In service to the PATIENT, COMMUNITY *and* MEDICINE *since 1879.*

Suicide Prevention Blueprint Style

Vermont Blueprint Conference
Lake Morey
20th October 2014

Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

FletcherAllen.org

Suicide is a public health concern

- Over 38,364 died by suicide in U.S. (2010)
  12.43 per 100,000
- 2nd leading cause of death for college students
- Half of people who die by suicide saw PCP in previous month…70% among older men
- 30% of people who died by suicide saw MHP in previous 30 days

www.zerosuicide.com

Suicide is a public health concern

- 8th leading cause of death in Vermont
- Vermont has highest suicide rate New England 16.94 in 100,000 (versus 12.43 U.S.)
- 23-25% of those who die by suicide in Vermont have sought and received MH care in CMHC's

www.zerosuicide.com

You Can Make a Difference

- Blueprint is helping to build:
- "A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems."
- We need to treat suicide directly - no matter what the diagnosis.
- www.zerosuicide.com

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Chittenden County Community Health Team Suicide Screening

Diane Collias, LICSW
Pam Farnham, RN
Community Health Team

Multidisciplinary CHT

Licensed Independent Clinical Social Workers
Registered Nurses
Registered Dieticians
Health Coaches

CHT Intake Assessment

- All members of the CHT complete the same intake process with new patients
  - General Health Screen
  - GAD-7
  - Alcohol Use Disorders Identification Test: Self-Report Version (AUDIT)
  - PHQ-9

General Health Screen

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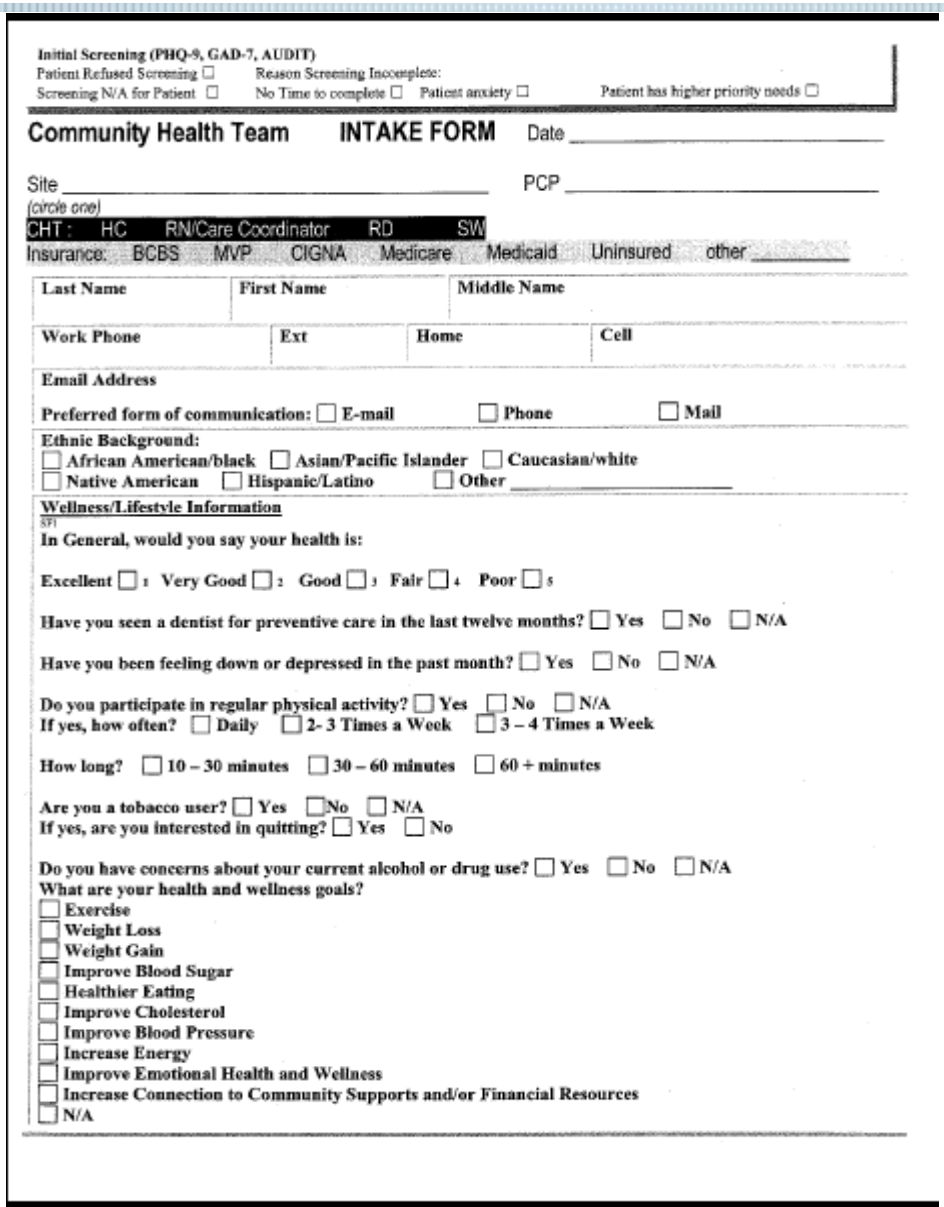

Initial Screening (PHQ-9, GAD-7, AUDIT)
Patient Refused Screening ☐ Reason Screening Incomplete:
Screening N/A for Patient ☐ No Time to complete ☐ Patient anxiety ☐ Patient has higher priority needs ☐

Community Health Team INTAKE FORM Date _____

Site _____ PCP _____
(circle one)
CHT : HC RN/Care Coordinator RD SW
Insurance: BCBS MVP CIGNA Medicare Medicaid Uninsured other _____

Last Name	First Name	Middle Name

Work Phone	Ext	Home	Cell

Email Address

Preferred form of communication: ☐ E-mail ☐ Phone ☐ Mail

Ethnic Background:
☐ African American/black ☐ Asian/Pacific Islander ☐ Caucasian/white
☐ Native American ☐ Hispanic/Latino ☐ Other _____

Wellness/Lifestyle Information
SFI
In General, would you say your health is:

Excellent ☐ 1 Very Good ☐ 2 Good ☐ 3 Fair ☐ 4 Poor ☐ 5

Have you seen a dentist for preventive care in the last twelve months? ☐ Yes ☐ No ☐ N/A

Have you been feeling down or depressed in the past month? ☐ Yes ☐ No ☐ N/A

Do you participate in regular physical activity? ☐ Yes ☐ No ☐ N/A
If yes, how often? ☐ Daily ☐ 2- 3 Times a Week ☐ 3 – 4 Times a Week

How long? ☐ 10 – 30 minutes ☐ 30 – 60 minutes ☐ 60 + minutes

Are you a tobacco user? ☐ Yes ☐ No ☐ N/A
If yes, are you interested in quitting? ☐ Yes ☐ No

Do you have concerns about your current alcohol or drug use? ☐ Yes ☐ No ☐ N/A
What are your health and wellness goals?
☐ Exercise
☐ Weight Loss
☐ Weight Gain
☐ Improve Blood Sugar
☐ Healthier Eating
☐ Improve Cholesterol
☐ Improve Blood Pressure
☐ Increase Energy
☐ Improve Emotional Health and Wellness
☐ Increase Connection to Community Supports and/or Financial Resources
☐ N/A

GAD-7

developed by Dr. Robert L Sptizer, Dr. K. Kroenke, et al

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How often during the past 2 weeks have you felt bothered by:

1. **Feeling nervous, anxious, or on edge?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

2. **Not being able to stop or control worrying?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

3. **Worrying too much about different things?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

4. **Trouble relaxing?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

5. **Being so restless that it is hard to sit still?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

6. **Becoming easily annoyed or irritable?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

7. **Feeling afraid as if something awful might happen?**
   - 0 = not at all
   - 1 = several days
   - 2 = more than half the days
   - 3 = nearly everyday

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

Scoring: Add the results for question number one through seven to get a total score.

If you score 10 or above you might want to consider one or more of the following: discuss your symptoms with your doctor, contact a local mental health care provider or contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

Alcohol Use Disorders Identification Test: Self-Report Version

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1. How often do you have a drink containing alcohol?

Never (0) Monthly or less (1) 2-4 times a month (2) 2-3 times a week (3) 4 or more times a week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4)

3. How often do you have six or more drinks on one occasion?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

9. Have you or someone else been injured because of your drinking?

No (0) Yes, but not in the last year (2) Yes, during the last year (4)

10.Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?

No (0) Yes, but not in the last year (2) Yes, during the last year (4)

PHQ-9
Nine Symptom Checklist

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Over the last 2 weeks, how often have you been bothered by any of the following problems?
Read each item carefully, and circle your response.

1. Little interest or pleasure in doing things
Not at all Several days More than half the days Nearly every day

2. Feeling down, depressed, or hopeless
Not at all Several days More than half the days Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much
Not at all Several days More than half the days Nearly every day

4. Feeling tired or having little energy
Not at all Several days More than half the days Nearly every day

5. Poor appetite or overeating
Not at all Several days More than half the days Nearly every day

6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
Not at all Several days More than half the days Nearly every day

7. Trouble concentrating on things such as reading the newspaper or watching television
Not at all Several days More than half the days Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
Not at all Several days More than half the days Nearly every day

9. Thinking that you would be better off dead or that you want to hurt yourself in some way
Not at all Several days More than half the days Nearly every day

If you checked off any problem on this questionnaire so far, 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

Next step
Social Work Staff

- If any suicidal ideation is indicated

  (several days, more than half the days, nearly every day) this triggers additional screening tool

Columbia-Suicide Severity Rating Scale

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SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***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.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***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) Suicide Behavior Question: ***Have you ever 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. **If YES, ask: *How long ago did you do any of these?*** ☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months?		

Columbia-Suicide Severity Rating Scale with Triage Points

(Linked to last item answered YES)

- Item 1 – Mental Health Referral at discharge
- Item 2 – Mental Health Referral at discharge
- Item 3 – Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
- Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
- Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
- Item 6 – If over a year ago, Mental Health Referral at discharge
- If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
- If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition:

- Mental Health Referral at discharge
- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
- Psychiatric Consultation and Patient Safety Monitor/ Procedures

Reading Hospital Response Protocol to C-SSRS Screening

(Triage points developed by Pumariega and Millsaps)

Disposition

- Option 1:
  - Mental heath referral at discharge
    - CHT LICSW assists in coordinating appointment with community mental health provider and/or with LICSW as appropriate

Disposition continued

- Option 2
  - Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/Procedures
    - LICSW assists pt with developing safety plan/procedures
    - Consult with treating or available medical provider (MD, PA, NP) at practice
    - Schedule clinic follow-up appointment with patient and/or to community-based mental health provider

Disposition continued

- Option 3
  - Psychiatric Consultation and Patient Safety Monitor/Procedures
    - Referral to Fletcher Allen Health Care Emergency Department or Howard Center Crisis Services
      - Inform treating provider of plan to refer to patient to Crisis/Emergency Department, coordinate referral with provider
    - LICSW assists with developing safety plan and coordinating logistics to Emergency Department/Crisis

Follow-up

- After Option 1, 2, or 3
  - CHT LICSW calls patient after discharge from Emergency Department or Crisis for wellness check and to determine mental health care plan
  - CHT LICSW remains available to patient as needed

Rationale for Integrating C-SSRS into practice

- Consistency among providers
- Evidenced-based triage planning
- Patient Education

Suicide Screening Process for other CHT disciplines

- RN, RD, and HC and non-licensed mental health providers, therefore follow a different protocol when patients indicate suicidal ideation

Chittenden County CHT Suicide Risk Screening Algorithm

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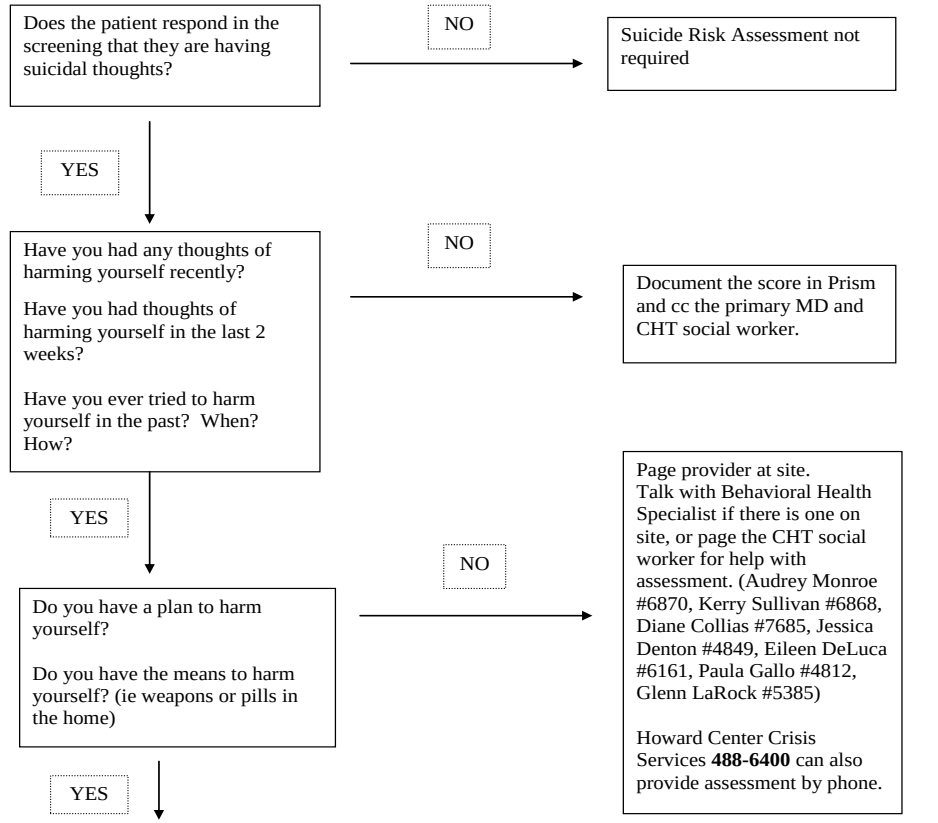
AMBULATORY SUICIDE RISK SCREENING



Plan: Crisis Referral

- Contact **Howard Center Crisis Services 802-488-6400**– For evaluation
- **FAHC Emergency Department (ED) 802-847-2434** or local Emergency Department* – Arrange for safe transport (if family cannot transport then a plan for local police or ambulance transport)
- If patient refuses – request Crisis on-site evaluation
- If patient leaves against medical advice – **Call 911 to alert police and Call Crisis at 802-488-6400**

The patient is suicidal

- Now what?

- Remember: Talking about suicide does NOT make someone more likely to act on suicidal impulses.

Elements of Evidence-based Suicide Prevention

- Safety Planning
- Problem-solving Therapies
- Collaborative Treatment
- Interventions Outside or After the Clinical Visit

Safety Planning

- Increasing chaos? Increase structure!
- All persons with suicide risk need to have a safety plan in hand when they leave care.
- Safety planning is collaborative and includes: aggressive means restriction, communication with family members and other caregivers, and regular review and revision of the plan.

Problem-Solving Therapies

- Research has shown that suicidal individuals have specific deficits in problem-solving, conceptualizing problems, and thinking through their situation.

- Structured, problem-solving therapies like cognitive behavioral therapy and dialectic behavioral therapy are effective treatments for suicidal individuals.

www.zerosuicide.com

Cognitive Behavioral Therapy

- Cognitive behavioral therapy (CBT) is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors.

- CBT is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations, and events.

- By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people can modify their patterns of thinking to improve coping.

CBT *for* Suicide Prevention

- CBT-SP was developed using a risk reduction, relapse prevention approach and theoretically grounded in principles of cognitive behavior therapy, dialectical behavioral therapy and targeted therapies for suicidal, depressed youth.

- CBT-SP consists of acute and continuation phases, each lasting about 12 sessions, and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

www.zerosuicide.com

Dialectical Behavior Therapy

- Developed by Marsha Linehan, Ph.D., ABPP, DBT is a comprehensive cognitive-behavioral treatment originally developed to treat chronically suicidal individuals suffering from borderline personality disorder.

- DBT is effective in reducing suicidal behavior, psychiatric hospitalization, treatment dropout, substance abuse, anger, and interpersonal difficulties.

http://behavioraltech.org/resources/whatisdbt.cfm

DBT

- The most thoroughly studied and efficacious psychotherapy for suicidal behavior.

- A cognitive-behavioral treatment approach with two key characteristics:

  1) behavioral, problem-solving focus blended with acceptance-based strategies

  2) an emphasis on dialectical processes.

Collaborative Treatment (CAMS)

- Collaborative Assessment and Management of Suicidality - CAMS is best understood as a therapeutic framework that emphasizes a unique collaborative assessment and treatment planning process between the suicidal patient and clinician.

- Outpatient care is the explicit goal of CAMS, which is designed to strengthen the therapeutic alliance and increase patient motivation.

www.zerosuicide.com

Interventions Outside or After the Clinical Visit . . . Follow up

- "Persons at suicide risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver."

- "Access to follow-up resources is critical both for augmenting the limited hours that clinic-based and private-practice care may be available and to address limited access to face-to-face follow-up care in some geographic areas.

http://zerosuicide.actionallianceforsuicideprevention.org

Follow up

- Virtual or remote care enables persons in crisis to access help 24-hours a day, 7-days a week. Examples include telephone connections to crisis hotlines, tele-counseling, short message services, and texting; and online access, using video counseling, crisis chat, self-assessment, and self-help.”

Make a Connection*

- Listen
- Be real
- Stay present
- Honor ambivalence
- Offer hope

* The first and most critical task in working with suicidal patients

Questions???

THANK YOU

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