# Efficacy of Clinician and Health Provider Screening, Assessment and Treatment Tools for Suicide Prevention in Vermont

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Vermont's Blueprint for Health is the state initiative charged with guiding the process of reaching a sustainable health care delivery reform. In doing so, Blueprint is "integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management." [1]

As part of this charge, Blueprint has identified that it is working to build "a framework for systematic, clinical suicide prevention in behavioral health and healthcare systems." [2] At the October 2014 Vermont Blueprint Conference, Suicide Prevention Blueprint Style was presented by representatives of Fletcher Allen Health Care and Gifford Medical Center. The presentation focused on the implementation of the current national movement in suicide prevention – *Zero Suicide*. [3,4] The reason for this focus, and the driving force of Zero Suicide, is that primary care professionals and mental health clinicians interact daily with people at high risk for suicide, whose needs may not be met in the current system of care. [5]

Suicide kills over 38,000 Americans each year, is the 10th leading cause of death in the US, and the 8th leading cause of death in Vermont overall. Among college students that jumps to the 2nd leading cause of death, and among middle-aged adults, 4th leading cause. [6] The middle-aged age bracket has seen the sharpest increase in rates in the past decade, nationwide and in Vermont. [7,8]

Vermont has the highest suicide rate in New England at 16.94 per 100,000. This is also significantly higher than the US average of 12.43 per 100,000. [9]

In brief, current research indicates:

- 83% of persons who died by suicide received health services in the year prior to death. [10]
- 50% made a medical visit within four weeks of death. [11]
- 70% of older men had contact with primary care within a month before suicide. [12, 13]
- 50% of those who died by suicide did not have a mental health diagnosis and only 24% had a mental health diagnosis within the four week period prior to death. [14]
- Over 60% of those who died visited a medical specialist or primary care without a mental health diagnosis. [15]
- 30% of people who died saw a mental health professional in the previous month. [16]
- 23 – 25% of those who die by suicide in Vermont, have sought and received mental health care in community mental health clinics. [17]
- 67% of those who attempt suicide receive medical attention as a result, opening a further door to health care follow up for individuals at higher risk. [18]
- Primary care doctors – including family physicians and pediatricians – write four out of every five prescriptions for antidepressants. [19]

Underlying the mental health statistics above is the evidence that consistently indicates 90% of people who

[1] Vermont Blueprint for Health. www.hcr.vermont.gov/blueprint
[2] Collias,LICSW, Diane; Farnham, RN, Pam; Gould, LPMA, Cory. "Suicide Prevention Blueprint Style." Vermont Blueprint Conference: October 2014.
[3] Ibid.
[4] Zero Suicide. www.zerosuicide.com
[5] Ibid.
[6] Ibid.
[7] Surprising Health Disparity: Men in their Middle Years. Webinar. Injury Control Research Center for Suicide Prevention. 11 March 2014.
[8] Vermont Vital Statistics System, Vermont Department of Health. 2001 – February 2014. (2014 represents preliminary data current as of May 7, 2014, for cases up to and including February 2014.)
[9] Collias et al. "Suicide Prevention Blue Print Style."
[10] Ahmedani, B. et al. "Health Care Contacts in the Year Before Suicide Death." Journal of General Internal Medicine. DOI:10.1007/s11606-014-2767-3
[11] Ibid.
[12] Zero Suicide, Identifying & Assessing Suicide Risk Level. www.zerosuicide.actionallianceforsuicideprevention.org/identifying-and-assessing-suicide-risk-level
[13] Luoma JB; CE Martin, JL Pearson. "Contact with mental health and primary care providers before suicide: a review of the evidence." American Journal of Psychiatry. 159(6):909-16. 2002.
[14] Ahmedani, et al.
[15] Ibid.
[16] Zero Suicide. www.zerosuicide.com
[17] Ibid.
[18] "Primary Care: A Crucial Setting for Suicide Prevention." Jerry Reed, PhD, MSW, Director, Suicide Prevention Resource Center. www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care
[19] Smith, Brendan L. "Inappropriate prescribing." APA Monitor. Vol 43, No 6. June 2012. www.apa.org/monitor/2012/06/prescribing.aspx

die by suicide are suffering from a mental illness, often undiagnosed and untreated. [20]

The key to effective primary care and behavioral health care for those presenting as suicidal is to ask about suicide in order to find the people who need to be referred for additional services or treatment. Physicians and other primary care professionals are not asked to engage in therapy or take the role of a mental health professional.

In support of the implementation of Zero Suicide in Vermont, this report summarizes selected recommended screening tools, treatments and strategies with the highest evidence-based efficacy, and additional resources.

## Zero Suicide

Zero Suicide focuses on the evidence-based foundation that suicide is preventable. It promotes the goal of zero suicides among persons under care in health systems, through improved care, a commitment to patient safety, and support of clinical staff on the front line.

Zero Suicide has an excellent collection of resources available for review, along with the Suicide Prevention Blueprint Style presentation available from the Vermont Conference. At www.zerosuicide.com, under the auspices of the Action Alliance for Suicide Prevention, there exist webinars, slide shows, and primary care tool kits. Materials are available on safety planning and assessment tools.

The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide with a direct, simple approach:

- People must be asked about suicide in health care settings – both medical and behavioral health settings;
- If they screen positive for suicidal thoughts, assessment must be completed, followed by referral if appropriate;
- Suicidality must be treated directly, no matter the additional diagnoses;
- Patients need follow-up after an out-patient visit or in-patient stay, in order to determine if they need additional care, and because the follow-up contact itself is considered to be a protective factor, associated with lowered rates of suicide post-visit.

## Screening

Primary care health professionals are overwhelmed with demands and consistently asked to fit "too much" into their brief time with their patients. Simultaneously, given the number of individuals visiting non-mental health medical professionals in the months leading up to a death by suicide, there is an opportunity to find people at risk that may not be found in other ways. The emphasis is maintaining a simple, streamlined, short process for physicians and other primary care professionals and clinicians, to integrate screening.

## Tools

The following three tools are recommended by Zero Suicide:

1. *Patient Health Questionnaire-2 (PHQ-2)*: This is recommended for every visit. It consists of two simple questions that screen for basic depression symptoms, asking for an easily-rated patient response from 0 to 3. A one, two or three on the PHQ-2 triggers a PHQ-9.

2. *Patient Health Questionnaire-9 (PHQ-9)*: This is another short screening form that gives nine additional questions for the patient to rate on a scale of 0 to 3. Questions progress from depressive symptoms to the direct question about thoughts of self-harm. The numerical totaled score offers a quick guide to level of depression and allows for immediate assessment of potential suicidal thoughts and referral needs.

3. *Columbia-Suicide Severity Rating Scale (C-SSRS)*: This two-page rating scale provides a simple six question yes/no response section directly related to suicidal thoughts and behaviors. Following those are five "intensity of ideation" questions rated from 1 to 5, then the second page moves to four specific question/prompts concerning suicidal behaviors – including actual attempts and interrupted attempts – for a total of 15 short screening

[20] American Foundation for Suicide Prevention. www.afsp.org

questions.

The following tool is published by the Suicide Prevention Resource Center (SPRC), nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. This tool utilizes Best Practice models as assessed by SPRC's rigorous process:

*Pocket Guide for Primary Care Professionals - Assessment and Interventions with Potentially Suicidal Patients*: This four-fold card is designed to fit in a wallet or pocket, and outlines a short flow chart for next steps in identifying a potentially suicidal patient. This is part of a larger resource, the Suicide Prevention Toolkit for Rural Primary Care Practices.

The professionals conducting the Blueprint Conference presentation referenced on the first page of this article, highlighted a standardized, consistent intake process for screening and assessment utilized by the Chittenden County Community Health Team, a multi-disciplinary team with social workers, nurses, dieticians, and health coaches:

1. *General Health Screen*: Gathers general health information such as exercise, alcohol, dental, and includes a depression-specific question that is comparable to the PHQ-2.

2. *Generalized Anxiety Disorder 7 (GAD-7)*: Seven question scale rated from 0 to 3 that screens for generalized anxiety, frequency, and severity.

3. *Alcohol Use Disorders Identification Test Self-Report Version (AUDIT)*: Ten question screening for frequency of alcohol use, taken by the patient as opposed to completion in interview format.

4. *PHQ-9* referenced above

5. Positive screens for suicidal ideation during the intake screens trigger the administration of the C-SSRS, referenced above, by the social work staff.

The Community Health Team then has specific follow-up steps outlined, depending on patient responses, severity of symptoms expressed, and the assessment of the team. These clearly-defined options include referrals and connections to further care, safety planning, and emergency response should that be necessary, followed by post-care wellness checks. The Chittenden County CHT has a Suicide Risk Screening Algorithm for these steps.

## Screening For Lethal Means

When a patient screens at high risk for suicide, an imperative next step is to determine if the individual has immediate access to lethal means. Referral by the primary care setting for follow up assessment and care through emergency or behavioral health services is appropriate rather than delivering that care in the moment. However, immediate knowledge of the presence of lethal means is one of the most important factors in saving lives in order to take steps to minimize access during the crisis period.

Expert research from the United States and internationally clearly indicates that having access to the means to kill oneself, particularly a firearm, greatly increases the risk that someone will attempt suicide if they are experiencing suicidal thoughts or ideation.[21, 22, 23, 24, 25, 26, 27]

Repeated efforts to reduce access to lethal means in Sri Lanka, the United Kingdom, and Israel have all shown significant reductions in suicide rates, by 50%, 30%, and 40%, respectively. [28]

While the length of time an individual is experiencing suicidal thoughts and ideation can be extended – days, months, years – the acute phase of a specifically suicidal crisis is often (not always) brief. Among people inter-

[21] Barber, Catherine; Harvard Injury Control Research Center. "Why Means Matter." VT Suicide Prevention Symposium: 26 June, 2013.
[22] Dahlberg, L., et al. "Guns in the Home and Risk of a Violent Death in the Home." Am J of Epidemiology. 160 (10):929-936. 2004.
[23] Miller, M. et al. "Firearms and Suicide in the United States." Am J of Epidemiology. Vol. 178, No 6, p. 947. August 2011.
[24] Alcohol Abuse and Suicide. Webinar. Injury Control Research Center for Suicide Prevention. 29 January 2014.
[25] CALM: Counseling on Access to Lethal Means. Best Practice Registry, Section III. Suicide Prevention Resource Center. www.sprc.org
[26] Surprising Health Disparity: Men in their Middle Years. Webinar. Injury Control Research Center for Suicide Prevention. 11 March 2014.
[27] Dr. David Jobes' assessment/treatment model, CAMS, covered later in this document, stresses the importance of screening for lethal means.
[28] Barber, Catherine. "Why Means Matter." Vermont Suicide Prevention Symposium: 26 June, 2013. Means Matter, www.meansmatter.org

viewed who attempted suicide but did not die, 24% stated that less than 5 minutes elapsed between deciding to attempt suicide, and making the actual attempt. A further 47% stated that it was under one hour. Only 13% reported one day or more. [29]

Further, in states with high gun ownership, firearm deaths by suicide counted for 7,492 of a total of 246,024 suicide attempts. Non-firearm suicide deaths stood at 4,397. By contrast, in low gun-owning states, the firearm deaths by suicide were 1,697 versus 4,341 non-firearm suicides. [30]

The almost identical number of non-firearm suicide deaths coupled with the four times higher rate of firearm suicide deaths indicates that the presence of an easily accessible, highly lethal means of death made a huge difference in the individual going forward with the attempt. An important note is that people who own guns are not inherently more suicidal than those who don't. [31] Owning a gun simply makes that acute period of despair that much more lethal for individuals who are suicidal.

Research by the Injury Control Research Center for Suicide Prevention (ICRC-S) also indicates that alcohol use plays a large role in the culmination of a suicidal crisis, with 37% of suicide deaths preceded by acute alcohol use and 40% of suicide attempts preceded by acute alcohol use. [32] Drinking bouts confer a six- to ten-fold risk for making a suicide attempt and a six-fold risk of dying by suicide. [33] Compromised cognition in the moment contributes to the immediacy of suicidal decisions and attempts, also indicating a specific window of time.

While firearms are one of the most lethal means of dying by suicide, asking about other means is equally important, including drugs, medications, and poisons.

Counseling on Access to Lethal Means: CALM, is an SPRC Best Practice Program offering a guided example of talking with patients about lethal means. Zero Suicide recommends this program as well, and a 30-minute recorded webinar on CALM is available through the SPRC's website, www.sprc.org.

## Treatment Referral: Efficacy & Efficiency

As suicidal behavior is preventable, suicidal ideation and behavior is also treatable. The gold standard treatment of choice for suicidality has remained "problem solving therapy" such as cognitive behavioral therapy and dialectical behavioral therapy. [34, 35, 36, 37]

In treating suicidality, as opposed to treating underlying mental health conditions, brief goal-oriented interventions are needed. [38] When discussing therapy to treat suicidality, it is important to define exactly what is meant. The emphasis in successful treatment for suicidality is skills-building – developing immediate coping skills – not on long-term treatment of other conditions. This is in contrast to the concept of "therapy" assumed by many patients and clinicians which involves long-term commitments to regular sessions that address deep-seated issues and require intense emotional vulnerability.

Zero Suicide recommendations focus on interventions such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) that target suicidal thinking and behavior directly and use coping strategies more than pharmacotherapy or inpatient admissions. [39] A summary of the most efficacious treatment models follows.

## Cognitive Behavioral Therapy (Theory that underlies numerous SPRC Best Practices for Suicide Prevention)

Cognitive Behavioral Therapy (CBT) acknowledges that individuals at risk for suicidal ideation and behavior

[29] Simon, TR, et al. "Characteristics of impulsive suicide attempts and attempters." SLTR 2001: 32 (sup) 40-59.
[30] Miller, M, et al. Sources: Behavioral Risk Factor Surveillance System, National Survey of Drug Use and Health, National Vital Statistics System.
[31] Miller, MD, MPH, ScD, M.; et al. "Suicidal Behavior and Firearm Access: Results from the Second Injury Control and Risk Survey." Suicide and Life-Threatening Behavior. Volume 41, Issue 4, pages 384–391. August 2011.
[32] Alcohol Abuse and Suicide. Webinar. Injury Control Research Center for Suicide Prevention. 29 January 2014.
[33] Ibid.
[34] American Foundation for Suicide Prevention: Treatment. https://www.afsp.org/preventing-suicide/treatment
[35] Substance Abuse & Mental Health Services Administration National Registry for Evidence-Based Programs & Practices. www.nrepp.samhsa.gov
[36] Zero Suicide. www.zerosuicide.com
[37] National Alliance for the Mentally Ill. www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/
[38] Zero Suicide. www.zerosuicide.com
[39] Ibid.

likely have multiple stressors, problems, and mental health issues in their lives. Therefore, CBT focuses on developing specific skills when faced with those stressors. An individual experiencing suicidal crisis does not have the time to focus on the reasons underlying their long-term depression – they need skills for coping with that depression when it becomes a crisis. [40]

Suicidal individuals are prone to difficulties in exactly these areas: problem-solving, conceptualizing problems, and thinking through coping strategies. Evidence-based treatments that target suicidal behaviors are the interventions with the strongest body of supporting literature. [41] Many evidence-based programs and practices incorporate basic tenets of CBT. [42]

## Dialectical Behavioral Therapy (SPRC Best Practice)

Dialectical Behavioral Therapy (DBT) has been thoroughly studied for use with suicidal behavior – combining the cognitive behavioral approach with acceptance-based strategies, and working from a treatment hierarchy of attending to the immediate crisis of suicidality, then focusing on the behaviors that interfere with positive progress in therapy, then focusing on personal improvement/development. DBT concentrates on triggers to self-harming behaviors, acceptance of feelings of discomfort rather than struggling against them, and the ability to tolerate distress. [43, 44]

## Safety Planning (SPRC Best Practice)

Safety Planning – also known as crisis response planning – consists of creating a physical, written list of coping strategies and support sources, developed by the patient in partnership with their clinician. Safety planning has a proven, strong correlational relationship with decreased suicide attempts and is under clinical trial. [45] It is important that the plan be in the patient's own words and easy to read. If family members and other clinical individuals are identified as sources of support in the patient's safety plan list, they should be notified and made a partner in the plan. Zero Suicide promotes safety planning as a method for discussing and enacting lethal means restrictions on items such as pills and firearms. [46]

## Collaborative Assessment and Management of Suicidality (CAMS)

Dr. David Jobes pioneered Collaborative Assessment and Management of Suicidality (CAMS) as a therapeutic approach emphasizing collaborative assessment and treatment planning between the suicidal patient and their clinician. It is designed to strengthen the patient/clinician alliance and increase patient motivation, with the explicit goal of outpatient care. CAMS has a strong scientific, evidence base, with strong correlational support for decreasing suicidal ideation and behavior in multiple studies, and a randomized clinical trial demonstrating causal effectiveness. [47]

While some aspects of CAMS may appear to be screening-based, it is not a screening tool for a physician to implement in primary care. It is specifically an assessment that is a form of treatment, and is an efficacious and efficient treatment to which to refer suicidal patients.

## Importance of Continued Contact

While it is well known that individuals admitted to inpatient facilities or emergency rooms for suicidal behavior should be referred for follow-up therapeutic care, research is indicating that simple contact with a patient is beneficial and reduces reattempts and readmissions. [48]

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[40] Stanley, B. et al. "Cognitive Behavior Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility and Acceptability" J Am Acad Child Adolesc Psychiatry. Oct 2009; 48(10): 1005–1013. www.ncbi.nlm.nih.gov/pmc/articles/PMC2888910/

[41] Zero Suicide. www.zerosuicide.com

[42] National Registry for Evidence-Based Programs and Practices. www.nrepp.samhsa.gov

[43] National Alliance for the Mentally Ill. www.nami.org

[44] Zero Suicide. www.zerosuicide.com

[45] Ibid.

[46] Ibid.

[47] David Jobes, PhD, ABPP. Dr. Jobes' extensive body of research is noted on his faculty webpage. http://psychology.cua.edu/faculty/jobes.cfm

[48] Luxton, David D.; June, Jennifer D.; Comtois, Katherine Anne. "Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence." Crisis: The Journal of Crisis Intervention and Suicide Prevention. Vol 34(1), 2013, 32-41. www.dx.doi.org/10.1027/0227-5910/a000158

Numerous studies have demonstrated that ongoing contact with a patient after screening, assessment and treatment has a significant and lasting effect on their health and well-being. Summation of the numerous studies on this topic below indicates the danger present, and the impact of continued contact. [49]

Dangers:

- The majority of post-hospitalization suicides occur during the first month after discharge, peaking within a week after discharge
- The rate of suicide during first month after discharge has been shown to be more than 100 times the rate in the general population
- Only between 25 – 50% of suicidal patients actually attend outpatient treatment referral appointments given to them on discharge from inpatient or emergency care

Impact of Caring Contact:

- Contact with patients within the first month after their attempt reduces readmission significantly
- Multiple forms of caring contact work: telephone calls, crisis cards, postcards, letters, texts and emails, personal appointment reminders, up to home visits
- Caring contact can be as simple as a letter expressing interest in how the patient is faring
- The majority of patients participating in the studies reported liking the contact and wanting it to continue

This is a role primary care health professionals and behavioral health clinicians can take to support their patients with suicidal ideation and/or crises. Isolation increases the risk for suicide – caring contact from health professionals is a strong method of breaking that isolation.

## Conclusion

There are a number of tools available to clinicians and health care providers for screening, assessing and treating suicidality, including reducing access to lethal means. The role that clinicians play in the prevention of suicide, and the tools available to for screening, assessment and treatment discussed in this report, have been drawn from an extensive body of scientific literature, with proven results.

Providers in each setting ideally determine the tools they will use and establish a written protocol to ensure all staff is following the same protocol. The succinct model of implementation of Zero Suicide developed by the Chittenden County Community Health Team demonstrates how straightforward the integration of these tools and protocols can be.

In particular, this report references the following tools:

- **Screening**
  - ☐ General Health Screen
  - ☐ Generalized Anxiety Disorder 7-item Scale (GAD-7)
  - ☐ Alcohol Use Disorders Identification Test: Self-Report Version (AUDIT)
  - ☐ Patient Health Questionnaire 2 (PHQ-2)
  - ☐ Patient Health Questionnaire 9 (PHQ-9)
  - ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
  - ☐ Pocket Guide for Primary Care Professionals - Assessment and Interventions with Potentially Suicidal Patients
- **Securing Lethal Means**
  - ☐ Counseling on Access to Lethal Means (CALM)
- **Assessment**
  - ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- **Treatment**
  - ☐ Cognitive Behavioral Therapy
  - ☐ Dialectical Behavioral Therapy
  - ☐ Safety Planning
  - ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- **Follow Up**
  - ☐ Continued Caring Contact

[49] Ibid.

The sources cited in this report, as well as the additional list of resources provided at the end, offer evidence and models to assist you in making your practice suicide safe, and participating in Vermont's implementation of Zero Suicide.

## Additional Resources: Quick Guides for Free Download

Safety Plan QUICK GUIDE for Clinicians. Published by the Department of Veteran Affairs. One page folded guide, downloaded from: http://www.mentalhealth.va.gov/docs/vasafetyplancolor.pdf

Safety Planning: A Quick Guide for Clinicians. Published by the Suicide Prevention Resource Center. Two page guide, downloaded from: http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf

A Pocket Guide for Primary Care Professionals: Assessment & Interventions with Potentially Suicidal Patients. Four fold wallet card, downloaded from: http://www.sprc.org/sites/sprc.org/files/PCPocketCard.pdf

Patient Safety Plan Template. One page simple template for immediately safety lists. http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

## Complete Toolkits for Free Downlaod

Suicide Prevention Toolkit for Rural Primary Care Practices: available for download at www.sprc.org

Zero Suicide Toolkit: Suicide Care in Systems Framework. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

## Webinars & Online Learning at no Cost

http://zerosuicide.actionallianceforsuicideprevention.org/ Zero Suicide provides webinars, e-learning workshops, and Power Point presentations.

## General Resources

Vermont Suicide Prevention Center. www.vtspc.org

Suicide Prevention Resource Center. www.sprc.org

Zero Suicide. www.zerosuicide.com

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