

Zeroing In: Integrating Suicide and Overdose Prevention

Module 2: Mental Health and SUD Screening in Behavioral Health Settings

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Presented by Christa Labouliere, PhD & Tom McCarry, LMHC



Please take a brief pre-training survey:



Objectives

- Integrate universal screening approaches for BH/SUD settings
- Review key screening tools and best practices for use



Recap: Module 1

- ✓ Suicide and overdose have shared risks, complexities, protective factors, and opportunities for prevention
- ✓ Any substance is associated with an increased risk for suicidal behavior/deaths and unintentional/intentional overdoses
- ✓ Helpful to consider intentionality on a continuum, as opposed to all or none
- ✓ Accurate assessment and effective treatment should address suicide, substance misuse, and mental health **together**

Overview: Module 2

- Zero Overdose & Zero Suicide Frameworks
- Universal Screening Overview
- Deep dive into select Screening Tools
 - Best Practices
 - Mental Health
 - Substance Use / Overdose
 - Suicide
- Review & Next Steps

Zero Overdose Framework

Preventing Overdose Events Through Screening and Safety Planning –
Starting with Screening



SCREENING

Screening identifies those at risk, allowing for personalized safety plans



SAFETY PLANNING

Safety plans address substance use, mental health, and social factors



SUPPORT

Collaboration among professionals and communities strengthens prevention efforts

Zero Suicide Framework

Preventing suicide events through systems-based improvement and tailored suicide-specific care – **Starting with Screening**





Suicide and substance use are not “moral failings” or “weakness”

- ❖ Both occur when people are overwhelmed, in intolerable situations, and do not have better ways to cope
- ❖ Our job is to understand what the substance is doing for the person
- ❖ People turn to substances to manage trauma, anxiety, depression, and more
- ❖ Treating substance use and suicide means treating the pain underneath

American Psychiatric Association (2013)

Universal Screening

- Suicidal thoughts and substance misuse are ***treatable***... But we can only help if we know about it
- Mental Health Disorders + Substance Use Disorder frequently co-occur
 - MH settings should screen for substance use/SUD settings should screen for MH
 - Co-occurring disorders should be treated in an integrated manner
 - Unidentified MH or substance use concerns adversely affect prognosis
- Both MH and SUD populations are at much higher risk for suicide or overdose than the general population
- Suicide and overdose prevention is *everyone's* business (*not just clinicians!*)
- **Screening = Early detection, engagement, and prevention**

When to Screen & Rescreen

Risk fluctuates over time—a negative screen today does not mean no risk tomorrow.

At intake / first contact

Screen all clients in BH/SUD care for depression, substance use, suicide, and overdose risk (universal screening).

At regular intervals

Re-screen on a consistent schedule (e.g., at least annually for lower-risk clients; more often in higher-risk programs or per agency policy).

Whenever risk changes

New/worsening symptoms, major losses or stressors, new trauma, relapse or overdose, ED/hospital visit, incarceration, or change in level of care.

For clients already identified as at risk

Use a brief tool (e.g., C-SSRS, ASQ, Overdose Risk Tool) at every encounter until risk meaningfully decreases.

Before discharge / transitions

Re-assess risk, update safety or overdose plans, and ensure warm handoffs and follow-up appointments.

Common Challenges & Barriers to Universal Screening

1	Time & workflow pressure: Competing demands make screening feel hard to fit in.
2	Limited training & confidence: Staff may feel unsure how to ask or what to do after a positive screen.
3	Unclear follow-up pathways: Lack of clear protocols or crisis resources can create hesitation.
4	Client mistrust & fear of consequences: Worries about hospitalization, child welfare, or legal implications can limit disclosure.
5	Stigma & myths: Persistent belief that asking increases risk (it does not).
6	Structural inequities: Fewer culturally responsive tools and supports for BIPOC, LGBTQ+, rural, and disabled clients.
7	EHR-related barriers: Screening tools may be hard to locate, not embedded in workflow, lack auto-scoring, or fail to trigger follow-up prompts.

Who Needs Extra Attention in Screening?

Youth & young adults

Suicide is a leading cause of death for ages 10–34.

LGBTQ+ youth

39% of LGBTQ+ youth and 46% of transgender / nonbinary youth seriously considered suicide in the past year.

BIPOC communities (especially AI/AN)

Suicide rate among American Indian/Alaska Native people is ~91% higher than the U.S. population.

Veterans & service members

In some states, Veterans account for >11% of suicides, with rates ~29 per 100,000.

Pregnant & Postpartum clients

Suicide and drug-related deaths are leading contributors to maternal mortality in the U.S.

Older adults

Suicide deaths have recently increased among adults 65+; rates are particularly high for older men.

Diagnostic Overview of SUD

Substance Use is a pattern of substance use that may cause harm, whereas **Dependence** involves physiological tolerance and withdrawal. Not every use is a disorder.



Substance Use

May include occasional or risky use without meeting criteria for a disorder

Substance Use Disorder (DSM-5-TR)

A problematic pattern of use leading to clinically significant impairment or distress, as manifested by two or more of the 11 criteria across 4 domains occurring within a 12-month period:

1. Impaired control
2. Social impairment
3. Risky Use
4. Pharmacological (tolerance/withdrawal)

American Psychiatric Association (2013)

Screening Tools Overview

Mental Health		Substance Use	
Adults: ● PHQ-9* ● GAD-7* ● PCL-5 ● DSM-5 SR L1 ● CCSM Youth: ● PHQ-A or CDI-2 ● SCARED ● CAPS-CA-5 ● PSC	Suicide Risk: ● C-SSRS ● ASQ	Adults: ● BAM ● ASSIST ● AUDIT* Youth: ● CRAFFT ● ASSIST-Y	Overdose Risk: ● Overdose Risk Tool

**Measure often also used with youth*

Best Practices for Screening

How to Screen:

- **DO NOT BE AFRAID TO ASK!** Screening does not “put ideas in people’s heads”
- **Have a conversation;** don’t complete a form
- Ask if it’s ok and if they say no, explore their reasons why
- Ask the questions **warmly, directly, and matter-of-factly** as you would ask any other questions
- Try to achieve the “sweet spot” between over- and under-reaction
- Administer self-reports and ask screening questions in a **private location**
- Always review and discuss the information from screeners during your session (even for self-reports)
- Integrate clinician-administered screens into your regular clinical interview or session dialogue
- Try to problem-solve barriers, give psychoeducation, and set expectations upfront

Best Practices for Screening

Do not...

- ✗ treat screening as something you “have to do”
- ✗ read from the form or computer
- ✗ ask the questions in a rote manner
- ✗ fill out the form in front of them or do so unobtrusively
- ✗ need to ask the questions verbatim
- ✗ automatically assume they’ll be willing to answer

Assessment is how you begin to inform your subsequent treatment. **Think of the screener as a means of obtaining life-saving information.**

Be familiar with the questions so you can ask them naturally, and **be able to explain the concepts.**

Experiences of **trauma or systematic oppression** can lead to fear or difficulty trusting, which influence clients’ and families’ ability or willingness to open up.

What does a trauma-informed, client-centered approach to screening look like?

1

Focus on the
"spirit of the law"
– be a good
clinician (and
human) first!

2

Communicate
that the client is
in the driver's
seat

3

Make clear that
they have
choices

4

Remember the
difficulty of
reaching out for
help

Mental Health Screening Tools

Why it matters:

- Depression and anxiety are the most common co-occurring conditions with SUD.
- Untreated mental health conditions increase the risk of relapse, overdose, and suicide.
- Early detection allows providers to tailor interventions (therapy, medication, safety planning).
- **Screening ensures that underlying conditions are addressed, not just substance use.**

Adult:

- PHQ-9
- GAD-7
- PCL-5
- DSM-5 SR L1 CCSM

Youth:

- PHQ-A or CDI-2
- SCARED
- CAPS-CA-5
- PSC

Patient Health Questionnaire-9 (PHQ-9)

- **Population/Use:**
 - Screens adults (and sometimes adolescents) in behavioral health and primary care for depression
 - Item 9 assesses suicide risk
 - PHQ-A for adolescents or CDI-2 for 7+
- **Positive Screen:** Score ≥ 10 = moderate/severe depression; any response >0 on item 9 = suicide risk
- **Prevalence:** 10-20% in primary care

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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Kroenke et al. (2001); American Psychological Association (n.d.)

<https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf>

Generalized Anxiety Disorder-7 (GAD-7)

- **Population/Use:** Screens adults (and sometimes adolescents) in behavioral health and primary care for anxiety
- **Positive Screen:** Score ≥ 10 indicates moderate anxiety; ≥ 15 suggests severe anxiety
- **Prevalence:** ~8-15%

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals: _____ + _____ + _____ + _____ = _____
Total score: _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

*Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at adaa@spitzer.edu. PRIME-MD is a trademark of Pfizer Inc. Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

- 0-4: minimal anxiety
- 5-9: mild anxiety
- 10-14: moderate anxiety
- 15-21: severe anxiety

PCL-5 (PTSD Checklist for DSM-5-TR)

- **Population/Use:** Adult screening for trauma severity & PTSD symptoms
- **Positive Screen:** Score $\geq 31-33$ = probable PTSD
- **Prevalence:** 12%

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, place, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being "superalert" or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

Weathers, F.W., et al. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. Scale available from the National Center for PTSD at www.ptsd.va.gov.

Additional Screeners

Broad Range Symptoms

- **DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure**: Adult MH screen for depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors/OCD, dissociation, personality functioning, and substance use

Youth Measures

- **PHQ-A or CDI-2** for depression screening
- **Screen for Child Anxiety Related Emotional Disorders (SCARED)** for anxiety screening
- **Clinician Administered PTSD Scale for DSM-5 - Child Adolescent Version (CAPS-CA-5)**: Screening for trauma severity & PTSD symptoms
- **CRAFFT**: Adolescents and young adult substance abuse screening (ages 12–21)
- **Pediatric Symptom Checklist (PSC)**: Broad psychosocial screen (attention, externalizing, internalizing)

Special Populations

- **Edinburgh Postnatal Depression Scale (EPDS)**: Perinatal and postpartum depression and anxiety screening

A Deeper Dive

Diagnostic Assessments and more comprehensive tools

- **Beck Depression Inventory-II (BDI-II)**
- **Hamilton Depression Rating Scale (HDRS)**
- **Composite International Diagnostic Interview (CIDI) or Structured Diagnostic Interview for DSM-5 (SCID-5):** Diagnostic assessment for adults and adolescents, but not typically used due to length

Helpful APA website - DSM-5 Online Assessment Measures:

- Level 1 Cross-Cutting Symptom Measures
- Level 2 Symptom Specific Measures
- Disorder-Specific Severity Measures
- Disability Measures
- Personality Inventories
- Early Development and Home Background
- Cultural Formulation Interviews

Substance Use Screening Tools

Why it matters:

- Substance use disorders increase the risk of overdose, accidents, medical complications, and suicide.
- Fentanyl and other synthetics have made overdose risk much higher, even with non-opioid drugs (e.g., counterfeit pills, laced cannabis).
- Many people use substances to cope with untreated mental health issues or trauma — screening helps identify this cycle.
- **Substance use and overdose risk screening are essential for prevention, safety planning, and linking clients to harm reduction and treatment.**

Adults:

- BAM
- ASSIST
- AUDIT*

Youth:

- CRAFFT
- ASSIST-Y

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

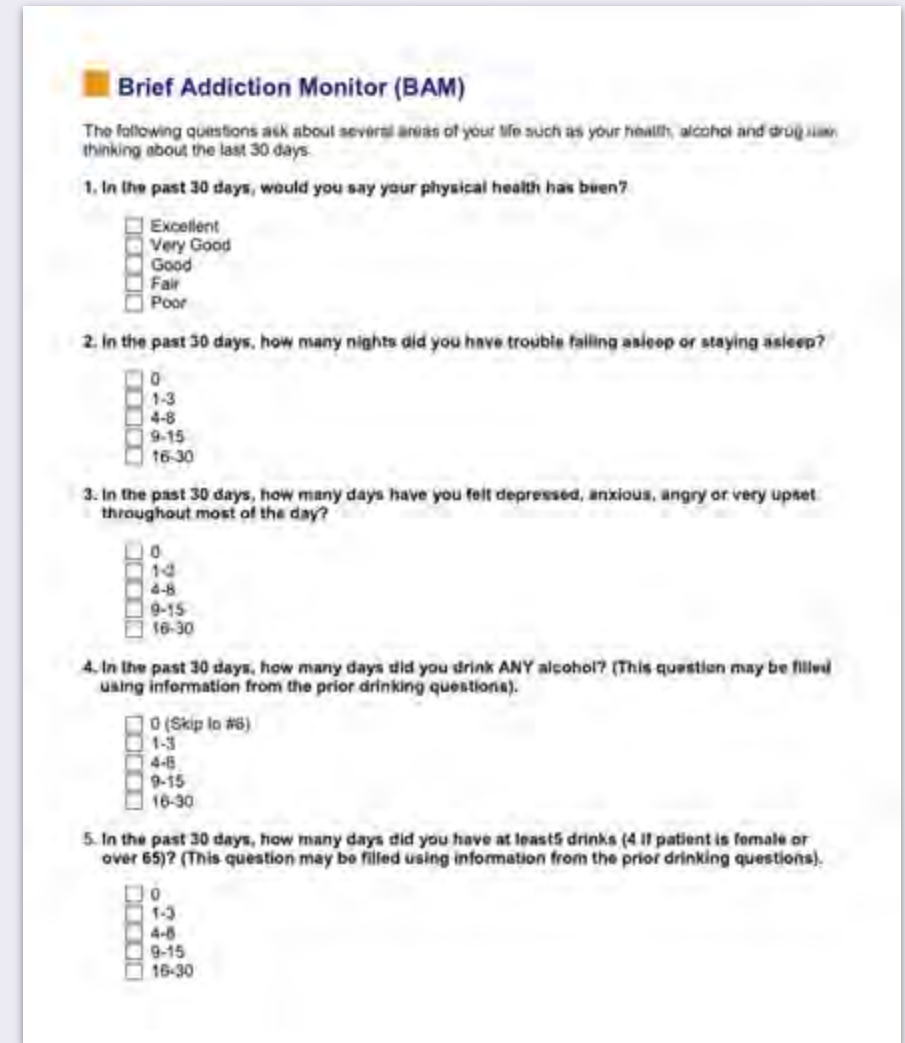
- **Population/Use:** Screen adults with use risk across all substances (drugs, alcohol, tobacco etc.)
- **Positive Screen:** Substance-specific cutoffs (e.g., alcohol ≥ 11 = high risk)
- **Prevalence:** 10-25%

Questionnaire	Baseline Med (IQR)	Follow-up Med (IQR)
ASSIST [†] (alcohol and substance use)		
Highest score*	17.5 (15-24)	6 (6-8)
Alcohol	17.5 (15-23)	6 (6-8)
Cannabis	0 (0-6)	0 (0-6)
Amphetamines	0 (0-0)	0 (0-0)
CES-D (depression)	23.5 (18-34)	17 (13-22)
FTND ^{††} (nicotine dependence)	2 (2-4)	1 (1-2)
EQ-5D 3L (health status)		
Descriptive elements	5.5 (5-7)	5 (5-5)
Visual analogue scale	70 (57-80)	90 (80-100)
SHS (disability)		
Work/School	0 (0-3)	0 (0-0)
Social life	2.5 (0-5)	0 (0-3)
Family life/home responsibilities	4 (0-7)	0 (0-3)
SRQ-20 (psychological distress)	8 (4-10)	3 (1-4)
SOCRATES (readiness for change)		
Recognition	20 (19-22)	15 (15-19)
Ambivalence	13 (11-15)	8 (4-10)
Taking steps	35 (32-39)	40 (38-40)
MDSPSS (social support)		
Significant other	8 (4-10)	3 (1-4)
Family	7 (6-7)	7 (6-7)
Friends	6 (4-6)	5 (4-6)
Total	6 (5-6)	6 (6-7)

Weathers et al. (2013)

Brief Addiction Monitor (BAM)

- **Population/Use:** Tracks recovery progress across substance use (frequency, type, risk) risk factors (cravings, psychiatric distress, triggers), and protective factors (support, housing stability, engagement in recovery activities) for adults in SUD treatment
- **Frequency:** Monthly or every 2–4 weeks early in care
- **Positive Screen:**
 - Higher scores in risk domains = need for intervention
 - Higher scores in protective domains = recovery progress
- **Next steps:** Use trends to adjust care plan; escalate supports if risk domain rises



Brief Addiction Monitor (BAM)

The following questions ask about several areas of your life such as your health, alcohol and drug use, thinking about the last 30 days.

1. In the past 30 days, would you say your physical health has been?
 - ☐ Excellent
 - ☐ Very Good
 - ☐ Good
 - ☐ Fair
 - ☐ Poor
2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?
 - ☐ 0
 - ☐ 1-3
 - ☐ 4-8
 - ☐ 9-15
 - ☐ 16-30
3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?
 - ☐ 0
 - ☐ 1-3
 - ☐ 4-8
 - ☐ 9-15
 - ☐ 16-30
4. In the past 30 days, how many days did you drink ANY alcohol? (This question may be filled using information from the prior drinking questions).
 - ☐ 0 (Skip to #6)
 - ☐ 1-3
 - ☐ 4-8
 - ☐ 9-15
 - ☐ 16-30
5. In the past 30 days, how many days did you have at least 5 drinks (4 if patient is female or over 65)? (This question may be filled using information from the prior drinking questions).
 - ☐ 0
 - ☐ 1-3
 - ☐ 4-8
 - ☐ 9-15
 - ☐ 16-30

Cacciola, J. S., et al. (2013).

Overdose Risk Questionnaire

- **Population/Use:** Assesses overdose risk for individuals across opioid and non-opioid drug use history and patterns
- **Best practice:** Use alongside Overdose Safety Plan to identify patterns that increase risk and proactively take steps to address them

Overdose Risk Questionnaire

While all substance use carries some risk, we also know that risk varies greatly depending on what, how, and when someone uses. We care about your wellness and want to better understand your experiences. After completing this screener, we will collaborate to develop a safety plan that fits you where you are now. Please select all that apply from the lists below.

Recent Opioid or Substance Use Associated with an Increased Risk of Accidental Overdose	
☐	Opioids such as pain medication, fentanyl, methadone, or heroin, etc., even occasionally or as prescribed
☐	Non-opioid substances or medications obtained illicitly, such as Xanax®, cocaine, MDMA, etc., even occasionally

Drug Overdose History	
☐	Accidental drug overdose
☐	More than one accidental drug overdose
☐	Intentional use of drugs to overdose

Health and Wellness	
☐	Do you have any health concerns that could impact your risk of overdose? (e.g., liver, immune, eye, or respiratory issues)
☐	Have you had any recent stressors that may impact your risk of overdose? (e.g., loss of a loved one, financial hardship, relationship issues, or incarceration)
☐	Are there any other factors that you believe may impact your risk of overdose? Please describe below.

Pattern of Use: What, How, and When	
☐	Using substances of different strengths or quality
☐	Using when feeling rushed, afraid, or in unfamiliar surroundings
☐	Using when you are alone
☐	Using when having suicidal thoughts or not caring if you wake up
☐	Using substances through an intravenous line (IV) or a needle
☐	Changing how you use substances (e.g., snorting, smoking, or swallowing)
☐	Using more than one substance at the same time or within a short period of time
☐	Using other substances while under the influence of alcohol

NOTES:

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Suicide Screening

Why it matters:

- Suicide and overdose are leading causes of death for behavioral health populations
- Suicide and overdose often overlap (intentional overdoses, “I didn’t care if I woke up”)
- ***Risk fluctuates over time***, so asking regularly increases the likelihood of identification
- Standardized screening identifies ***up to 60%*** more than informal methods
- Most individuals who die by suicide or overdose saw a provider within the prior year, but *were not screened*
 - ***Standard of care in behavioral health settings***

Suicide:

- C-SSRS (6+)
- ASQ (8+)

Universal screening saves lives by detecting risk in patients who may not disclose it voluntarily

Columbia Suicide Severity Rating Scale (C-SSRS)

- **Population/Use:** Universal safety screening (ages 6+) when symptoms are present, any positive PHQ item-9, SUD, ED/urgent care encounters, or per clinic protocol
- **Frequency:** At the visit when risk emerges (positive PHQ, crisis, intoxication, major stressor); re-check every encounter until stable
- **Research:** Validated in multiple studies; adopted by NIMH and SAMHSA
- **Positive Screen:** Any endorsement of suicidal ideation/behavior prompts further risk stratification

Columbia Suicide Severity Rating Scale (C-SSRS) - Screener -

	PAST MONTH
Ask questions 1 and 2.	
1. Have you wished that you could go to sleep and never wake up or that you were dead?	
2. Have you thought about killing yourself?	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.	
3. Did you think about ways you could kill yourself?	
4. Some people think about killing themselves but know they would NEVER do it. Others think about killing themselves and think that they might do something. Was there a time when you thought about killing yourself and it was something you MIGHT do, even if you weren't completely sure?	
5. Did you make a plan for how you would kill yourself (things like when, how, and where) and, even if you weren't completely sure when you made this plan, was it something that you thought you MIGHT do?	
Always ask question 6.	
6. Have you EVER tried to kill yourself, started to do something to kill yourself or done anything to get ready to kill yourself?	
If YES, was this in the past 3 months?	
Examples: took pills, tried to shoot yourself, cut yourself or hang yourself, 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, wrote, or sent a goodbye message, did research on the internet about killing yourself, or got what you needed to kill yourself, etc.	

Low Risk
 Moderate Risk
 High Risk

Columbia Suicide Severity Rating Scale (C-SSRS)

Be prepared to simplify constructs or explain in different language. All questions are asked on a dichotomous yes/no scale.

#1. Wish to be Dead/Passive Ideation: “Passive ideation” (e.g., wish to be dead or not alive anymore, wish to fall asleep and not wake up) *without* thinking of suicide specifically

Have you wished you were dead?

Have you wished you could go to sleep and not wake up?

Have you thought about being dead or what it would be like to be dead?

Do you ever wish you weren’t alive anymore?

Have you felt that you or your family would be better off if you were dead?

#2. Non-Specific Active Suicidal Thoughts: General non-specific thoughts of wanting to kill oneself, without specific thoughts of ways to kill oneself, associated *methods, intent, or plan*

Have you had thoughts of killing yourself?

Have you thought about doing something to make yourself not alive anymore?

If the answer to **both** is NO:

Skip to question 6 (suicidal behavior)

If the answer to Q2 is YES:

Ask questions 3-6

C-SSRS: Severity of Suicidal Ideation

#3. Active Suicidal Ideation with Any Method (without specific plan or intent to act): Active thoughts of killing oneself including at least one method, but the thoughts do not include intention to act or a specific plan with time, place, or method details worked out

Have you been thinking about how you might do this? What did you think about?

Have you thought about how you would kill yourself?

Have you thought about how you would make yourself not alive anymore?

#4. Active Suicidal Ideation with Some Intent to Act (without specific plan): Active thoughts of killing oneself and some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them”

When you have these thoughts of killing yourself, do you intend to act on them or do something to make it happen?

When you thought about making yourself not alive anymore or killing yourself, did you think that this was something you might actually do? This is different from having the thoughts but knowing you wouldn't do anything about it.

#5. Active Suicidal Ideation with Specific Plan and Intent: Active thoughts of killing oneself with details of plan fully or partially worked out and has some intent to carry plan out

Have you ever decided how or when you would make yourself not alive anymore/kill yourself?

Have you started to work out the details of how to kill yourself? Do you intend to carry out this plan? Have you ever planned out how you would do it? What was your plan?

When you made this plan, was any part of you thinking about actually doing it?

C-SSRS: Suicidal Behavior

#6. *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

There are different types of suicidal behavior:

- **Suicide attempt:** A self-injurious act committed with at least some intent to die
 - Have you made a suicide attempt (took an action to end your life)?*
 - Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*
 - Did you ever hurt yourself on purpose? Why did you do that? Did you _____ as a way to end your life?*
 - Did you want to die (even a little) when you _____?*
 - Were you trying to make yourself not alive anymore when you _____?*
 - Did you think it was possible you could have died from _____?*
- **Interrupted or aborted attempt:** Taking steps to end one's life, but someone or something else stops them (interrupted) or they stop themselves
 - Has there been a time when you started to do something to (make yourself not alive anymore, end your life, kill yourself) but someone or something stopped you before you actually did anything? What did you do?*
 - Has there been a time when you started to do something to (make yourself not alive anymore, end your life, kill yourself) but you changed your mind or stopped yourself before you actually did anything? What did you do?*
- **Preparatory behavior:** Taking action necessary to end one's life, collecting or buying pills, purchasing a gun, writing a will or suicide note
 - Have you done anything to get ready to (make yourself not alive anymore, end your life, kill yourself) – Like giving things away? Writing a goodbye note or post? Getting things you need to kill yourself?*

Screening for Non-Suicidal Self-Injury

- NSSI is relatively common in young people – up to 30% of community youth and 50-90% of youth in mental health treatment
- The difference is **intent**: careless or reckless behavior could be indicative of poor judgment and impulse control, or could be a suicide attempt.
- The C-SSRS screener does **NOT** ask about reckless behavior or non-suicidal self-injury, **but you should!**

Have you ever done something dangerous or reckless where you did not care if you got hurt?

(Example: Riding in a car with a drunk driver, climbing a cliff or water tower without safety equipment, taking drugs without knowing what they were, etc.)

Have you ever done something that other people thought was dangerous or were worried that you would get hurt, even if you didn't think so?

(Example: Unintended self-harm from delusions, reckless behavior they don't acknowledge as dangerous, etc.)

Have you ever done anything to hurt yourself on purpose without intending to kill yourself?

(Example: Cutting, scratching, burning, or banging the body for any reason other than killing oneself – to regulate emotions, communicate pain, “feel something,” etc.)

Tips for Weekly (or Frequent) Screening

If a client is determined to be at elevated risk for suicide, they should be screened at every encounter until risk drops. This can be awkward if not handled well.

Always explain why you are asking frequently – e.g., share that you didn't forget, but suicidal states fluctuate, so it's important to touch base often

Be conversational – treat it like a “check-in” about any other symptom at the start of session

- Start open-ended then follow-up about suicide specifically
- *How have things been going? When you say X, are you referring to the suicidal/self-harm thoughts we talked about before?*
- *I wanted to check-in about the thoughts you said were having. How have they been?*

It's ok to start with what you know and assess changes:

- *I know in the last few weeks you said that you've been having thoughts of overdosing; have there been any changes since we last spoke about it?*
- Always assess changes in intent, but changes in frequency, intensity, and duration are also relevant

If a client is reluctant, be curious, not commanding

- **Why are they reluctant?**

- Other things are more important to them
- They feel like that's in the past and they want to move on
- Makes them feel “othered” or “crazy”
- Fear of hospitalization or clinician response
- Difficult to talk about or manage symptoms
- Feels perfunctory or not client-centered

- **Is there a way to address their concerns?**

- Be genuine and honest
- Realize that there are no words to “make” them trust you or realize you're different than past providers – you have to earn it with your behavior over time
- Acknowledge their autonomy and agenda
- Agree to setting aside a certain portion of time dedicated to the issues the client wants to discuss
- Provide psychoeducation about the fluctuation of suicidal states, that they are common for folks going through difficult times, and that you're asking so you can help
- Emphasize that they are the expert in their symptoms and that you want to engage in shared decision-making
- Discuss explicitly that “checking in” frequently about suicidal thoughts is the best way to keep them safe in the least restrictive environment – we do not want to hospitalize unnecessarily
- Discuss levels of care and options *other* than hospitalization (e.g., peer support, respite, voluntary crisis stabilization centers, mobile crisis, hotlines, etc.)
- Teach skills to manage symptoms or help them regulate in real-time

Best practices for screening

What to do next:

- Negative screen → Re-assess at regular intervals (symptoms fluctuate)
- Positive screen →
 - + Additional symptom screens for deeper information
 - + Diagnostic interview and/or symptom/functional review
 - + Comprehensive risk assessment (*more on this next time!*)
 - + Safety check and safety planning/brief interventions if indicated
 - + Refer to MH/SUD treatment and/or psychiatry consult (“warm hand-offs”)
 - + Shared decision-making re: treatment options
 - + Ensure treatment and follow-up plan are documented
 - + Follow-up monitoring

Review of Module 2

- ✓ Universal Screening is a critical in identifying risk for suicidality/overdose.
- ✓ Mental Health Disorders and Substance Use Disorder commonly overlap.
- ✓ Positive screening can help providers implement life-saving interventions such as Overdose Safety Planning.

Join us for Module 3



SIPPS Module 3:
Risk Assessment for Suicide and
Overdose (*including the difference
between screening and risk
assessment*)

**Thursday Jan 8, 2026
12:30pm – 2:30pm ET**



Post-Training Survey:
Please complete this brief survey.
Your responses help us evaluate and
improve our programs. All data is
confidential and reported in
aggregate.

Key Screening & Safety Planning Resources

Zero Suicide Toolkit – “Identify: Screening & Assessment”

Practical guidance for universal suicide risk screening in health and behavioral health systems. (zerosuicide.edc.org → Toolkit → *Identify*).
[Zero Suicide+1](#)

Zero Overdose – Overdose Safety Planning Tools

Overdose Risk Questionnaire and Overdose Safety Plan templates referenced in this training. (zerooverdose.org).

SAMHSA ORCCA Practice Guide

Opioid-Overdose Reduction Continuum of Care Approach – national guidance on overdose prevention and safety planning. (samhsa.gov → ORCCA). [Zero Suicide](#)

SAFE-T Suicide Assessment Five-Step Evaluation and Triage

Pocket guide for suicide risk assessment, intervention, and documentation. (SAMHSA publication PEP24-01-036).

APA DSM-5 Online Assessment Measures

Download PHQ-9, GAD-7, PCL-5, cross-cutting, youth, and disorder-specific tools. (psychiatry.org → DSM → Assessment Measures).
Module 2_ Mental Health and SUD...

988 Suicide & Crisis Lifeline

Call or text **988** or chat at 988lifeline.org for 24/7 crisis support; **Veterans press 1** for the Veterans Crisis Line. [Veterans Crisis Line](#)

The Trevor Project – LGBTQ+ Youth Crisis Support

24/7 text, chat, and phone support plus education resources for LGBTQ+ young people. (thetrevorproject.org). [The Trevor Project+1](#)

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