Depression Screening & Suicide Prevention

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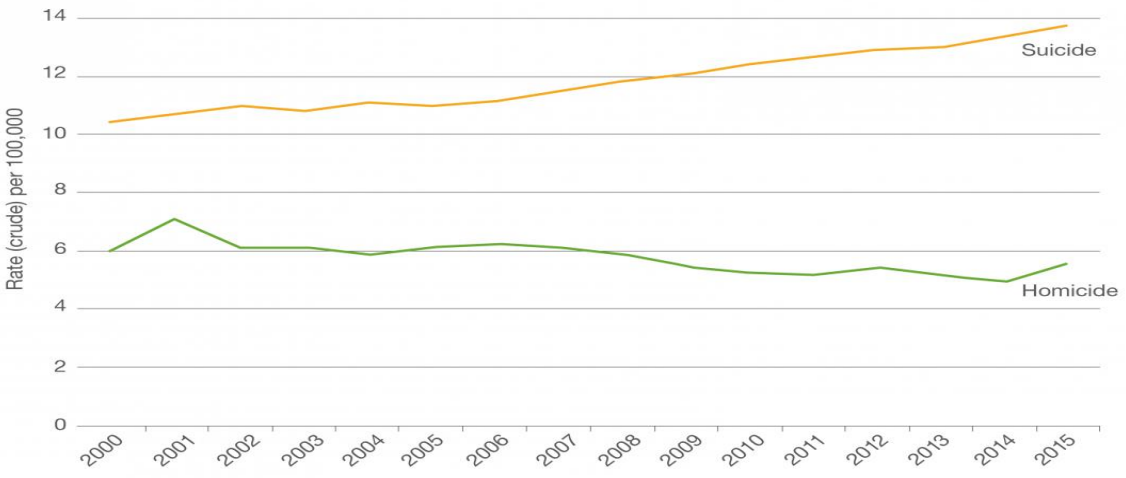
U.S. Suicide Data

- 43,000 per year
- 13.5% per 100K
- 1 every 13 min
- 10th leading cause of death

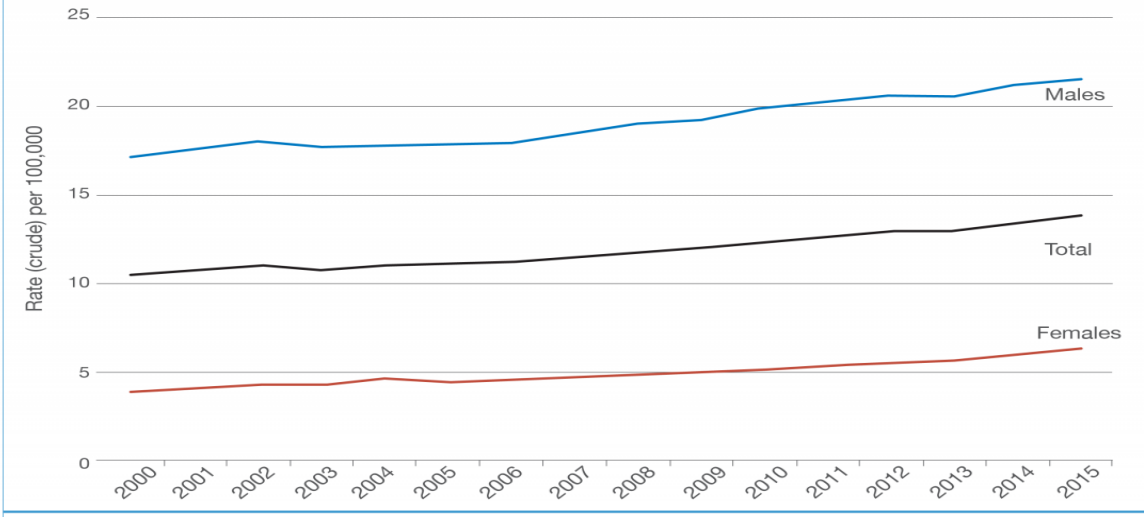
Suicide and Homicide Rates in the United States, 2000–2015



Source: WISQARS Fatal Injury Reports, 1999–2015

http://www.sprc.org/scope/united-states

Suicide Deaths in the United States by Sex, 2000–2015



Source: WISQARS Fatal Injury Reports, 1999–2015

http://www.sprc.org/scope/united-states

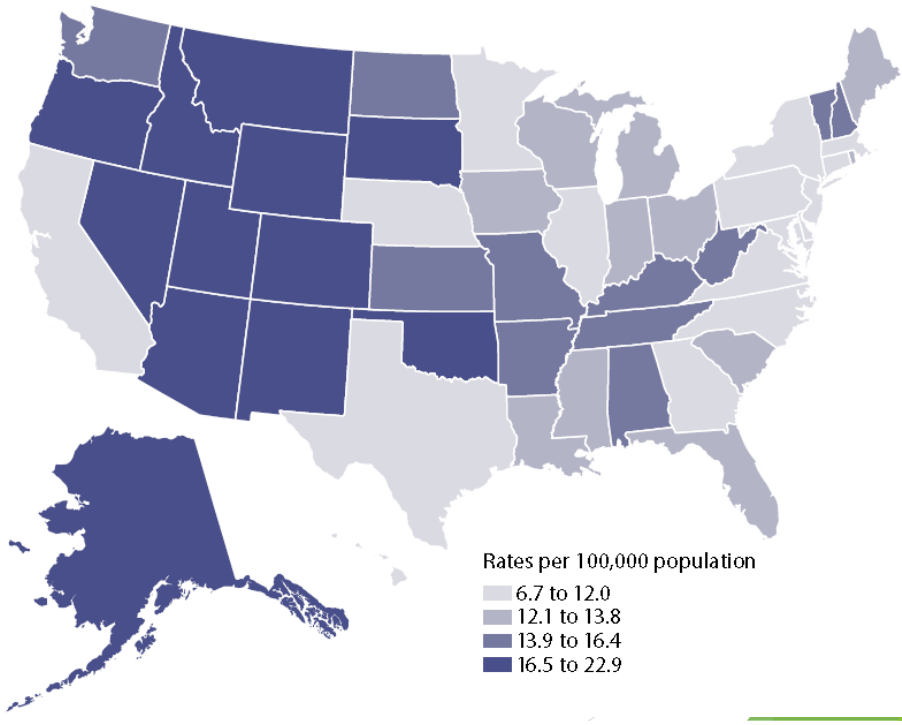
Leading Causes of Death by Age

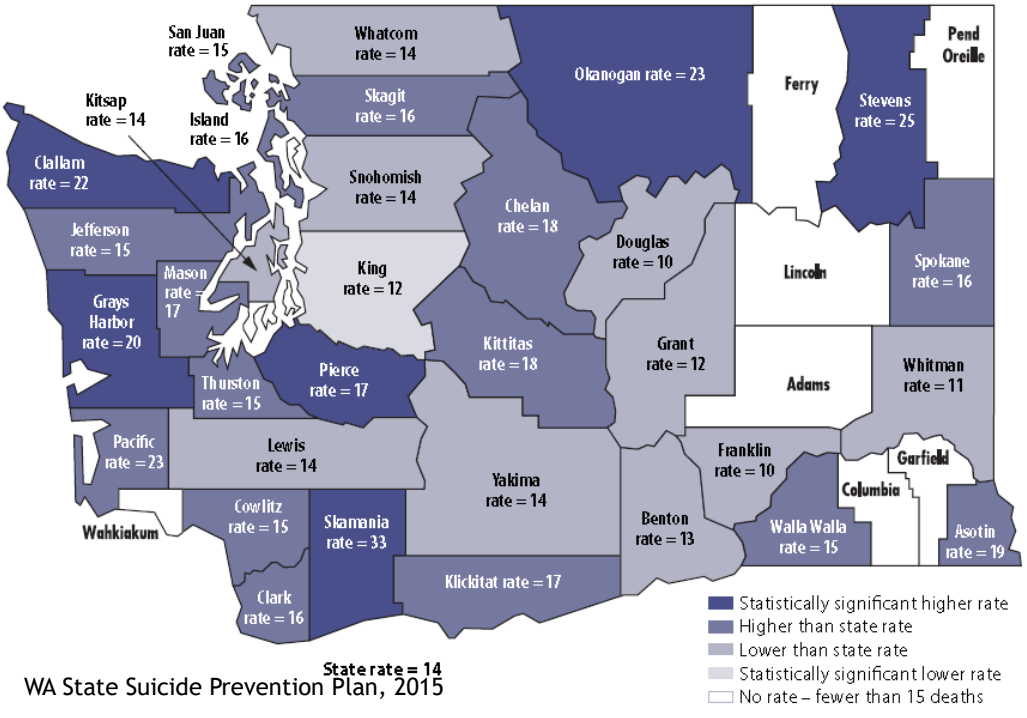
www.nimh.nih.gov/health/statistics/suicide/index.shtml

Table 1. Leading Causes of Death in the United States (2015)

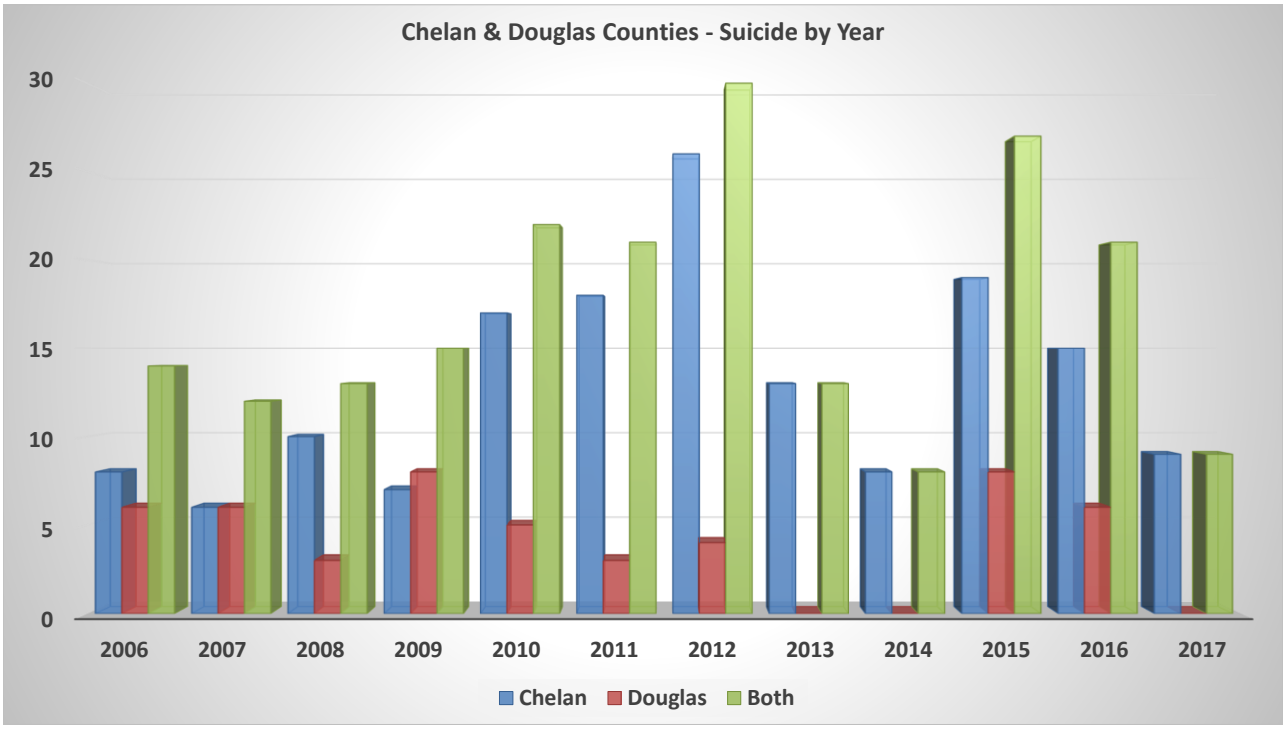
	Select Age Groups						
Rank	**10-14**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**All Ages**
1	Unintentional Injury 763	Unintentional Injury 12,514	Unintentional Injury 19,795	Unintentional Injury 17,818	Malignant Neoplasms 43,054	Malignant Neoplasms 116,122	Heart Disease 633,842
2	Malignant Neoplasms 428	**Suicide 5,491**	**Suicide 6,947**	Malignant Neoplasms 10,909	Heart Disease 34,248	Heart Disease 76,872	Malignant Neoplasms 595,930
3	**Suicide 409**	Homicide 4,733	Homicide 4,863	Heart Disease 10,387	Unintentional Injury 21,499	Unintentional Injury 19,488	CLRD 155,041
4	Homicide 158	Malignant Neoplasms 1,469	Malignant Neoplasms 3,704	**Suicide 6,936**	Liver Disease 8,874	CLRD 17,457	Unintentional Injury 146,571
5	Congenital Anomalies 156	Heart Disease 997	Heart Disease 3,522	Homicide 2,895	**Suicide 8,751**	Diabetes Mellitus 14,166	Cerebro-vascular 140,323
6	Heart Disease 125	Congenital Anomalies 386	Liver Disease 844	Liver Disease 2,861	Diabetes Mellitus 6,212	Liver Disease 13,278	Alzheimer's Disease 110,561
7	CLRD 93	CLRD 202	Diabetes Mellitus 798	Diabetes Mellitus 1,986	Cerebro-vascular 5,307	Cerebro-vascular 12,116	Diabetes Mellitus 79,535
8	Cerebro-vascular 42	Diabetes Mellitus 196	Cerebro-vascular 567	Cerebro-vascular 1,788	CLRD 4,345	**Suicide 7,739**	Influenza & Pneumonia 57,062
9	Influenza & Pneumonia 39	Influenza & Pneumonia 184	HIV 529	HIV 1,055	Septicemia 2,542	Septicemia 5,774	Nephritis 49,959
10	Two Tied 33	Cerebro-vascular 166	Congenital Anomalies 443	Septicemia 829	Nephritis 2,124	Nephritis 5,452	**Suicide 44,193**

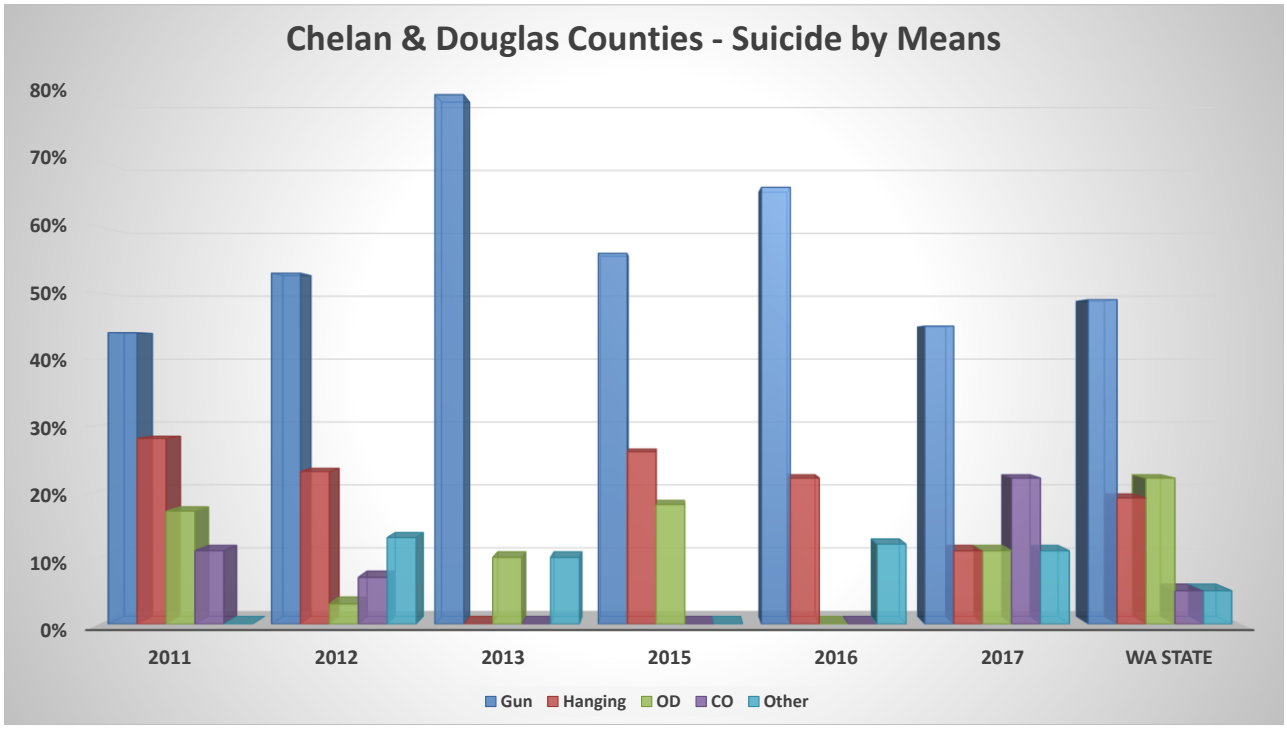
Data courtesy of CDC

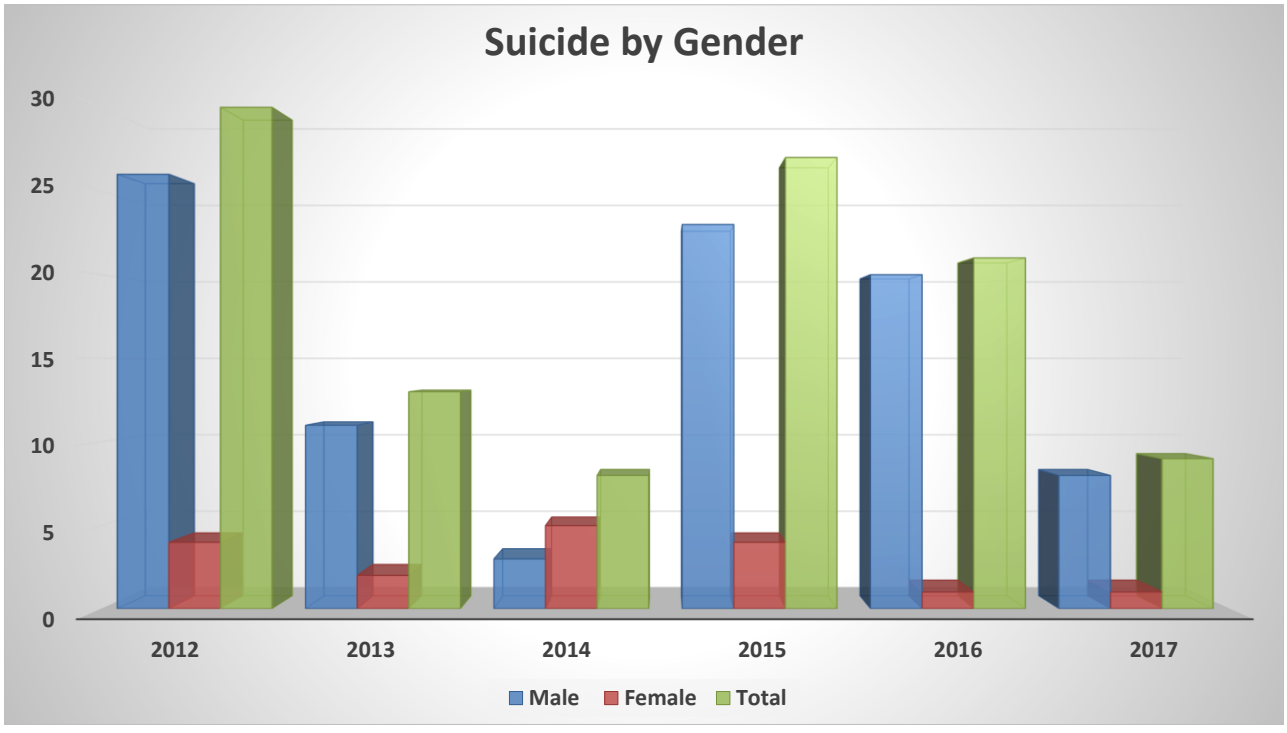


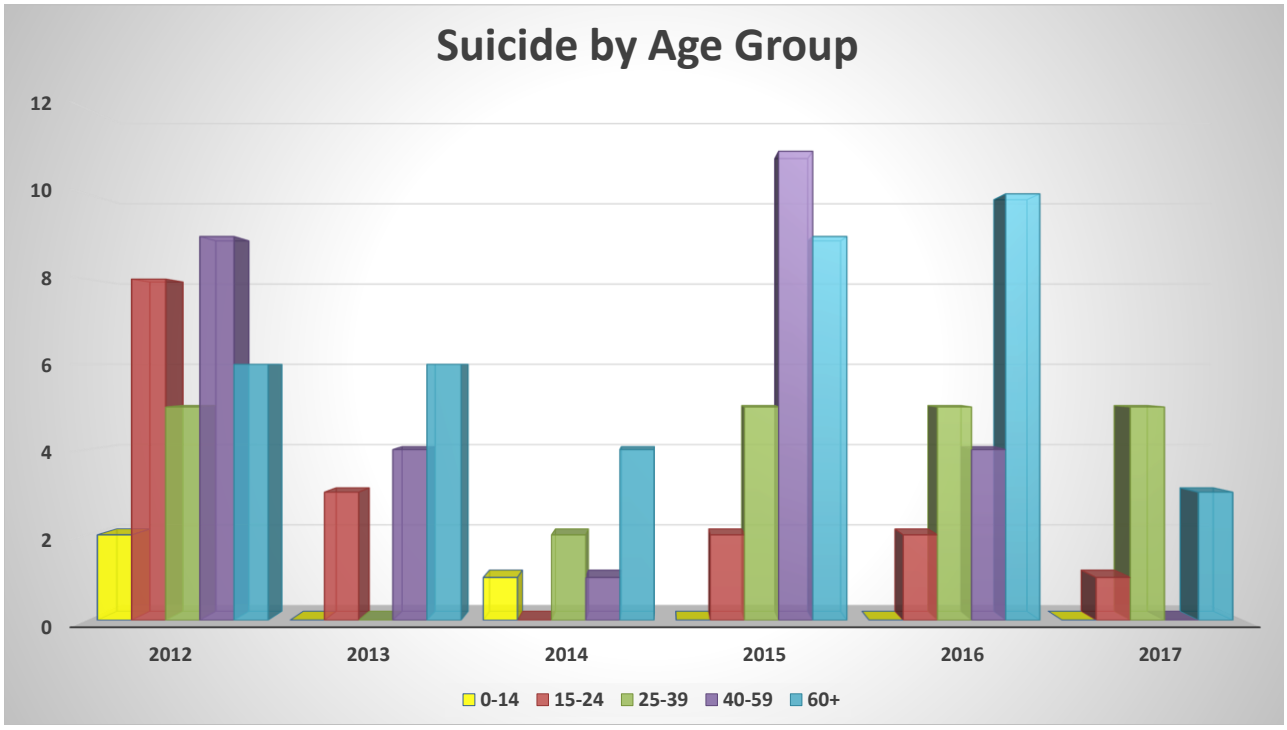


WA State Suicide Prevention Plan, 2015




Chelan & Douglas Counties - Suicide by Means
80%
70%
60%
50%
40%
30%
20%
10%
0%
2011
2012
2013
2015
2016
2017
WA STATE
Gun
Hanging
OD
CO
Other


Suicide by Gender
30
25
20
15
10
5
0
2012
2013
2014
2015
2016
2017
Male
Female
Total



High Risk Groups

- Teens
- Veterans
- Seniors
- LGBTQQ
- Vulnerable Populations

Risk Factors for Suicide

Personal Characteristics	Life Experiences	Physical & MH	Personality & Outlook
Membership in a vulnerable group: * Men >45 yo * Small/rural community * AI/AN or White * Participation in Military * LGBTQQ **Family History:** * Mental Illness * Phys / Sex Abuse * Substance Abuse	Childhood trauma (ACEs), hx & recent trauma **Loss:** ✓ Breakup / divorce ✓ Job demotion / loss ✓ Loss of fxn ✓ Death in family/ community, esp by suicide ✓ Loss of stability (identity, eviction, deployment of family, $, sex violence) ****Prev suicide attempts** Isolation Barriers to accessing care (MH or PCP) ****Access to lethal means**	Mental illness Substance use / abuse Traumatic Brain Injury (TBI) Stroke **Changes in phys/mental fxn:** ✓ Illness ✓ Disability ✓ Chronic pain ✓ Chronic illness ✓ Terminal illness ✓ Loss of limb/s	Hopelessness Impulsivity Aggression ****Feeling like a burden** ****Capacity for self-harm** Personal / cultural beliefs validating suicide Rumination on death Unwillingness to seek help

Protective Factors

Individual	Relationship	Community	Societal
3 or more children Problem solving skills Conflict resolution skills Positive outlook Good social supports Pets Religious beliefs against suicide Lack of capacity for self-harm Unfinished business Working or a purpose Sense of independence	Married if male Divorced if female Involved with support group Actively engaged in life Caring for children Feeling loved / cared for Friends Online group participation if unable to get out Engaged in church Others participate in medical appts Removing weapons / means	Engaged in a variety of activities ✓ Church ✓ Book clubs ✓ Knitting / sewing ✓ Online ✓ Exercise Issue of driving has been addressed if unable to drive Sense being part of something Being checked on Being told nice things Reminded you have value Checking on the person regularly	Restricted access to means Others that note changes in behavior Access to help when needed Cultural beliefs that discourage suicide No bullying Strong sense of values Stable political climate Limited social media / news access Caring connections with providers

Purpose of Screening

- Recognizing symptoms of depression
- Seeking treatment sooner
- Have high risk issues addressed
- Saving lives
- Helps label changes away from baseline you are seeing in the person

Screening is a MUST!

How often should I screen?

- SUICIDE SAFE CARE – recognizing when mood is worsening emotional or medical issues
- Scores can change visit to visit, week to week
- Patients coming in with a cold or pain can have unrecognized depression and/or suicidal thoughts
- Screening, when you actually tell the person WHY you are screening it is helpful…regardless of how often
- Once a year per CMS guidelines… ?? Once during each 4 month activity period or as clinically indicated for Care Coordinators…

Talking to Patients About the PHQ-9

- ***Script: In a medical setting***

  We are asking patients to complete this screener on emotional wellness. Your provider will talk to you about the meaning of your scores during your visit.

- ***Script: In non-medical setting***

  I have a questionnaire that I would like you to complete due to changes I have noticed in your mood. This will help us understand if there is something more we need to do about you (*being so sad, crying, being down*)…

PHQ – 9
Depression Screener

- Developed in 1994 as the PRIME-MD
- Now standard of care in Primary Care Practices across U.S.A.
- Based on the DSM-IV-TR
- Sensitivity (correctly identifies those with the disease) = 0.69/0.91.
- Specificity (correctly identifies those without the disease) = 0.84/0.80.
  - False positive rate was about 17%, false negative rate about 18%.

Spitzer RL, Williams JBW, Kroenke K, et al. Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. JAMA. 1994;272:1749-56. [PubMed]

Form Matters

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 figety 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	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

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 _____

Form Matters

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

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 ☐

Patient Complaints

- Unsure why they are completing the form
- No one talks to them about the form
- Form is difficult to understand
- Font is too small (I can't read it)
- Things are bunched together
- Color of the form makes it difficult to see

Form Matters

Over the last 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. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
If you answered 1 or higher on any of the above questions, please continue below.				
4. Trouble falling/staying asleep, sleeping too much	0	1	2	3
5. Feeling tired or having little energy	0	1	2	3
6. Poor appetite or overeating	0	1	2	3
7. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
8. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
9. 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

Do you currently have a mental health provider? ☐ **Yes** ☐ **No**

If yes: _____
Name of mental health provider

Part of whole-person care is prevention. One in 5 people will experience some mental health condition in a given year and 1 in 20 will seriously consider suicide. Please enter the Crisis Line **800-273-8255** and Crisis Text Line **741741** (text "start") into your phone now. You never know when someone you care about may need it.

Depression Symptoms

Emotional Symptoms

- Sadness
- Loss of interest
- Anxiety / irritability
- Hopelessness
- Poor concentration
- Guilt
- Suicidal thinking

Physical Symptoms

- Fatigue / Tiredness
- Sleep disturbances
- Headaches
- Psychomotor changes (restless)
- GI upset
- Body aches
- Increased pain

PHQ-9 Administration

- Ask the patient to complete the questionnaire
  - Patients tend to be more honest in responses
- Administer PHQ-9 when person is unable to see or read
  - When asking the questions. Try not to show judgment in their responses or coax them to respond differently
  - Voice should be slow & steady with well enunciated words

PHQ-9 Scoring

- Points from Q1-9 are added up for a total score
- Score of 10 or more indicates possible depression
- Scores on the lower end tend to cause less impairment in the individual, so less motivation to fix the issue
- Have handouts that you can discuss on depression
  - It is treatable and not something they must suffer with
- Offer a referral for proper assessment & treatment
- Document
- Follow up within 30 days or sooner (talk to supervisor on policy)

PHQ-9 Scores and Proposed Treatment Actions *

Total PHQ Score	Depression Severity	Proposed Treatment Actions
0-4	None - Minimal	None / Acknowledge things going well.
5-9	Mild	PCP acknowledge & discuss, watchful waiting, repeat PHQ-9 at follow-up visit
10-14	Moderate	Treatment plan & follow-up, bring in Integrated Behavioral Health provider (if available) or refer to Specialty Behavioral Health, consider pharmacotherapy. PHQ every visit.
15-19	Moderately Severe	Urgent (same day) referral to Behavioral Health (Integrated BH Provider, if available*, or Specialty BH Department). Active treatment with pharmacotherapy. PHQ every visit. and psychotherapy.
20-27	Severe	Immediate initiation of pharmacotherapy, Urgent (same day) referral to Behavioral Health (Integrated BH Provider, if available*, or Specialty BH). PHQ every visit, every provider.

*From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

Source: Pfizer website accessed 9/7/2017: https://phqscreeners.pfizer.edrupalgardens.com/sites/g/files/g10016261/f/201412/instructions.pdf

Scores

- Scores are only helpful if you know what to do with them
- Two scores on the PHQ.
  - The depression score (Q1 + Q9 = Total Score)
  - Function Score (Q10 alone) – with level of depression how are they functioning?
- Make sure to normalize any score a person has.
  - Low score – It looks like you are doing really well and we will periodically give you this questionnaire just to check on how this is maintained.
  - High score – It looks like you have a high score. It is not uncommon for people with medical conditions or _____ to have periods of depression. What are your thoughts on getting you in to see your doctor to talk about this and see what can be done?

PHQ-9, Question 9 (Suicide Question)

- Ask clarifying questions or screen further.
- Call Designated Mental Health Provider (DMHP) if person can't be safe or you are unsure or 9-1-1
- Who else needs to be notified (family, caregiver, providers)
  - You can break confidentiality due to risk of harm
- Locate DMHP's in your area https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/state-mental-health-crisis-lines
- Consult with a supervisor

What Helps Depression?

- Walking 4x per week, 20 min per time
- Multi-vitamins (avoid iron unless specifically needed)
- Water – improves efficacy of medication
- Sleep – Helps cognitive function
- Eating – Helps everything when it is balanced
- Light – Lights in the home, getting outside in the sun, full spectrum lamps
- Exercise – Even small goals make big differences

What Helps Depression?

- Support
- Lack of secondary gain
- Stable housing
- Stable relationships
- Consistent care providers
- People they can talk to
- Music – not the sad sappy stuff
- Avoiding the news
- Mindfulness, meditation, prayer

Screening Further with CSSRS

- Any patient with a score on the suicide question of **1**, **2**, or **3** should be further screened using the **Columbia Suicide Severity Rating Scale (CSSRS)** to determine level of **immanency** and **risk**
- This CSSRS screen allows you to not worry if you missed an important area to ask about
- Anyone can ask about suicide
- Only RNs, Master's clinicians, PhD/PsyDs, MD/DO can also do treatment planning with the person.
  - Work within your scope of practice
  - Work within your role or job description

Columbia Suicide Severity Rating Scale

	In the Past Month	
Answer 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 actually had any thoughts about killing yourself?		
If YES to 2, answer questions 3, 4, 5 and 6 If NO to 2, go directly to question 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 or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
Always Ask Question 6	In the Past 3 Months	
6) Have you 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, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.
If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for care.

http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

Risk Rating

- **High Suicide Risk**
  - Suicidal ideation w/ intent or intent with a plan **in past 1 mth** (#4, #5) Or
  - Suicidal bx w/in past 3 mths
- **Moderate Suicide Risk**
  - Suicidal ideation w/ method, **without plan, intent, or bx** in past 1 mth (#3) Or
  - Suicidal bx more than 3 months ago Or
  - Multiple risk factors and few protective factors
- **Low Suicide Risk**
  - Wish to die or SI w/o method, intent, plan or bx (#1, #2) Or
  - No hx of self harm Or
  - Risk factors are modifiable & strong protective factors

Documentation

- Your Clinical Observation
- Relevant Mental Status Information
- Methods of Suicide Risk Evaluation
- Warning Signs
- Risk Indicators
- Protective Factors
- Access to Lethal Means
- Collateral Sources Used and Relevant Information Obtained
- Specific Assessment Data to Support Risk Determination
- Rationale for Actions Taken and Not Taken

Documentation for Suicidal Patients

- Document immediately on suicidal patients
  - Late or missing documentation does not get to be added in later if the person dies. Basically it doesn't exist
- What is the level of perceived risk?
- What is the likelihood of them following through?
- Do your actions match your perception?

What can be done?

- Understanding what to do when someone is identified as suicidal
- Know warning signs & risk factors
- Know local resources
- Have a pathway to care developed to manage crises
  - Community partners

What can be done?

- **Smooth transitions in services**
  - Changing providers
- **Means restrictions**
  - Remove the means
  - Communicate risk even when it is low

What can be done?

- **Advocate to make sure something is being done & you agree with the plan**
  - Only ~50% of people that admit to suicidal thinking will have it addressed at a MH or PCP visit
  - People struggling can't advocate

Questions

People get better when they access help that knows what to do!

Other Resources

Webinar on older adults and depression:

http://www.todaysgeriatricmedicine.com/archive/SO16p24.shtml

RCW 43.70.442 Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. (*Effective until January 1, 2017.*)

http://app.leg.wa.gov/RCW/default.aspx?cite=43.70.442

Today's Geriatric Medicine: Free Subscription

http://www.todaysgeriatricmedicine.com/subscribe.shtml

Other Resources (cont.)

1. Suicide facts. Suicide Awareness Voices of Education website. http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=705D5DF4-055B-F1EC-3F66462866FCB4E6

2. Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf. Published November 2014.

3. Suicide and depression. Suicide Awareness Voices of Education website. http://www.save.org/index.cfm?fuseaction=home.viewpage&page_id=705c8cb8-9321-f1bd-867e811b1b404c94

Other Resources (cont.)

4. Salvatore T. Suicide risk in older adults: a growing challenge for law enforcement. Federal Bureau of Investigation website. https://leb.fbi.gov/2016/january/suicide-risk-in-older-adults-a-growing-challenge-for-law-enforcement. Updated January 6, 2016.
5. Administration on Aging highlights. Administration for Community Living website. http://www.aoa.acl.gov/Aging_Statistics/Profile/2014/2.aspx. Updated October 7, 2014.
6. Older Americans Behavioral Health. Issue Brief 4: Preventing Suicide in Older Adults. http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Issue%20Brief%204%20Preventing%20Suicide.pdf
7. Beck Depression Inventory. Encyclopedia of Mental Disorders website. http://www.minddisorders.com/A-Br/Beck-Depression-Inventory.html

Tips for Managing the Holiday Blues

Link to short video:
https://www.youtube.com/watch?v=REOPKqTYKeo

Link to NAMI website:

https://www.nami.org/Blogs/NAMI-Blog/November-2015/Tips-for-Managing-the-Holiday-Blues

Health Home Program
Washington

Certificate of Completion

Assessment Screening Tools: Depression and the PHQ-9

Presented by
Dr. Julie Rickard, PhD
Physician and Healthcare Consulting., LLC
Wenatchee, Washington

Webinar aired on: December 14, 2017 in Lacey, Washington for Health Home Care Coordinators and Allied Staff

Training Credit of 1 Hour

Please sign and date to attest that you reviewed this PowerPoint

Your Signature _____ Date _____

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