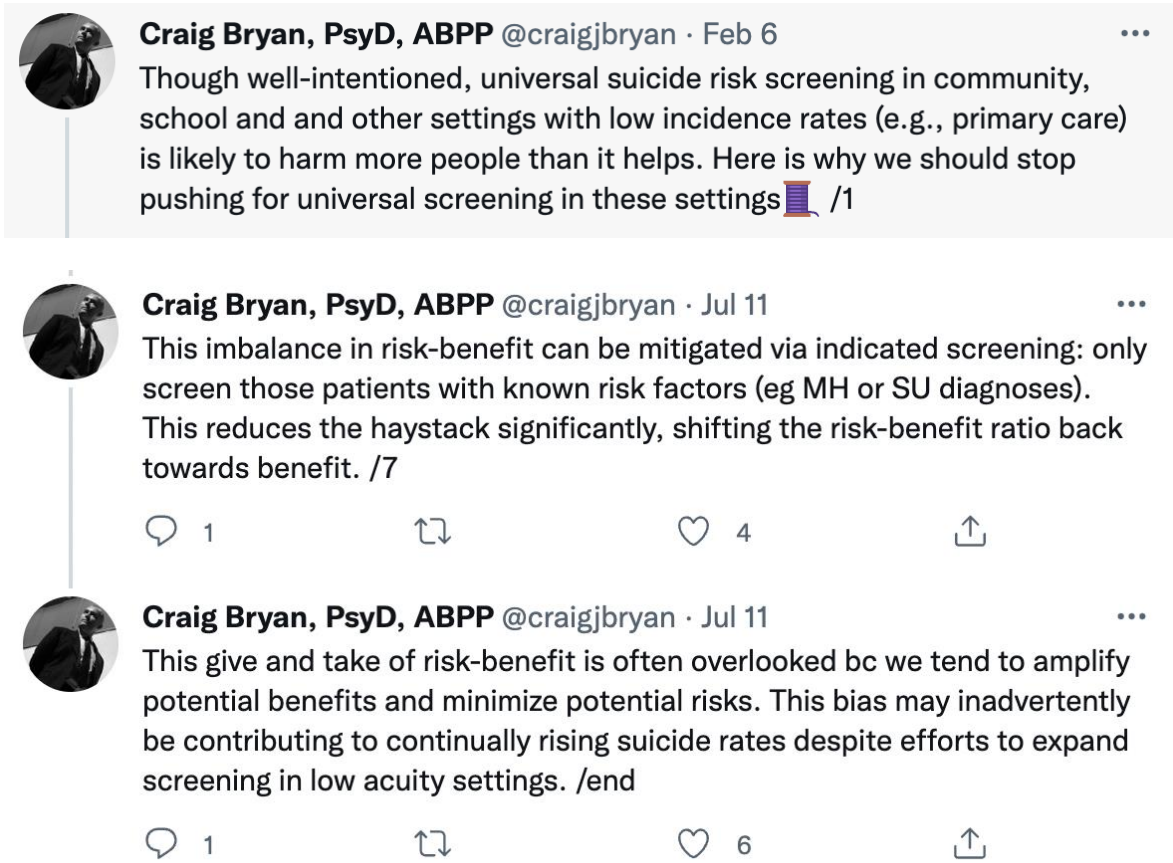
Screening for Suicidal Ideation

- USPSTF guidelines state insufficient evidence to recommend universal screening[1]
- BUT do recommend assessing for suicide risk among those with risk factors[1]



[1]LeFevre & USPSTF, 2014

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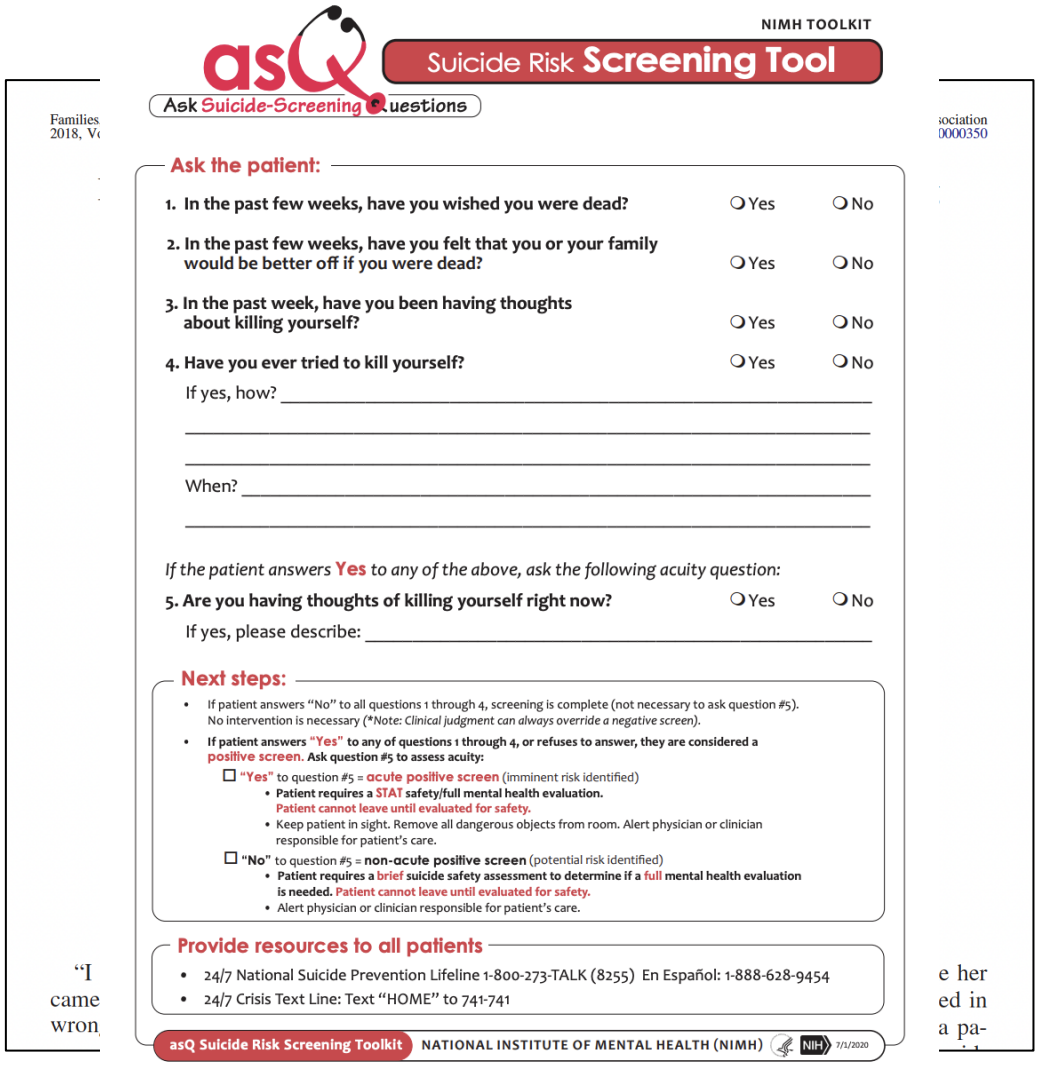
Screening for Suicidal Ideation

- Use of PHQ-2 / PHQ-9 item is not good enough[1,2]
- Use a direct approach like the ASQ instead[3]
- Asking about suicide does not "put the idea in their head"[4]



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

[1]Bryan et al. 2021; [2]Dueweke et al., 2018; [3]Horowitz et al., 2012; [4]Eynan et al., 2014

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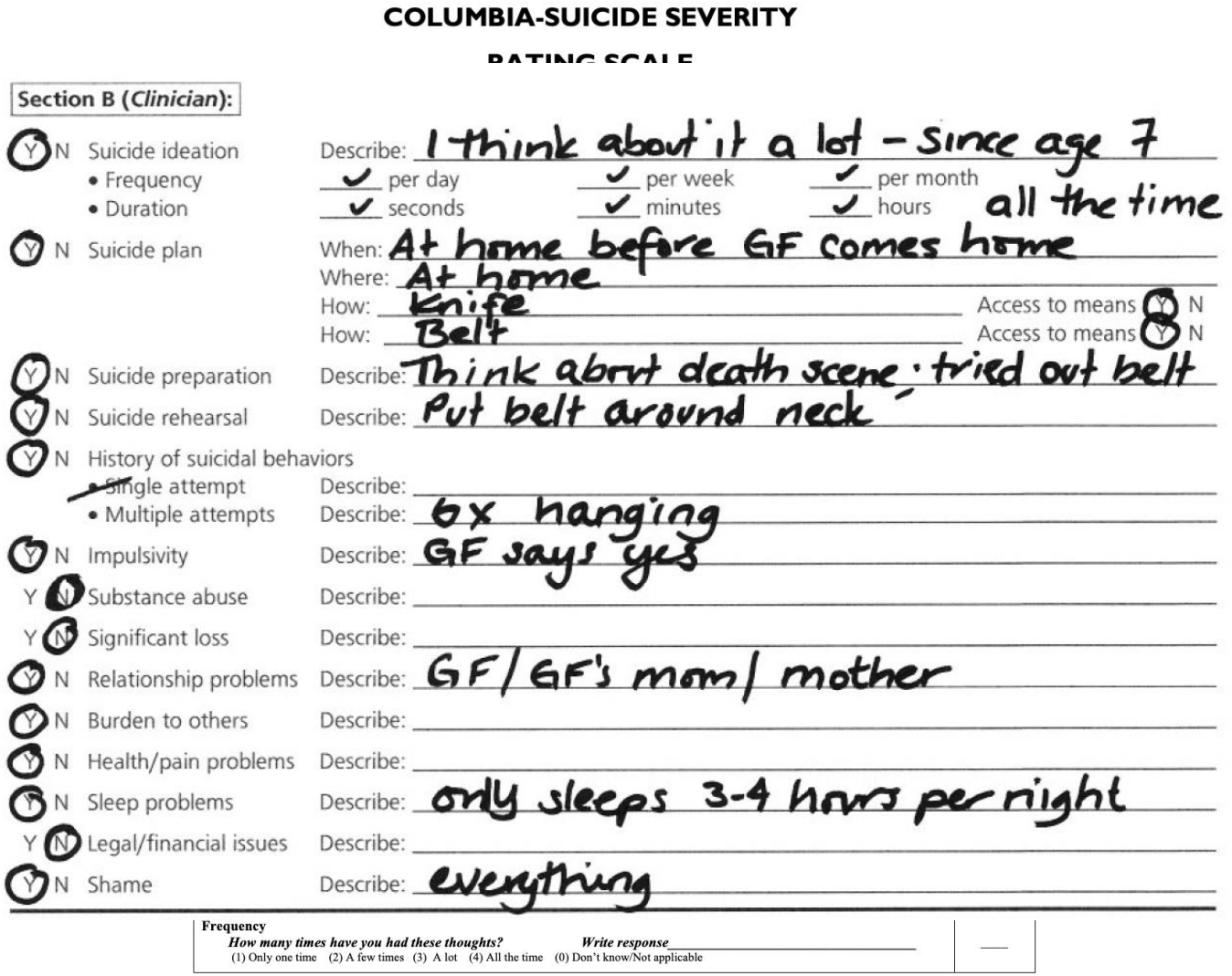
Risk Assessment

- History of suicidal behavior
- Hopelessness
- Impulsivity / self-control
- Nature of suicidal thinking
  - Frequency, intensity, duration
  - Suicide plan
  - Suicide intent
  - Preparatory behaviors
- Access to lethal means
- Protective factors
- Consider how intersecting identities might contribute to risk / protection
- Tools
  - Columbia (C-SSRS)
  - Suicide Status Form (SSF)



COLUMBIA-SUICIDE SEVERITY

RATING SCALE

Section B (*Clinician*):

(Y) N Suicide ideation — Describe: I think about it a lot - since age 7
- Frequency — ✓ per day ✓ per week ✓ per month
- Duration — ✓ seconds ✓ minutes ✓ hours all the time

(Y) N Suicide plan — When: At home before GF comes home
Where: At home
How: Knife — Access to means (Y) N
How: Belt — Access to means (Y) N

(Y) N Suicide preparation — Describe: Think about death scene; tried out belt

(Y) N Suicide rehearsal — Describe: Put belt around neck

(Y) N History of suicidal behaviors
- ~~Single attempt~~ — Describe:
- Multiple attempts — Describe: 6x hanging

(Y) N Impulsivity — Describe: GF says yes

Y (N) Substance abuse — Describe:

Y (N) Significant loss — Describe:

(Y) N Relationship problems — Describe: GF / GF's mom / mother

(Y) N Burden to others — Describe:

(Y) N Health/pain problems — Describe:

(Y) N Sleep problems — Describe: only sleeps 3-4 hours per night

Y (N) Legal/financial issues — Describe:

(Y) N Shame — Describe: everything

Frequency

How many times have you had these thoughts? ***Write response*** —

(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

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Acute Risk Management

- Safety Planning[1]
- Lethal Means Restriction[2]
- Crisis hotlines

Safety Planning Worksheet

Step 1: Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. Conversations or thoughts about money
2. Feeling like I can't support my family/feel like a loser

Step 4: People Whom I Can Ask for Help:

1. Name Girlfriend Phone

10. Place

On a scale of 0-100, how confident are you these distractions will work? 70

4. My dog
5.
6.

On a scale of 0-100, how confident are you that these things will stop you from killing yourself? ~~80~~ 90

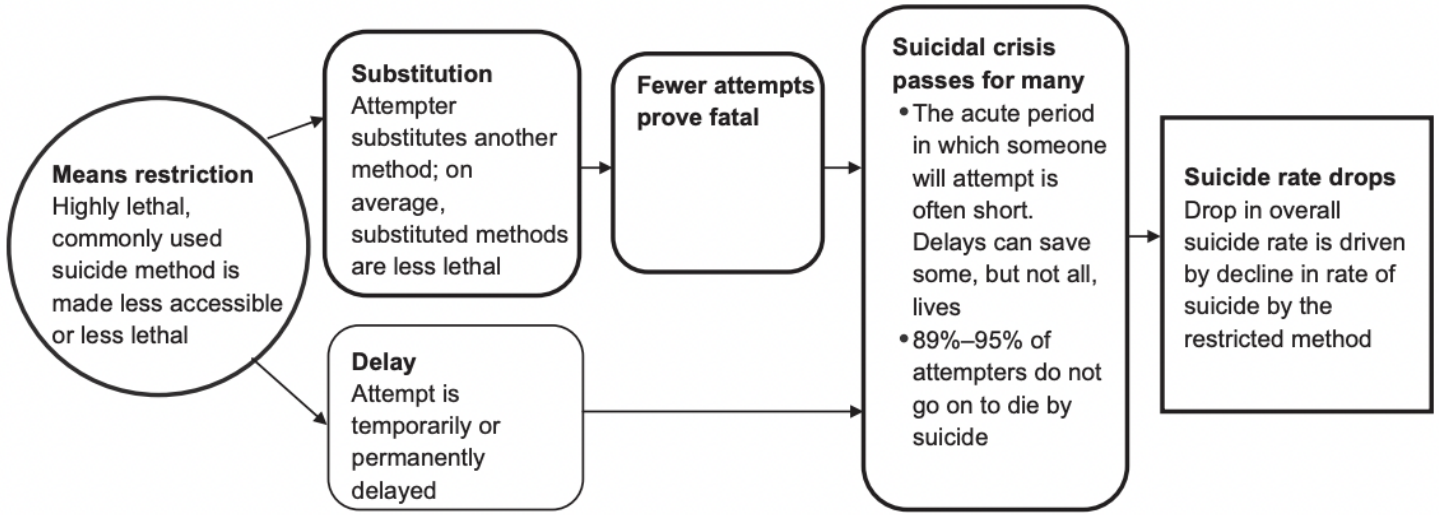

Figure 1. Conceptual model of how reducing access to a highly lethal and commonly used suicide method saves lives at the population level

[1]Nuij et al., 2021; [2]Barber & Miller, 2014

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A word about hospitalization…

- Increased risk of suicide post-discharge[1]
- Difficult to obtain insurance precertifications for admissions; repeated short-term hospitalizations may be problematic and over time might make things worse for the patient[2]
- Typically transported to ER in the back of a police or sheriff's car restrained by handcuffs

STATE OF TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES PART 1

→ Complete Part 1 for EMERGENCY DETENTION for immediate examination for emergency admission

→ Complete Part 2 for the 1st Certificate of Need for EMERGENCY INVOLUNTARY ADMISSION

→ Complete Part 3 for the 2nd Certificate of Need for EMERGENCY INVOLUNTARY ADMISSION

EMERGENCY DETENTION
FOR IMMEDIATE EXAMINATION FOR EMERGENCY ADMISSION

I am a (*check one*):

- ☐ Law enforcement officer authorized to make arrest in Tennessee
- ☐ Licensed physician
- ☐ Licensed psychologist with health service provider designation
- ☐ Qualified Mental Health Professional (QMHP), as identified in Tenn. Code Ann. § 33-1-101 and found on page 2, section A of this form, designated by the TDMHSAS Commissioner as a mandatory pre-screening agent

[1]Chung et al., 2017; [2]Jobes, 2006

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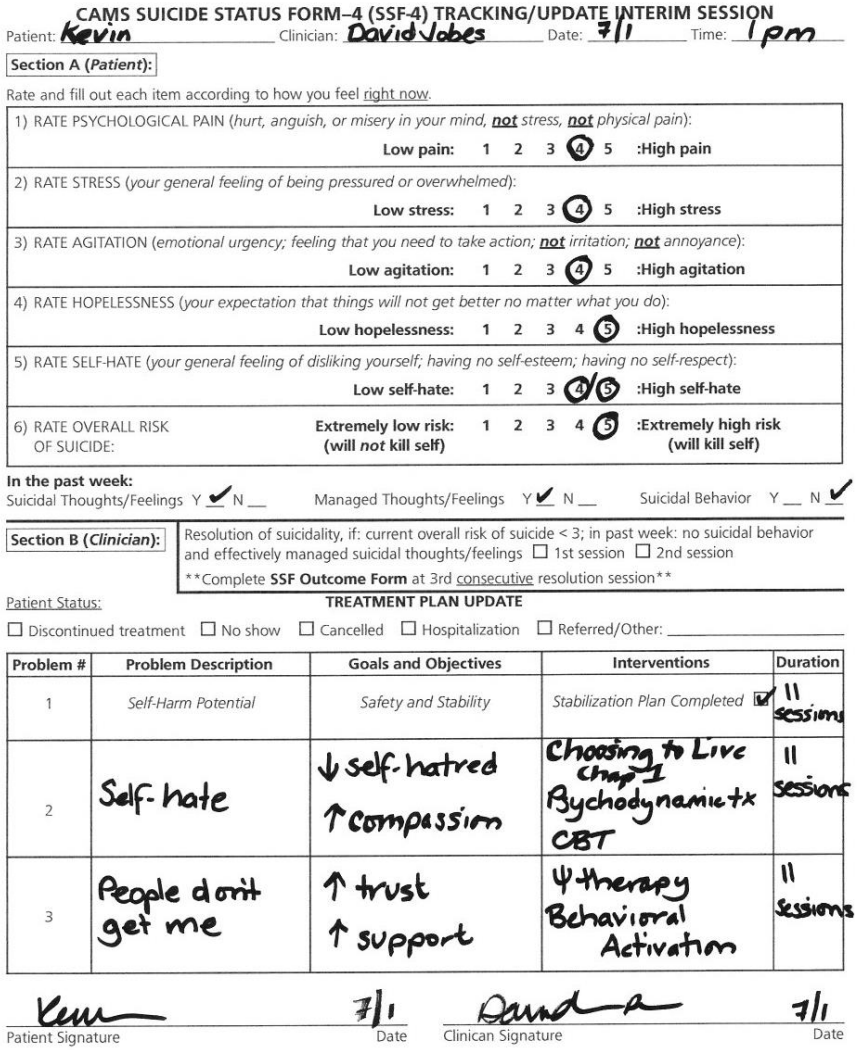
Long-term Risk Management

- Dialectical Behavior Therapy (DBT)[1]
- Suicide-specific CBT
  - Cognitive Therapy for Suicidal Patients (CT-SP)[2]
  - Brief CBT for Suicide Prevention (BCBT)[3]
- Collaborative Assessment and Management of Suicidality (CAMS)[4]



CAMS SUICIDE STATUS FORM–4 (SSF-4) TRACKING/UPDATE INTERIM SESSION

Patient: Kevin Clinician: David Jobes Date: 7/1 Time: 1pm

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):
Low pain: 1 2 3 (4) 5 **:High pain**

2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 2 3 (4) 5 **:High stress**

3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):
Low agitation: 1 2 3 (4) 5 **:High agitation**

4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):
Low hopelessness: 1 2 3 4 (5) **:High hopelessness**

5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 (4/5) **:High self-hate**

6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self)** 1 2 3 4 (5) **:Extremely high risk (will kill self)**

In the past week:
Suicidal Thoughts/Feelings Y ✔ N __ Managed Thoughts/Feelings Y ✔ N __ Suicidal Behavior Y __ N ✔

Section B (*Clinician*):
Resolution of suicidality, if: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session
Complete **SSF Outcome Form at 3rd consecutive resolution session**

Patient Status:

TREATMENT PLAN UPDATE

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☑	11 sessions
2	Self-hate	↓ self-hatred ↑ compassion	Choosing to Live Chap 1 Psychodynamic tx CBT	11 sessions
3	People don't get me	↑ trust ↑ support	ψ therapy Behavioral Activation	11 sessions

Kevin 7/1
Patient Signature Date

David Jobes 7/1
Clinician Signature Date

[1]Linehan et al., 2006; [2]Wenzel et al., 2009; [3]Bryan & Rudd, 2018; [4]Swift et al., 2021

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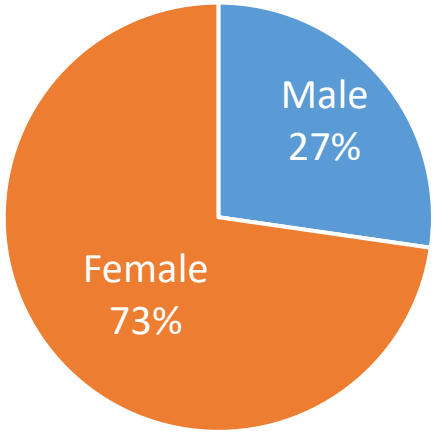
Preliminary Outcomes, Acceptability, and Feasibility of a Brief Safety Planning Intervention in PCBH

- Purpose
  - To evaluate the effectiveness of a single-session safety planning intervention at reducing suicide risk among patients at a moderate risk for suicide in a PCBH setting
  - **To explore the acceptability and feasibility of this intervention in a PCBH setting**
- Procedure
  - Patients endorsing suicidal ideation received an in-depth risk assessment facilitated by the Columbia
  - Patients at moderate risk received safety planning intervention
  - Pre-post measures and 4-month follow-up interview

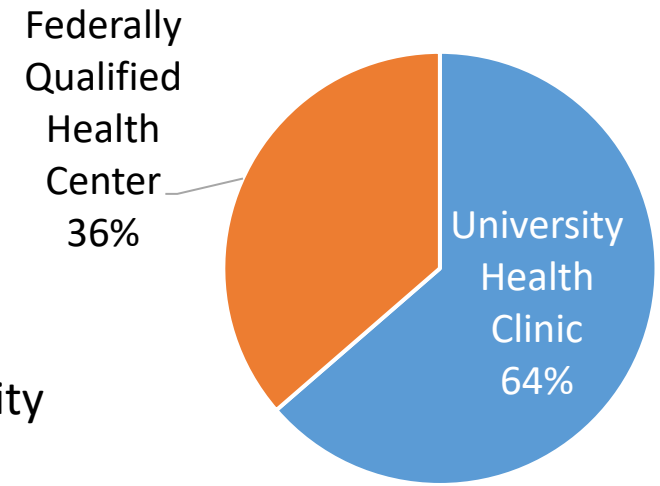
Participants (*n* = 22)

Mean age = 25.9 years
(range 18 to 53 years)

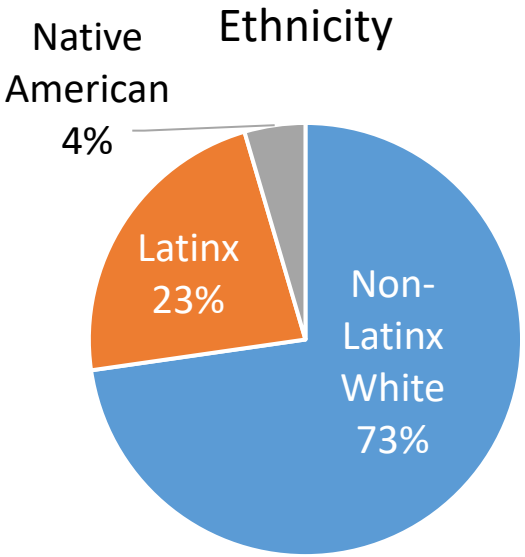
Gender



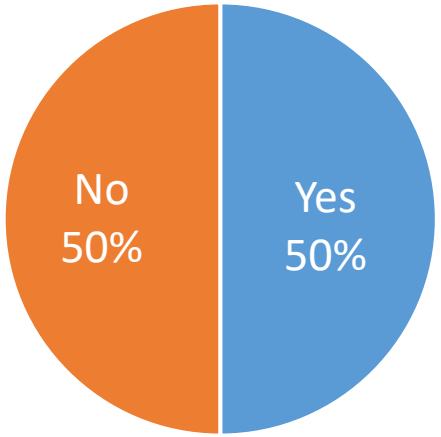
Study Site



Ethnicity



Suicide Attempt History



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Qualitative Data on Acceptability of Safety Planning to Patients

Theme	Number of participants	Percentage of participants
<u>What, if anything, did you find most helpful about that visit?</u>		
Characteristics of BHC	10	62.5%
Safety Plan Components	8	50%
Appreciated this intervention as an alternative to others	3	18.8%
Felt empowered	3	18.8%
Increased hope	3	18.8%
Normalized talking about suicide	2	12.5%
<u>What, if anything, did you find unhelpful about that visit?</u>		
Nothing	12	75%
Barriers not specific to intervention or PCBH	2	12.5%

"I remember [BHC] telling me it would be a good idea to do a crisis response intervention. I remember feeling worried when she said that, because I thought I was going to be hospitalized again. I was relieved when I realized that it was something I could just work on with [BHC]."

me get out of bed when I wanted to

"It made me feel like suicide is okay to talk about. Normally, I'm pretty embarrassed about my depression and anxiety. I was glad to be able to speak openly and honestly with somebody about my suicidal thoughts."

Dueweke, A. R. (2019)

How To Act

- Nonjudgmental
- Collaborative
- Direct, open
  - Don't use euphemisms or vague statements
- Normalize / validate feelings

"Given all that you have faced recently with the decline in your health and the loss of your job, it makes sense that you would be feeling down and hopeless."

"In the context of major stressors like those you've experienced, it's not unusual for people to report they've had thoughts about killing themselves. I'd like to ask you a few more questions about these thoughts you've been having if it's okay."

References

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Q&A With Dr. Dueweke

- Dr. Elchert will read select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

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