Health Home Program
Washington

DEPRESSION SCREENING AND SUICIDE

GUIDE SHEET

OVERVIEW

According to the National Institute of Mental Health, research suggests that people who have depression and another medical illness tend to have more severe symptoms of both illnesses. They may have more difficulty adapting to their co-occurring illness and more medical costs than those who do not have depression. *The National Institute of Mental Health has identified the follow **risk factors** for depression:

1. Personal or family history of depression
2. Major life changes, trauma, or stress
3. Certain physical illnesses and medications

Depression, even in the most severe cases, can be treated. **Symptoms of depression** include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decrease energy, fatigue, being "slowed down"
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Restlessness, irritability
- Persistent physical symptoms
- Difficulty concentrating, remembering, or making decisions
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment
- Thoughts of death or suicide, suicide attempts

Washington State has a goal to reduce hospitalizations due to suicide attempts and deaths due to suicide. This guide sheet provides information about depression screening and suicide and was created for Health Home Care Coordinators.

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) provide to clients is the opportunity to complete the **Patient Health Questionnaire – 9 (PHQ-9)**. The PHQ-9 is a screening assessment for depression. There are nine questions regarding mood and thoughts during the past two weeks.

How to administer and score the PHQ-9:

The CC may ask the client the nine questions, the client may complete the assessment, or a reliable surrogate may answer the questions. The nine questions are scored using four options:

1. Not at all (scoring = 0 points)
2. Several days (scoring = 1 point)
3. More than half the days (scoring = 2 points)
4. Nearly every day (scoring = 3 points)

*_Chronic Illness and Mental Health: Recognizing and Treating Depression_. Bethesda, MD: National Institute of Mental Health. **Retrieved November 21, 2017 from https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/nih-15-mh-8015_151898.pdf**

The points are **added up** to determine the total score with a maximum of **27 points**. Clients and surrogates retain the *right to decline* to complete the assessment. Document in the client file who was asked to complete the PHQ-9, the date, and the reason (if provided) that the PHQ-9 was not completed. If the CC has concerns about potential depression for a client who has not completed the screening they should ask the client if they may consult with their primary care or behavioral health provider. The screening assessment should be offered to the client or surrogate at least one time during each four month activity period. Scores of 10 or higher may indicate the need for more frequent screenings. CCs should use their professional judgment to determine when to offer additional screenings.

Before you complete face-to-face visits and administer any screenings:

- Know and follow your agency's policies related to responding to potential suicide.
- Effective April 2018 designated mental health professionals (DMHPS) were renamed designated crisis responders (DCRs). Research your area's Designated Crisis Responders (DCRs) and keep these phone numbers with you while visiting clients.
    - Use this link to locate DCRs in your area: https://www.hca.wa.gov/assets/billers-and-providers/designated-crisis-responders-contact-list.pdf

ITS ABOUT THE CONVERSATION

First, ask for permission to have a conversation about depression:

CCs might consider opening the conversation about possible depression:

- For example: "Depression often occurs with other diseases, such as _____. I have a few questions I would like to ask to see if this might be happening with you. Would you be willing to talk with me about this?"

If the client answers **yes to the ninth question** on PHQ related to suicide

***SAMHSA recommends asking these four questions about suicidal ideation:**

- **Past Suicide Attempt**: "Have you ever attempted to harm yourself in the past?"
- **Suicide Plan**: "Have you had thoughts about how you might actually hurt yourself?" (This could include thoughts of timing, location, lethality, availability of means, and preparatory acts.) If yes, "Do you have the means to follow it through?"
- **Probability (Perceived)**: "How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?"
- **Preventive (Protective) Factors**: "Is there anything that would prevent or keep you from harming yourself?"

If the client responds "**no or in a manner indicating they are not at risk**" to the above questions then no further immediate action is needed. The client should be referred for an evaluation to determine what is causing the elevated suicide question on the PHQ and a plan set up to address whatever the identified issue is. Document the responses in the client file.

If a client responds "**yes or in a manner that is concerning**" to having a suicide plan with high probability then a DCR should be contacted to evaluate the person further. Having a history of suicide attempts is a concern if the attempts are recent or in addition with having a plan and the intent to carry it out. Use of the Columbia Suicide Severity Rating Scale may be more objective and easier to determine who is a concern and who needs an immediate referral to a DCR.

Determine who else needs to be notified (family, caregiver, or provider/s). You can break confidentiality due to a safety concern.

Document the responses and any actions taken.

* *Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults.* (2012). Rockville, MD: Substance Abuse and Mental Health Services Administration. **Retrieved November 21, 2017 from https://www.ncoa.org/wp-content/uploads/Older-Americans-Issue-Brief-4_Preventing-Suicide_508.pdf**

NEXT STEPS

- Make sure the client has signed the Participation Authorization and Information Sharing Consent form indicating consent to disclose mental health information.
- For immediate crisis intervention call 9-1-1. Have the client's address and phone number available for your report.
- Stay with the client until a family member, client representative, DCR, emergency responder, or law enforcement arrives.
- Consult with your supervisor either on the phone for emergencies or in person for non-emergencies. Document the results of the screening and all actions taken.
- Follow up with phone calls or face-to-face visits with the client, family members, or client representative to discuss outcomes from hospitalizations and/or treatment and counseling. Using a person-centered approach review the Health Action Plan with the client to see if it could be revised to include goals and actions steps to better manage depressive symptoms.

RESOURCES

Chronic Illness and Mental Health: Recognizing and Treating Depression: https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

Columbia-Suicide Severity Rating Scale (C-SSRS): http://cssrs.columbia.edu/

Evaluation and Triage Card: Safe-T Card: https://adaa.org/sites/default/files/SMA09-4432.pdf

National Suicide Prevention Lifeline: 1-800 273-8255 (TALK)

Patient Health Questionnaire – 9 (PHQ-9): https://www.phqscreeners.com/

SAMHSA Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults: https://acl.gov/sites/default/files/programs/2016-11/Issue%20Brief%204%20Preventing%20Suicide.pdf