Screening and Assessment of Suicide Risk in School-based Health Centers; A Comprehensive Approach

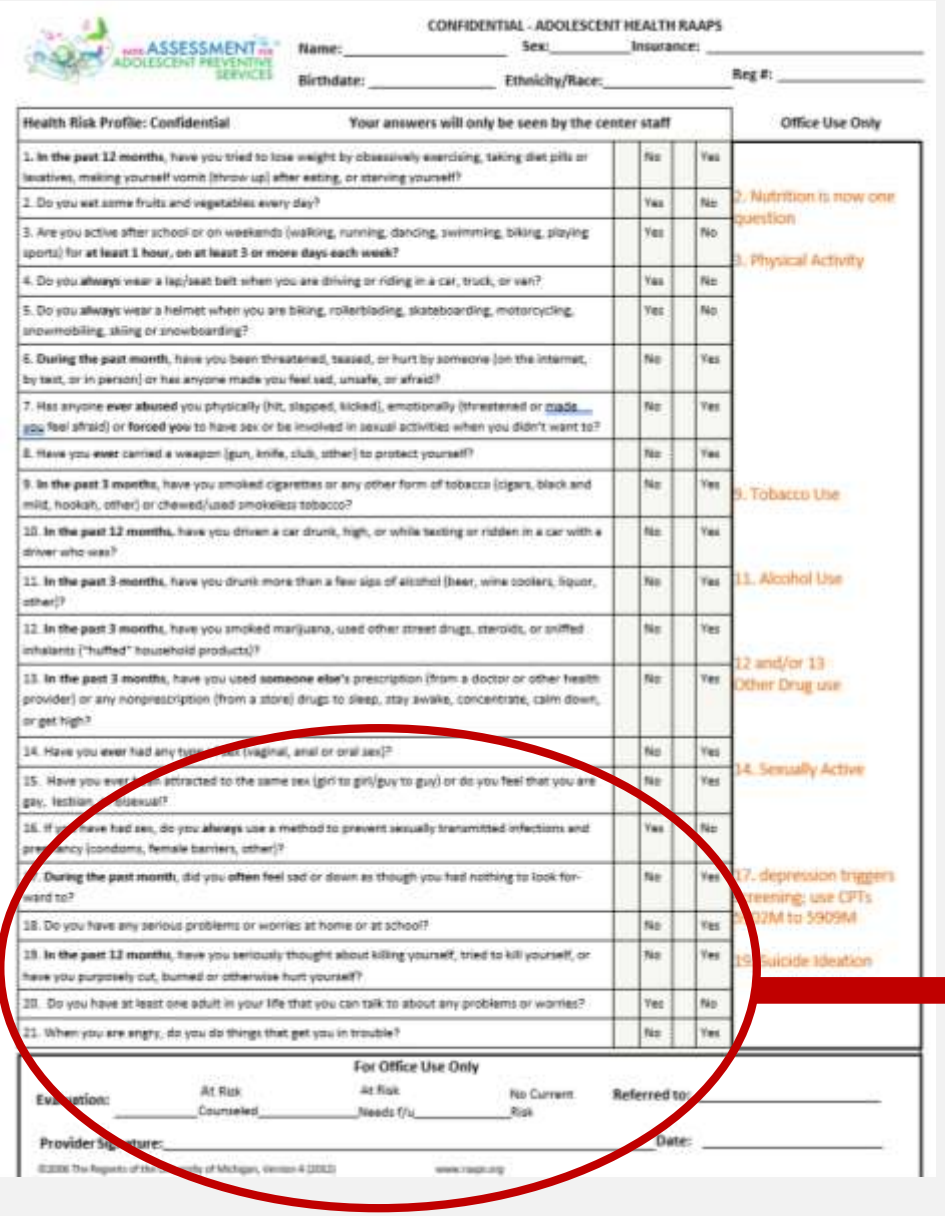
Greg A Marley, LCSW

Maine Suicide Prevention Program

In partnership with: NAMI Maine

Education, Resources and Support—It's Up to All of Us.

The planners and speaker for this presentation have no relevant financial relationships to disclose.



CONFIDENTIAL - ADOLESCENT HEALTH RAAPS

Name:_____ Sex:_____ Insurance: _____

Birthdate: _____ Ethnicity/Race:_____ Reg #: _____

Health Risk Profile: Confidential — Your answers will only be seen by the center staff					Office Use Only
1. **In the past 12 months**, have you tried to lose weight by obsessively exercising, taking diet pills or laxatives, making yourself vomit (throw up) after eating, or starving yourself?		No		Yes	
2. Do you **eat** some fruits and vegetables every day?		Yes		No	2. Nutrition is now one question
3. Are you active after school or on weekends (walking, running, dancing, swimming, biking, playing sports) for **at least 1 hour, on at least 3 or more days each week?**		Yes		No	3. Physical Activity
4. Do you **always** wear a lap/seat belt when you are driving or riding in a car, truck, or van?		Yes		No	
5. Do you **always** wear a helmet when you are biking, rollerblading, skateboarding, motorcycling, snowmobiling, skiing or snowboarding?		Yes		No	
6. **During the past month**, have you been threatened, teased, or hurt by someone (on the internet, by text, or in person) or has anyone made you feel sad, unsafe, or afraid?		No		Yes	
7. Has anyone **ever abused** you physically (hit, slapped, kicked), emotionally (threatened or made you feel afraid) or **forced you** to have sex or be involved in sexual activities when you didn't want to?		No		Yes	
8. Have you **ever** carried a weapon (gun, knife, club, other) to protect yourself?		No		Yes	
9. **In the past 3 months**, have you smoked cigarettes or any other form of tobacco (cigars, black and mild, hookah, other) or chewed/used smokeless tobacco?		No		Yes	9. Tobacco Use
10. **In the past 12 months**, have you driven a car drunk, high, or while texting or ridden in a car with a driver who was?		No		Yes	
11. **In the past 3 months**, have you drunk more than a few sips of alcohol (beer, wine coolers, liquor, other)?		No		Yes	11. Alcohol Use
12. **In the past 3 months**, have you smoked marijuana, used other street drugs, steroids, or sniffed inhalants ("huffed" household products)?		No		Yes	
13. **In the past 3 months**, have you used **someone else's** prescription (from a doctor or other health provider) or any nonprescription (from a store) drugs to sleep, stay awake, concentrate, calm down, or get high?		No		Yes	12 and/or 13 Other Drug use
14. Have you **ever** had any type of sex (vaginal, anal or oral sex)?		No		Yes	14. Sexually Active
15. Have you ever been attracted to the same sex (girl to girl/guy to guy) or do you feel that you are gay, lesbian or bisexual?		No		Yes	
16. If you have had sex, do you **always** use a method to prevent sexually transmitted infections and pregnancy (condoms, female barriers, other)?		Yes		No	
17. **During the past month**, did you **often** feel sad or down as though you had nothing to look forward to?		No		Yes	17. depression triggers Screening: use CPTs 96202M to 96909M
18. Do you have any serious problems or worries at home or at school?		No		Yes	
19. **In the past 12 months**, have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself?		No		Yes	19. Suicide Ideation
20. Do you have at least one adult in your life that you can talk to about any problems or worries?		Yes		No	
21. When you are angry, do you do things that get you in trouble?		No		Yes	

For Office Use Only

Evaluation: _____ At Risk Counseled _____ At Risk Needs f/u _____ No Current Risk Referred to: _____

Provider Signature: _____ Date: _____

Rapid Assessment for Adolescent Preventive Services (RAAPS)

Administered to all students as initial Health Risk Assessment and screening tool

17. **During the past month**, did you **often** feel sad or down as though you had nothing to look forward to?		No		Yes
18. Do you have any serious problems or worries at home or at school?		No		Yes
19. **In the past 12 months**, have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself?		No		Yes
20. Do you have at least one adult in your life that you can talk to about any problems or worries?		Yes		No
21. When you are angry, do you do things that get you in trouble?		No		Yes

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

Always ask questions 1 and 2.	Past Month
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, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3) Have you been thinking about how you might do this?	
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**

Always Ask Question 6	Life-time	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.		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Any YES indicates that someone should seek behavioral healthcare.

However, if the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Because suicide is often preventable…

Working toward Suicide Safer Care

Systematic Suicide Care
Plugs the Holes in Health Care

Suicidal Person

Develop **Collaborative Safety Plan** with Lethal Means Restriction

Directly Treat Suicidality:
Suicide-Informed CBT, DBT, CAMS, Support, referrals for Tx

Assure Excellent Follow-up, and Stay in Touch

Screen, then **Assess** for Suicidality

Death or Serious Injury Avoided

Developing a Suicide-Informed School Practice

- All SBHC staff see suicide prevention as part of their work and within their role.

- Training and support is available for their roles.

- **Protocols** are in place guiding screening, identification, assessment, management of risk
  - Screening is done to identify flags for suicide risk
  - A standardized **assessment** tool is used
  - **Referrals** are made for treatment as indicated
  - **Collaborative Safety Planning** is used as a management tool, including parent coordination.
  - Continuity of care is assured through **proactive follow-up** for those identified as at risk.

- Ongoing coordination with school clinical and admin. staff maintained

Asking About Suicide

Overcoming Societal Reluctance

- *Talk about suicide directly and without hesitation.*
  - *Asking will not increase risk; it is what is needed*

- *Ask using concrete and direct language.*
  - Are you thinking about dying today?
  - **How often** do you consider killing yourself?
  - Have you been thinking of ending your life?

- When in doubt about the answer, repeat the question differently. Not badgering, but gently persistent…

Assessing Risk using Columbia Suicide Severity Rating Scale (C-SSRS)

- An evidence-based suicide risk screening tool with applications as an assessment instrument
- Valid and reliable with many populations across the lifespan
- Versions available for use with children/adolescents.
- Level of information based upon clinical conversation guiding response
  - The art of this assessment is based on a conversation to establish rapport and to invite an honest disclosure of recent risk.

Suicide Assessment

(C-SSRS model inquiry; Screen Version)

- **Suicidal Ideation**
  - *"Have you wished you were dead or wished you could go to sleep and not wake up?"*
  - *"Have you actually had any thoughts of killing yourself?"*
- **Planning**
  - *"Have you been thinking about how you might kill yourself?"*
- **Intent**
  - *"Have you had these thoughts and had some intention of acting on them?"*
  - *"Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"*
- **History of suicidal Behavior**
  - *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*
  - "If yes, when, how long ago and details of the event(s)?"

***Over the past week or since the last visit**

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact – for Schools

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Contact**	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
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 of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		

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 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.		

AN increase in yes answers indicates an increased risk. Presence of current or recent intent and plan indicates care be taken to manage safety and to trigger a full assessment of risk.

C-SSRS Full Assessment

- If C-SSRS screen indicates suicide risk, complete assessment version to determine level of risk and level of care needs,
- Suicidal Behavior
  - Suicide attempt history and para suicidal behavior history and details including **self-injurious behavior** done without suicidal intent
  - **Actual Attempt:** Most recent, most severe and trend toward increasing severity of damage…
  - Details about attempts **aborted** by self or **interrupted** by others,
  - A detailed assessment of recent **preparatory actions** including acquisition or availability of lethal means, rehearsal, writing a note. . .
  - An assessment of lethality, **level of damage** of attempt made,
  - **Potential lethality** of means and methods identified even if no damage

When to Call or Text Crisis

- “Call early, call often”
- Crisis clinicians are:
  - Available 24 / 7 by phone call or text through a statewide center.
  - Clinicians available regionally to come to your location or meet in a safe place for an assessment
  - Gatekeepers for admission into a hospital
- Call or Text for a phone consult when you are:
  - Concerned about someone’s mental health
  - Need advice about how to help someone in distress
  - Worried about someone and need another opinion

1-888-568-1112
MAINE CRISIS LINE
CALL. TEXT. CHAT.

Questions?