1. Screening for Suicide Risk: *The Initial Approach is Key*

Screening for Suicide Risk Saves Lives!

- **Goal:**
  - Improve front-line clinician proficiency in performing an initial suicide risk screening
- **Objectives:**
  - Learn importance of suicide risk screening
  - Learn specific verbal and non-verbal techniques for delivering effective suicide risk screening

Suicide: Facts and Figures

- Suicide is the ***10th leading cause of death*** in the US
- Suicide results in ***>44,000 deaths*** annually

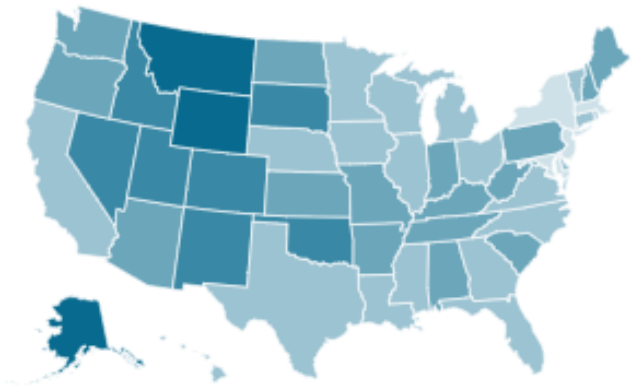
10 Leading Causes of Death, United States 2016, All Races, Both Sexes

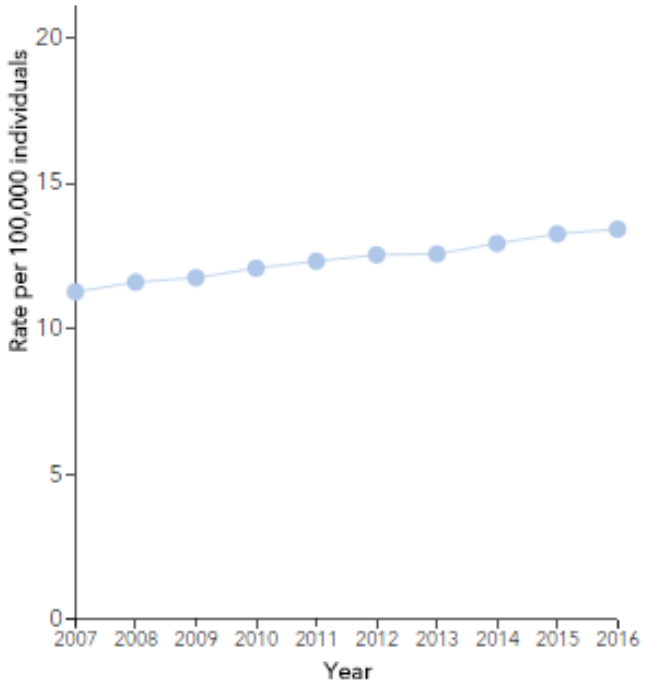
Ranking	Age groups 10–14	15–24	25–34	35–44	45–54	55–64	65+
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	Chronic Lower Respiratory Disease 131,002
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	Chronic Lower Respiratory Disease 17,810	Cerebrovascular 121,630
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452
7	Chronic Lower Respiratory Disease 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebrovascular 5,353	Cerebrovascular 12,310	Unintentional Injury 53,141
8	Cerebrovascular 50	Chronic Lower Respiratory Disease 206	Cerebrovascular 575	Cerebrovascular 1,851	Chronic Lower Respiratory Disease 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479
9	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095
10	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405

Source: WISQARS Leading Causes of Death Reports, 1999–2016

Suicide: Facts and Figures (cont.)

Deaths by suicide have been slowly rising over the past 2 decades in the US





AFSP (2018);CDC (2018)

Why is Suicide Screening Important?

- Up to 22% of those who die by suicide present to an emergency department within a month prior to their death[1]
- Over 60% of such presentations are for problems unrelated to mental health[1]

Why is Suicide Screening Important?

- Detecting suicide risk before the individual acts is an essential component for prevention.
- For every person presenting to an acute care setting for a suicide-related chief complaint, at least twice as many have suicidal ideation that goes undetected.[2-5]
- Universal suicide screening is a best practice that increases detection rates, especially for patients with "hidden risk" [6]

Why is Suicide Screening Important?

- When asked directly, most individuals will share this "hidden" risk with a clinician – they simply aren't being asked.
- Asking **ALL** patients removes stigma associated with screening
- **Asking about suicide does not cause suicide**

How Screening is Done is as Important as the Questions Asked

- Health care settings are fast-paced, but sensitivity and compassion should be practiced with *all* patients

"Due to the intensive nature of treatment and emergency and inpatient settings, it may be easy to neglect interpersonal aspects of care. Yet, people are at their most fragile and sensitive state in crisis settings, and they can benefit greatly from compassionate care."

The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention

Screening Techniques

- Deliver sensitive and compassionate screening to every patient
- Demonstrate interest in patient's answers
- Levels of disclosure, honesty, and self-reporting are higher if a patient perceives the provider as being engaged
- Listen actively, without passing judgment, rushing the person, interrupting, or giving advice

Screening Techniques (cont.)

- Check the tone and rate of your speech
- Summarize or reflect what you've heard
- Use encouraging verbal responses
  - "Uh-huh, okay"
  - "Seems like you've been going through a lot!"
- Non-verbal behavior is as important as verbal responses
  - Nod head
  - Attentive, compassionate facial expression
  - Sit, if you can

2. Screening for Suicide Risk: *The Patient Safety Screener (PSS-3)*

Screening for Suicide Risk: *The Patient Safety Screener (PSS-3)*

- **Goal:**
  - Familiarize ED staff with the Patient Safety Screener
- **Objectives:**
  - Provide overview of the PSS
  - Explain each PSS item along with a rationale for the inclusion of each
  - Provide some important screening tips

Screening for Suicide Risk: *The Patient Safety Screener (PSS-3)*

- **"Yes" to any of the items in Red = positive screen**
- **Apply protocols for further evaluation and management as appropriate to the clinical practice guidelines in place at your site**

Introductory script: *"Because some topics are hard to bring up, we ask these same questions of everyone."*
1. Over the past 2 weeks, have you felt down, depressed, or hopeless? ☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete
2. Over the past 2 weeks, have you had thoughts of killing yourself? ☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete
3. Have you ever attempted to kill yourself? ☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete When did this last happen? ☐ Within the past 24 hours (including today) ☐ Within the last month (but not today) ☐ Between 1 and 6 months ago ☐ More than a six months ago ☐ Refused ☐ Patient unable to complete

PSS-3: Overview

- Administered during triage or initial nursing assessment
- Used with all patients 12 years and older, regardless of presenting complaint
- Determines presence/absence of suicidality
- If the clinician judges patient is unable to respond accurately for clinical or maturity reasons, or other tasks interfere:
  - Indicate "patient unable to complete"
- All three questions should be asked every time
  - Do not skip later items just because the individual is negative on an earlier item

PSS-3: Introductory Script

"Because some topics are hard to bring up, we ask these same questions of everyone."

Rationale for introduction:

- To help reduce likelihood of a negative reaction to the screener questions
- To foster a non-threatening approach
- Use this segue as the introduction to administering the Patient Safety Screener
- Can be fit into process when other screeners are being asked

PSS-3: Depression

Item 1: Over the past 2 weeks, have you felt down, depressed or hopeless?

Yes = Positive screen for depressed mood, should be followed up with additional assessment and actions per clinical setting and protocols

Rationale:

- Provides additional segue into the suicide questions
- Depression most common diagnosis associated with suicide
  - Elderly: depression can be mistaken for natural effects of aging
  - Youth: depression may be masked by acting out, hyperactivity
- Hopelessness found to predict suicide ideation, attempts, and death by suicide

PSS-3: Active ideation

Item 2**. Over the past 2 weeks, **have you had thoughts of killing yourself?

Yes = Active suicidal ideation, requires additional assessment, including whether suicidal during the day of visit (e.g., suicidal now), and following clinical pathways established for positive suicide risk

Rationale:

- Intent to die is the type of ideation thought to be most predictive of suicide
- Thoughts of suicide precede suicidal behaviors
- Determining presence of ideation is key in suicide risk screening, usually followed up by questions related to whether they have begun to develop a plan and have had intent to act on their thoughts

PSS-3: Lifetime attempts

Item 3. Have you ever attempted to kill yourself?

Yes = Lifetime attempt (best single predictor), requires additional evaluation for most recent attempt

Rationale:

- People who have a history of suicide or self-harm fall within the high-risk group for suicide
- 30% to 40% of persons who complete suicide have made a previous attempt
- Suicide attempters have a high incidence of mortality, risk of repetition is highest immediately after the attempt, and repetition is positively associated with subsequent suicide

PSS-3: Recent attempt

If Yes to Item 3 (lifetime attempt):"When did this last happen?"

Yes = Recent attempt (positive for attempt within 6 months), follow clinical pathways established for positive suicide risk

Rationale:

- Recent attempt may be associated with greater probability of another attempt in the near future
- Helps to remove "false positives" for individuals with distant past attempts

Important Screening Tips

- Building trust is important
- Avoid asking questions in a rapid-fire manner
- Display compassion and empathy while conducting screening
- ALL questions must be asked of every patient, regardless of presenting complaint or clinical appearance
  - Do not skip any of the three items
  - Do not bundle questions together
  - Follow exact wording

Screening Summary

- ✓ Screening increases detection, and detection makes prevention possible
- ✓ How you ask is as important as what you ask
- ✓ Screening complements, but does not replace, provider judgement
- ✓ Documenting results of primary screening is essential
- ✓ Justify judgements if positive primary screening does not lead to further evaluation with mental health

3. Screening for Suicide Risk: *Patient Scenarios*

Scenario 1: Positive Screen Patient

- Sally (43YO, separated 2 months prior from lesbian partner), drove self to ED. States she was out hiking and stepped in a small hole, injuring left ankle.
- Ankle severely swollen and discolored; slightly elevated BP, otherwise vitals within normal limits.
- Nurse conducts PSS with the following results:
  - Positive on item 1,(depression) Sally stated she feels sad about relationship ending; negative on Item 2 (ideation) no thoughts/ plans to kill herself; positive on Item 3, (previous attempt) OD'd with Tylenol at age 17 when she felt "depressed" with no recent attempt

- How would you interpret Sally's PSS results?

Scenario 1: Key Points

- Sally stated feeling depressed about her relationship breakup (Item 1)
- She reported no current ideation (Item 2)
- Although she had a previous suicide attempt, no recent attempt was reported (Item 3)

Pathway Protocol

- With no current ideation and recent attempt she would be considered low to moderate risk. After treating ankle issue, appropriate prevention protocols should be followed prior to her ED discharge.

Scenario 2: Intoxicated Patient

- Bill (42) brought to ED in police custody to be ‘checked out’ after driving his car at low-speed into a shallow ditch.
- Vital signs within normal limits.
- No visible injuries but appears intoxicated, unable to maintain balance, slurred speech, glassy eyes and strong ETOH breath odor.
- During patient safety screener, his eyes are closed and responses are unintelligible.

Scenario 2: Key Points

- Bill was intoxicated at time of screening
- Multiple risk factors and warning signs:
  - Middle aged-male
  - Intoxicated
  - In police custody

Scenario 3: Pediatric Patient

- Sue (15) brought to ED by mother to evaluate her infected thigh wound
- Alert, oriented, takes no meds. Vital signs within normal limits.
- Sue states she was preparing a sandwich and "the knife slipped".
- Has similar, healed wound on other thigh; shrugs shoulders and does not respond to inquiry about injury
- Mother worried because Sue has missed a lot of school lately after parents' recent marital breakup . A few days ago Sue said she "just can't take it anymore".

- How would this information relate to Sue's responses to the Patient Safety Screener?

Scenario 3: Key Points

- Patient denies previous suicidal behavior
- Patient denies current injury represents a suicide attempt
- Patient's mother provides key information

Suicide Risk Screening Protocol:

- Although this may be a "negative screen," because there is additional information suggestive of suicide risk, this indicates the need to follow standard risk management protocols

Scenario 4: Ambiguous Patient

- Fred (68) has lived alone since wife died 6 months prior, and was driven to ED by his daughter, who thinks he may have accidentally taken too much blood pressure medicine today.
- Daughter noticed "3 or 4 pills were missing" while preparing his weekly medication holder.
- He is pale, dry, with a low BP and heart rate around 50, but is mentating well and denies pain or difficulty breathing; states he is "a little dizzy."
- Unsure how much medication he took today and embarrassed by fuss daughter is making. Says, "I've just been such a burden to everyone since my wife died."

- What would you do about Fred?

Scenario 4: Key Points

- Multiple risk factors and warning signs:
  - Elderly male
  - Recent widower
  - Access to means
  - Indirect verbal clue – "I've been such a burden…"

Suicide Risk Screening Protocol:

- Although this may be a "negative screen," because there are additional factors suggestive of suicide risk, this indicates the need to follow standard risk management protocols

Scenario 5: Inpatient Screening

- Tom (34) was admitted from the ED with complications from a recent liver transplant
- He has been in recovery from alcohol misuse for the past three years. He is accompanied by his mother.
- His chart from the ED documents a "No" to both the "thoughts of killing yourself" and "ever attempted to kill yourself" items from the PSS-3

Patient Scenario: Successful Save

- Brenda (18) presents with complaint of headache for 3 days
- Alert, oriented, conversant
- Screened for suicidal ideation by primary nurse. Admitted to current active ideation, previous attempt 2 months ago.
- Psychiatry consulted, provided with MH appointment.
- Received treatment for depression, anxiety.
- Reduced suicidal thoughts, improved psychological and overall functioning.

References

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Acknowledgements

- The training was prepared by the System of Safety (SOS) team and supported by a grant from the National Institute of Mental Health (R01MH112138)

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Section 1 Quiz Questions:

1. Suicide rates have been declining over the past two decades
- ❑ True
- ✓ False

Rates for those dying by suicide have increased from 10.5 per 100,000 to 13 per 100,000 since 1999.

2. Universal suicide screening…
- ❑ Is a best care practice
- ❑ Detects patients with "hidden risk" for suicide
- ❑ Is the first step in preventing suicide
- ✓ All of the above

Universal suicide screening is considered a best care practice, is the first step to preventing suicide, and helps detect patients who may present with suicide as a non-primary complaint.

3. Asking ALL patients about suicide directly increases the chance of detecting suicidal risk.
- ✓ True
- ❑ False

Asking about suicide nearly doubles the rate of detecting suicide in hospital settings.

Section 1 Quiz Questions (cont):

4. Asking about suicide causes patients' to attempt suicide

- ❑ True
- ✓ False

Asking about suicide does not place the idea of suicide into patients minds. In fact, screening may help patients open up to health care providers and facilitate appropriate and important treatment.

5. All of the following are examples of effective listening techniques EXCEPT:

- ❑ Nodding
- ❑ Appropriate rate and tone of speech
- ❑ Reflecting back what you heard from the patient
- ✓ Interrupting

Delivering screening in a patient and compassionate manner increases patient engagement as well as the odds that patients will answer questions honestly.

Section 2 Quiz questions:

1. A patient must respond “yes” to ALL screening items to indicate a “positive” suicide screen

❑ True

✓ False

To screen positive, a patient must have (1) had thoughts of killing themselves over the past 2 weeks AND/OR (2) made a suicide attempt in the past 6 months

2. If the patient says “No” to the “thoughts of killing yourself” item, the provider can skip the rest of the screening items

❑ True

✓ False

Past suicide attempts are strongly associated with future suicide, even if a patient has not recently had thoughts about killing themselves

Section 2 Quiz Questions (cont):

3. The PSS-3 introductory script…
- ❑ Helps put patients at ease by normalizing and de-stigmatizing suicide screening
- ❑ Builds trust
- ❑ Provides segue into suicide items
- ✓ All of the above

  Providing patients with a brief introduction to the suicide screening will help normalize and de-stigmatize questions, build trust between the patient and provider, and provide an easier transition into asking suicide-related questions

4. Which diagnosis is most common among suicides?
- ✓ Depression
- ❑ Post-Traumatic Stress Disorder
- ❑ Bipolar Disorder
- ❑ Schizophrenia

  While not all patients with depression will go on to die by suicide, patients who kill themselves are often depressed

5. A recent suicide attempt is associated with a higher probability of a subsequent attempt
- ✓ True
- ❑ False

  History of a suicide attempt increases the likelihood of a future attempt by up to 20%

Section 3 Quiz questions:

1. What would be the next step for completing the Patient Safety Screener for Bill in this scenario?
- ❑ Patient does not need to be screened, document PSS-3 items as "no"
- ✓ Patient should be re-screened when clinically sober
- ❑ Patient's responses while intoxicated can be considered reliable

  Responses given by patients while intoxicated may be unreliable. Patient should be re-screened when sober to examine suicide risk and determine whether collision was intentional

2. Should you administer the PSS-3 suicide screener to Tom again upon intake?
- ❑ No, patient was admitted medically and does not need to be asked about suicide
- ✓ Yes, patient should be re-screened for suicide upon intake using all three PSS-3 questions
- ❑ No, patient does not need to be screened again. Document PSS-3 items as "no"

  Sometimes ED providers document a "No" on the PSS-3 without asking the questions in a sensitive or clear way. Moreover, suicidality can fluctuate over time. ALL patients should receive suicide screening at intake regardless of presenting problem, even if screening was already documented as being done in the ED