COMMUNITY CARE
Behavioral Health Organization

A Non-profit Behavioral Health Managed Care Company

Teenagers and Suicide

04/30/10 - Pocono Medical Center

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In partnership with

PENNSYLVANIA AHEC
NORTHEAST REGION
www.nepaahec.org

AHEC
Area Health Education Center

- ***Enhancing access to health care through education***

  Community experiences for health professions students

  Promoting Health Careers

  Preceptor / health practitioner support

  Support of community partners

the Advocacy Alliance

Director of Advocacy and Community Mental Health Services
Kathy Wallace

Our mission is to promote mental well-being, support Recovery for adults who have a mental illness, Resiliency in children and adolescents who have emotional disorders and Everyday Lives for persons who have mental retardation and other developmental disabilities and provide to them advocacy and culturally competent services.

Scranton Administrative Office
846 Jefferson Avenue, P.O. Box 1368
Scranton, PA 18501 Toll Free: 1 (877) 315-6855
TTY: 1 (877) 962-5593
Wilkes-Barre, Pottsville, Allentown, Hershey
Bloomsburg,Lehighton

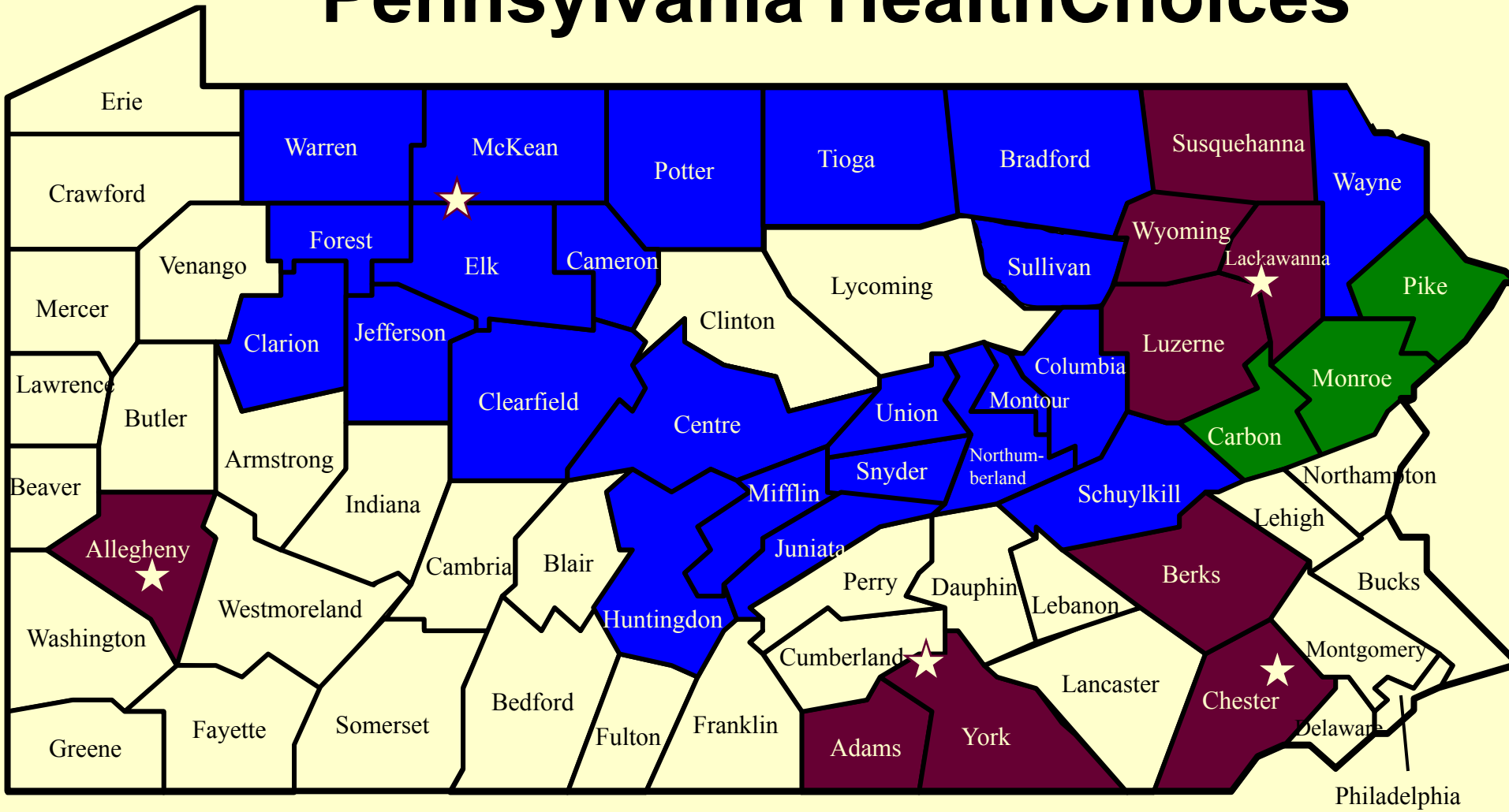
About Community Care…

- Founded in 1996
- Licensed 501 (c)3 (not-for-profit) behavioral managed care company
- Part of UPMC – an integrated health system in Western PA
- Major focus – publicly funded behavioral health care system
- Medicaid/HealthChoices membership – 600,000
- Commercial/Medicare membership - 400,000

Community Care Mission and Vision

- To improve the health and well-being of the community through the delivery of effective and accessible behavioral health services
- To improve the quality of services for members through a stakeholder partnership focused on outcomes
- To support high quality service delivery through a not-for-profit partnership with public agencies, experienced local providers, and involved members and families

Pennsylvania HealthChoices



☆ **Community Care Office**

Current Contracts

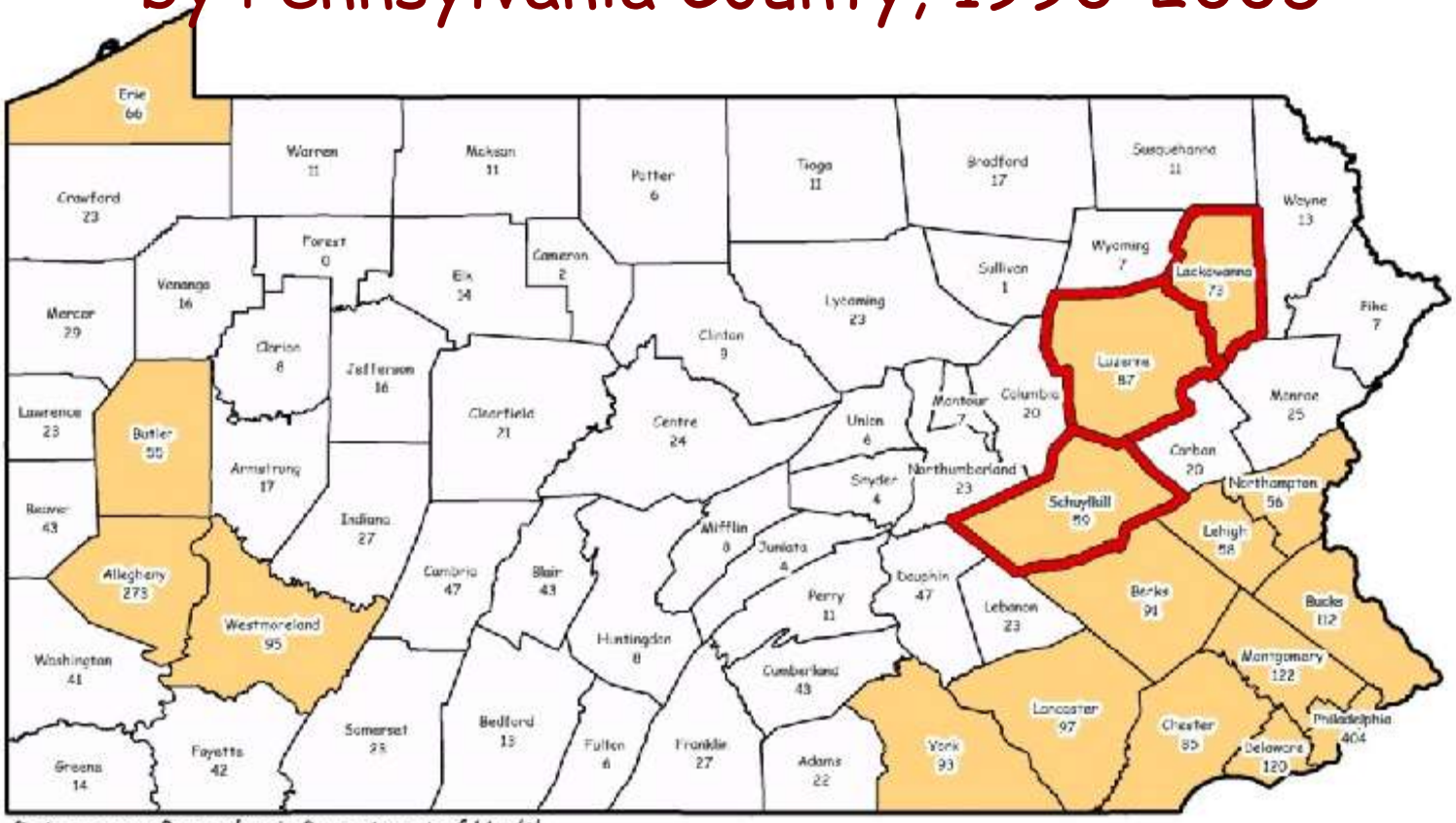
January 1, 2007 Implementation

July 1, 2007 Implementation

Youth Suicide

- Suicide is a major public health problem in our community.
- It is the 3rd leading cause of death among youth ages 15-24 (CDC, 2009).
- Youth suicides are an annual occurrence, with the majority of Pennsylvania's counties averaging at least one per year. (2005-2007)

Youth Suicides (15 to 24 years old), by Pennsylvania County, 1990-2005



Data source: Pennsylvania Department of Health

Less than 50 Youth Suicides

50+ Youth Suicides

Garrett Lee Smith
Youth Suicide Prevention in Primary Care

- Sherry Peters, MSW, ACSW (PA DPW; PI), Guy Diamond, PhD (CHOP; Co-Director)
  Denise Short (PA DPW; Co-Director), Alana O'Malley (CHOP; Project Coordinator)

- This project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- **A Systems Change Project** Passed by Congress in 2004 and named after Senator Gordon Smith's (OR) son who died by suicide at age 21
- **Provides funding for community based suicide prevention**
- Provide youth suicide "gatekeeper" training program to participating pcp's in designated counties.
- Provide free access to a web-based, patient self-report screening too to assess for suicide and related risk factors.

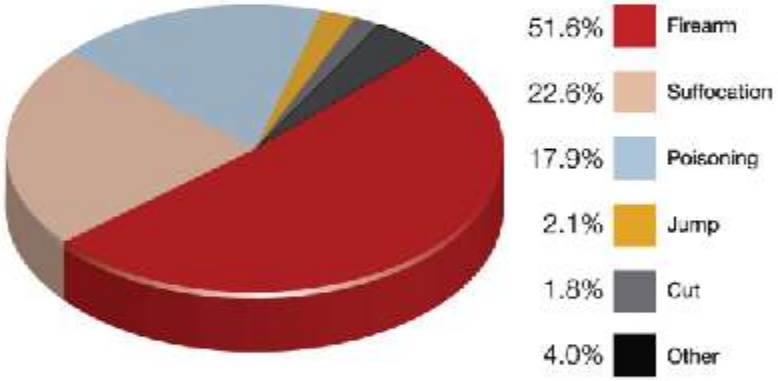
GLS - continued

- Increase the integration, if not collocation, of behavioral health services with medical services.
- Provide clinical training in best practice therapy models for suicidal youth to behavioral health providers
- Multiple state agencies, hospitals, universities and professional societies collaborating

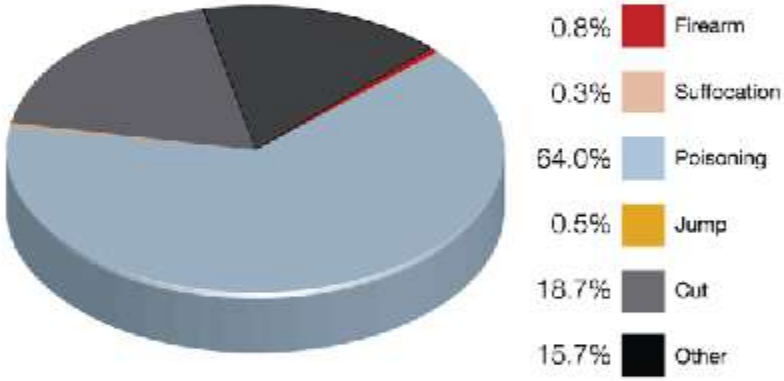
- “Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves.” (from The President’s New Freedom Commission on Mental Health, 2003)
- **Please say that an individual has died by suicide – not committed suicide**

WHO? WHAT? WHEN? WHERE? WHY? HOW?

How do people most commonly complete suicide?



Fatal (Suicide)

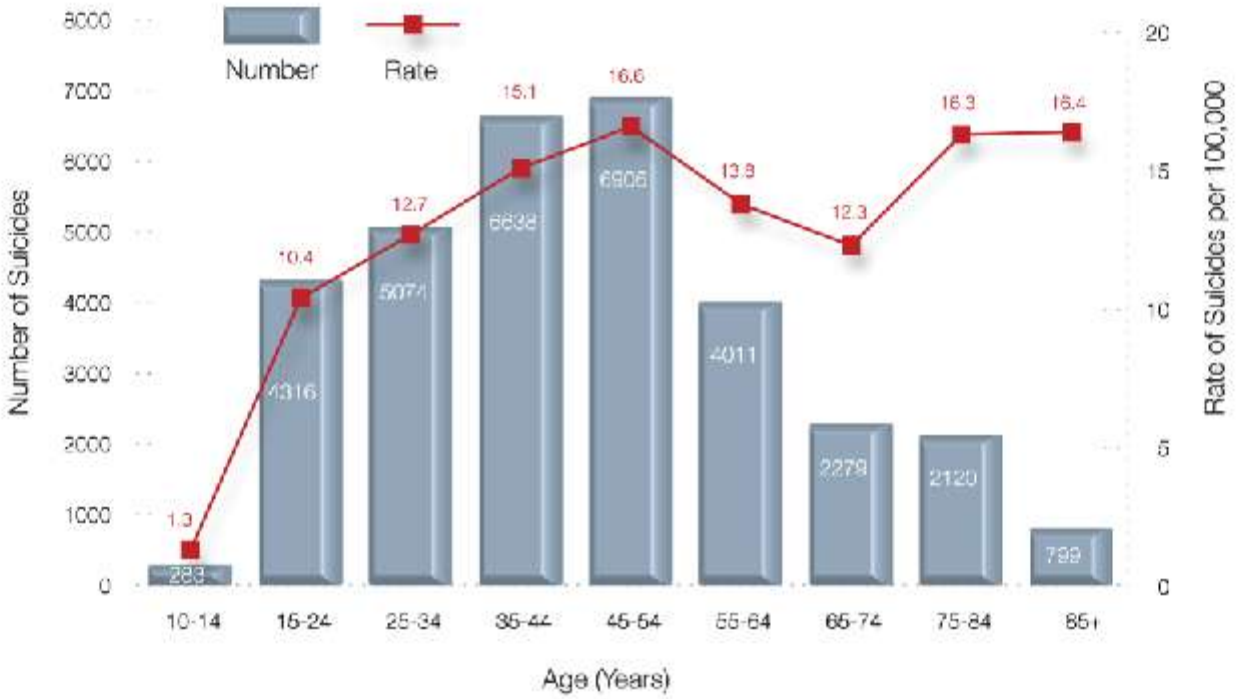


Nonfatal

Source: Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS). Available at: www.cdc.gov/ncipc/wisqars

Who is most affected by suicide?

Suicides by Age, 2004



Source: Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS). Available at: www.cdc.gov/ncipc/wisqars

Youth Suicidal Thinking

In a suicidal youth's mind:

- **Distress, torment and anxiety are seen as overwhelming**
- **Coping abilities are inadequate**
- **Suicide is seen as a way to end the turmoil**
- **The need to communicate pain is desperate**
- **Unable to think about the irreversibility of suicide or the consequences of death on their friends and family**
- **They believe that their thinking is rational.**

Often asking questions allows a suicidal person to let off steam and take steps toward accepting help. Without intervention, suicide may be seen as the only solution to solving the problems.

Supporting Parents/Guardians

Common Parental Reactions:

- Acute personal shock and distress
- Totally paralyzed by anxiety
- Very confused, in denial
- Embarrassed
- Blamed, stigmatized
- Angry, belligerent and threatening

Parents May Need Support to:

- Overcome their emotional reactions
- Accept the seriousness of the situation
- Recognize their key role in helping their child
- Recognize the importance of finding professional help
- Understand the importance of removing firearms
- Understand their limits
- Establish some hope

Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of Acute Suicide Risk

- **Talking about suicide**
- **Seeking lethal means**
- **Purposeless**
- **Anxiety or agitation**
- **Insomnia**
- **Substance abuse**
- **Hopelessness**
- **Social withdrawal**
- **Anger**
- **Recklessness**
- **Mood changes**

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

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

This 24-hour, toll-free hotline is available to those in suicidal crisis. The lifeline is not a resource for practitioners in providing care.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

Points about the poster

- **10% of all ED or 2-7% pcp pts are thinking of suicide, but most don't tell you.**
- **Patients may not spontaneously report SI, but 70% communicate their intentions to significant others. Ask pts. directly and seek collateral info. from family members, friends, EMS personnel, police, and others.**
- **1 in 10 suicides are by people seen in an ED or PCP within 2 months of dying**
  -Many were never assessed for suicide risk.

Is Your Patient Suicidal?

- Signs of Acute Suicide Risk
  - Talking about suicide
  - Seeking lethal means
  - Purposeless
  - Anxiety or agitation
  - Insomnia
  - Substance abuse
  - Hopelessness
  - Social withdrawal
  - Anger
  - Recklessness
  - Mood changes
- Medical illness increases SI and SA 50-67%
- Axis II (Borderline personality dis.) doubles

Is Your Patient Suicidal?

- Other factors
  - **Past suicide attempt** increases risk for a subsequent attempt or suicide multiple prior attempts dramatically increase risk.
  - **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
  - **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access

ASK!

No matter the CC if signs exist

1) **Have you ever thought about death or dying?**
2) **Have you ever thought that life was not worth living?**
3) **Have you ever thought about ending your life?**
4) **Have you ever attempted suicide?**
5) **Are you currently thinking about ending your life?**
6) **What are your reasons for wanting to die and your reasons for wanting to live?**

About these Questions

- Patients who respond “no” to the first question may be “faking good” to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about: frequency, intensity, and duration of thoughts; the existence of a plan and whether preparatory steps have been taken; and intent (e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

Questions

- ***How you ask the questions affects the likelihood of getting a truthful response.***
  - ***non-judgmental,***
  - ***non-condescending,***
  - ***matter-of-fact approach.***

Screenings

- These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

Screenings (GLS Survey)

- Majority (65%) of PCPs rarely screen for suicide or only screen when they suspect it.
- 14% report using a standardized screening tool to assess suicide risk.
- 83% would consider using a reliable suicide screening tool.
- 74% do not think that a screening tool would disrupt the patient-provider relationship.

Depression Screenings

PHQ-2

Over the past two weeks, how often have you been bothered by any of the following problems?

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

Feeling down, depressed, or hopeless
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Total point score: _____

Score interpretation:

PHQ-2 score	*Probability of major depressive disorder (%)*	*Probability of any depressive disorder (%)*
1	15.4	38.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

PHQ-9 - Nine Symptom Checklist

Patient Name: _____ Date: _____

1. 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
	0	1	2	3
a. *Little interest or pleasure in doing things*	☐	☐	☐	☐
b *Feeling down, depressed, or hopeless*	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Administer PHQ-9 if PHQ-2 is positive

Score 0-4: No depression symptoms
Score 5-9: Minor depression symptoms
Score 10-14: Moderate depression symptoms
Score 15-19: Moderate to severe depression symptoms
Score 20 or more: Severe depression symptoms

Efficacy

Test Sensitivity: 88%
Test Specificity: 88%

Rapid Triage Approach

High Risk	Moderate Risk	Low Risk
• Made a serious or nearly lethal suicide attempt • Persistent suicide ideation with intent and/or planning • Psychosis, including command hallucinations • Recent onset of major psychiatric syndromes, especially depression • Been recently discharged from a psychiatric inpatient unit • History of acts/threats of aggression or impulsivity	Suicide ideation with some level of suicide intent, but have taken no action on the plan • No other acute risk factors • A confirmed, current and active therapeutic alliance with a MHP	• Some mild or passive suicide ideation, with no intent or plan • No history of suicide attempt • Available social support

When patients elope

- Follow p and p specific to retrieving all suicidal patients who have eloped
- Document the timeliness and reasonableness of actions taken
- For Involuntary Patients or Patients with High Suicidal Intent: Follow PA's mental health statute dealing with involuntary tx.
- Immediately ask security and law enforcement personnel to return patient
- Have a policy for authorizing physical restraint matching the risks posed

When patients elope –
Voluntary Patients with Low Suicidal Intent:

- Attempt to contact the patient or significant others and request return
- If an emergency exists, it may be necessary to breach patient confidentiality

When is it best not to hospitalize?

- Suicidality is a reaction to precipitating events (eg, exam failure, relationship issues) particularly if the patient's view of situation has changed since coming to the e d
- Plan/method and intent have low lethality
- Pt has stable and supportive living situation
- Patient is able to cooperate with follow-up, plan with treater contacted, if patient is currently in tx.
- Patient has chronic suicidal ideation and/or self injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psych. care is ongoing

Before Discharge or Leaving the Office

- Firearms and lethal medications have been secured or made inaccessible to patient
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk
- A follow-up appt. with a mental health professional has been recommended & if possible, scheduled
- The patient has the name and number of a local agency that can be called in a crisis, knows that the National Suicide Prevention Lifeline 1-800-273-TALK (8255) is available any time, and understands the conditions that would warrant a return to the ED

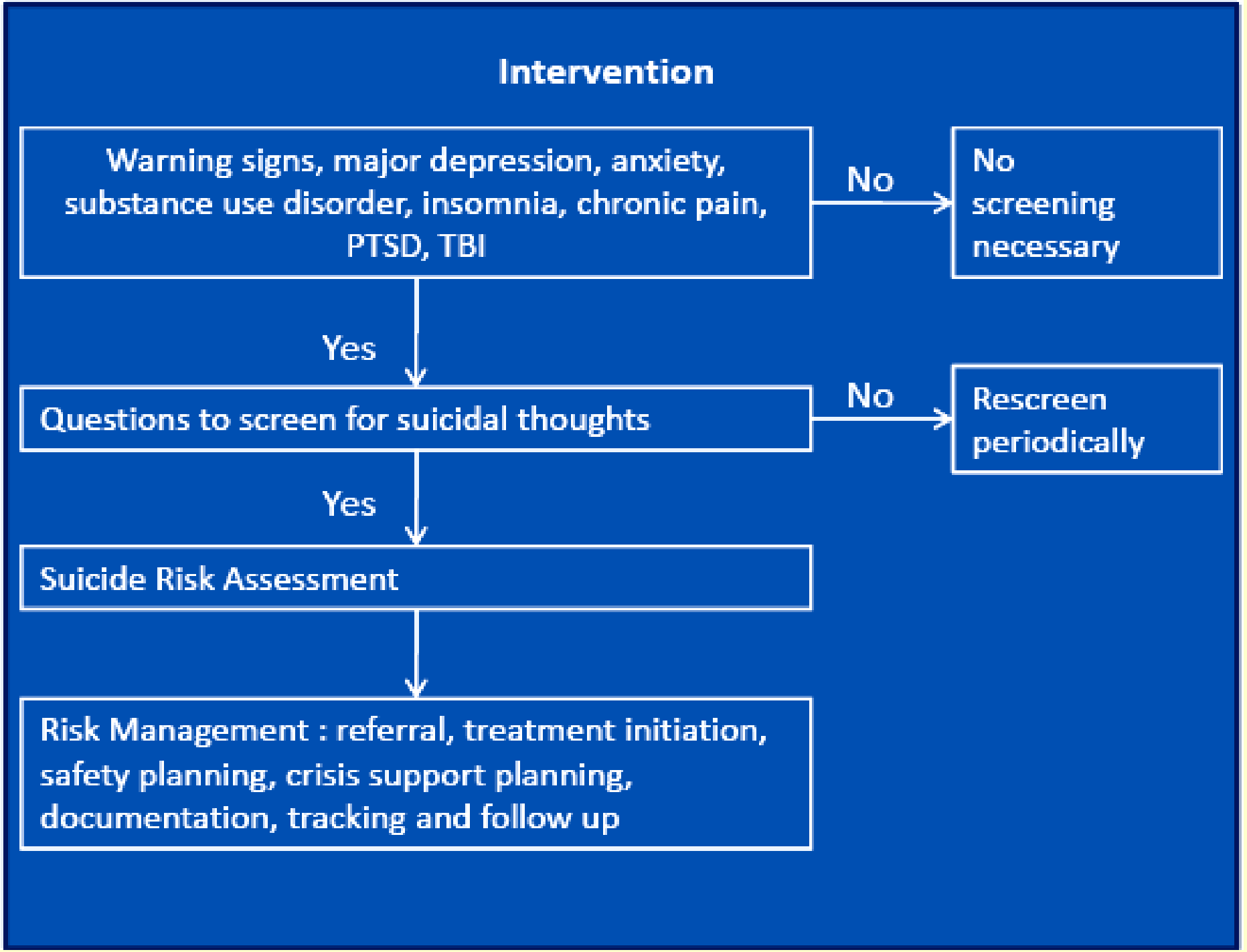
Primary Care Suicide Prevention Model

Preparation Phase

1. Develop office policies and protocols
2. Staff Education
   All staff- warning signs, risk factors, protective factors, response
   Clinicians – suicide risk assessment; depression screening and tx
3. Strengthen communication with mental health partners

Prevention Practices

1. Staff vigilance for warning signs & key risk factors
2. Depression screening for adults and adolescents
3. Patient education:
   Safe firearm storage
   Suicide warning signs & 1-800-273-TALK (8255)


Intervention
Warning signs, major depression, anxiety, substance use disorder, insomnia, chronic pain, PTSD, TBI
No
No screening necessary
Yes
Questions to screen for suicidal thoughts
No
Rescreen periodically
Yes
Suicide Risk Assessment
Risk Management : referral, treatment initiation, safety planning, crisis support planning, documentation, tracking and follow up

Referral and Treatment

- Safety Plans
- Therapies – Individual and Family
- Medications - **The general consensus of experts has been that the benefits of prescribing antidepressants to adolescents and young adults for treatment of depression far outweighs the risk of inducing suicidal thoughts**
- Close follow up

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

Therapies

- Regardless of the theoretical basis or type, the key element in psychotherapy is a positive and sustaining therapeutic relationship.
- May be CBT, DBT or done in combination with medications for best results

Somatic Therapies

- Medications
  - Anti-Depressants – may be an important help but there are black box warnings and no clear outcome studies
  - Lithium – good outcome studies not in evidence with other mood stabilizers
  - Clozapine (Clozaril) – good outcome studies that may well be similar for some other newer antipsychotics
- ECT – for most acute suicidal behavior and for psychosis with depression

HOW TO LEARN MORE AND REFERENCES

- **National Suicide Prevention Lifeline at 800-273-TALK (1-800-273-8255)**
- **National Institute for Mental Health**
  - » www.nimh.nih.gov
- **Substance Abuse and Mental Health Services Admin.**
  - » www.samhsa.gov
- **Suicide Prevention Resource Center**
  - » www.sprc.org
- **Surgeon General's Call to Action to Prevent Suicide**
  - www.surgeongeneral.gov/library/calltoaction/default.htm
- **1-800-CDC-INFO • www.cdc.gov/violenceprevention • cdcinfo@cdc.gov**