Suicide Prevention in Pediatric & Family Practice

Maya Strange, M.D., UVMMC, Vermont Center for Children, Youth & Families

Steve Broer, Psy.D., Northwestern Counseling & Support Services (NCSS)

Rebecca Chaplin, M.S., Northwestern Pediatrics & NCSS

C.H.A.M.P. Learning Session
October 9, 2018
Disclosures

- We have no relevant financial relationships to disclose or conflicts of interest to resolve

- We will discuss no unapproved or off-label pharmaceuticals
Introductions & Overview

1) Suicide Trends in VT & Nation
2) Considerations with Children Youth & Families
3) Zero Suicide Initiative & VT Pilot Sites
4) Illustrate use of CAMS in a Pediatric Practice
5) Resources
6) Challenges & Opportunities
Over the past 5 years, Vermont's suicide death rate has averaged about 30% higher than the US rate.

Source: CDC WISQARS
Trends in Vermont and US Youth and Young Adult Suicide Deaths

VT and US Youth and Young Adult Suicide Death Rates (3 Year Bins) 2000-2014

Felt sad or hopeless 2+ weeks
- 2009: 4%
- 2011: 4%
- 2013: 5%
- 2015: 6%
- 2017: 5%

Purposely hurt self without wanting to die
- 2009: 9%
- 2011: 8%
- 2013: 11%
- 2015: 12%
- 2017: 11%

Made a suicide plan, past year
- 2009: 15%
- 2011: 13%
- 2013: 16%
- 2015: 17%
- 2017: 16%
Suicide: A Growing Problem

- CDC Vital Signs Report June 2018 - A Call to action

- Suicide rates increased in almost every state. VT had 2\textsuperscript{nd} highest rate of increase since 1999

- Since 2004, Vermont suicide death rates have averaged 30\% higher than the US rates

- Suicide is the second leading cause of death for Vermonters aged 15 through 34 & the third leading cause of death for Vermonters aged 35-44

- Vermonters use firearms to take their lives at very high rates; according to the most recent 5 years of data, 59\% of Vermont suicides involve firearms, while the rest of the Northeastern US only 36\% of suicide deaths involved firearms
At Risks Populations

- Individuals with medical conditions
- Individuals who are lesbian, gay, bisexual, or transgender
- Individuals in justice and child welfare settings
- Individuals who intentionally hurt themselves
- Individuals who have previously attempted suicide
- Individuals with mental and/or substance use disorders
- Members of military and veterans
- Men in midlife and older men
- Other factors- (Bullying....)

(SAMHSA, 2018)
Brain matures in non-linear fashion

Delayed maturation of the PFC and other frontal regions

- Cognitive control
- Attentional regulation
- Response inhibition
- Other advanced cognitive functions

Neurodevelopment

- While youth may perform well on tasks under certain conditions, impairments may be seen with increased demands, increased arousal, or in heightened emotional state
- Elevated activation of reward-relevant brain regions
- Sensitivity to aversive stimuli may be attenuated
  - Amygdala of adolescents is activated less than that of adults in response to aversive outcomes

Adolescent Brain Matures in a Non-Linearly
As of 1/1/2018, minors may consent to outpatient treatment from a mental health professional, including psychotherapy and other counseling services, but not to receive prescription medications.

Minors 12+ may provide informed consent to treatment for STIs, as well as alcohol and drug use. If immediate hospitalization is needed, parent(s)/guardian(s) must be notified.

Minors 14+ may also voluntarily admit themselves to a hospital for mental health related treatment if written informed consent is given.

Minors of any age may give informed consent to medical treatment associated with rape, incest, or sexual abuse.
Exceptions to Confidentiality

- Harm toward self
- Harm toward others
- Harm by others
Safety Planning

- Warning signs
- Internal coping strategies
- Others who I can contact
  - Distraction
  - Support
- Professionals who I can contact
- How I can make my environment safe
- Reason(s) to live
SENSEITIVE USE OF LANGUAGE

Terms that perpetuate stigma or misinformation about suicide are strongly discouraged.

Those who have lost a loved one to suicide are **suicide survivors**.
Those who have lived through a suicide attempt are **suicide attempt survivors**.

**PLEASE USE:**
- Death by suicide
- Took his or her own life
- Died of suicide
- Killed him- or herself
- Suicide death

**PLEASE AVOID:**
- Committed suicide (because it implies that suicide is a sin or a crime)
- A completed suicide
- A successful suicide
- Failed suicide attempt
ZERO SUICIDE is a commitment to suicide prevention in health and mental health care systems and is also a specific set of strategies and tools.
What is Zero Suicide?

“The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.”

Key elements include:
• Acknowledging and acting upon the need to support and train providers and staff
• Embracing the idea that people at risk for suicide often “fall through the cracks” and so a more systematic approach to providing care for these people is needed
• Having a system-wide approach to improve outcomes and close gaps in patient care

Adapted from http://zerosuicide.sprc.org/about
Lead

Make an explicit commitment to reduce suicide deaths.
Give leadership to an Implementation Team representing key functional areas and suicide attempt and loss survivors.
SYSTEMATIC SUICIDE CARE

Bridging the Gaps

(Adapted from the National Action Alliance for Suicide Prevention, 2010)

SERIOUS INJURY OR DEATH AVOIDED

Continuity of Care: FOLLOW-UP Calls, after visits, Primary Care, Emergency Dept., Inpatient

SUICIDAL PERSON

SCREEN/ASSESS for Suicidality

Collaborative SAFETY PLAN Put in Place

TREAT SUICIDALITY: Suicide-specific Treatment

- Continuity of Care: FOLLOW-UP Calls, after visits, Primary Care, Emergency Dept., Inpatient
Zero Suicide Pilot Project in Vermont: Brief Overview

Pilot project started in spring 2015

Implementing in specific programs at three state-designated mental health treatment agencies ("DAs")

Supported through legislative allocation to Dept. of Mental Health and VT Suicide Prevention Center

High level implementation team with multiple stakeholders

DA-specific (internal) implementation teams

Three rounds (so far) of CAMS trainings for clinicians/leaders; CALM trainings

Leader trainings; previously part of ZS CoP and CS-CoIIN

External evaluator from University of Vermont (VCHIP)
Collaborative Assessment & Management of Suicide in a Pediatric Practice

Rebecca Chaplin, M.S.
Designated Agency & Integrated Health

- D.A. Services
  - Psychiatry Consults
  - Crisis & Mobile Outreach
  - Nursing Care Coordination
  - CRT Care Management
  - Medical Records Exchange

- NOTCH/FQ HC
- Social Workers Partnership

- NOTCH SAMHSA Grant For Kids

- Evidence Based Practices Across Settings
  - CAMS/Suicide
  - CBT/I/Insomnia
  - WRAP
  - EMDR

- NMC Partnership
  - PCP’s
  - Pain Clinic
  - Emergency Dep’t Embedded
  - Training for Sitters Program

- Blueprint Community Health Team in
  - PCP’s
  - MAT
  - OB/GYN
  - Planned Parenthood

- Blueprint Wellness Groups

- NOTCH/FQ HC
  - PCP’s
  - MAT
  - OB/GYN
  - Planned Parenthood

- Blueprint Wellness Groups
NCSS Integrated Health Team

- Self-Management Workshops
- Individual Counseling
- Cognitive Behavioral Therapy for Insomnia (group and individual)
- Community Learning Collaborative
- Women’s Health Initiative
- Medication Assisted Treatment (MAT)
- NOTCH Health Centers
Northwestern Pediatrics

- 2 FTE Master’s level Social Worker/Wellness Coach
- 8 Primary care provider teams (provider and Nurse/Medical Assistant)
- Support staff
What Behavioral Health Integration Looks Like in this Practice Setting

- 2 Social Worker assigned full time to for within three locations
- Role in Screening Workflows
- Care Coordination
- Scheduled Patients & Warm Hand-Offs
- Short Term, Solution Focused Therapy
- Referrals to Services
- Continues Provider consultation
Why Provide Suicide Specific Care in Primary Care

- 45% of those who have died by Suicide have seen their primary care provider 30 days prior to their death. The % is significantly higher for Elders (Ahmedani, Simon, Stewart, Beck, Waitzfelder, Rossom, et. al., 2014)

- Facts related to Youth at Risk

- Primary Care provides a unique access point for prevention & intervention
Collaborative Assessment & Management of Suicide

- Philosophical Aspects of CAMS
- CAMS Clinical Procedures
  - Step 1 - Early Identification of Risk
  - Step 2 - Collaborative Assessment Using SSF
  - Step 3 - Collaborative Treatment Planning
  - Step 4 - Clinical Tracking of Suicide Status
  - Step 5 - Clinical Resolution of Suicide Status
- Growing Evidence Base for CAMS
Integrated Health CAMS

Flowsheet 5.2018

- Patient presents in PCP office and is identified as needing CAMS
  - Check if patient is NCSS client;
  - If yes, Refer back to NCSS
  - If No, Complete Page 1 of CAMS SSF (Initial Session including Stabilization Plan)
    - Determined Low Risk
      - Continue with planned intervention/treatment; then be sure to document that in clinical note also making note at bottom of CAMS Form
    - Determined High Risk
    - If determined patient is stable enough to schedule future appointment; continue to complete CAMS SSF Section B and Stabilization Plan/Use CAMS to completion unless clinically determined otherwise; then be sure to document that in clinical note also making note at bottom of CAMS Form
    - If determined patient needs immediate follow-up and no time; Crisis should be called

- Patient referred to you from another NCSS Program as needing continuation of CAMS
  - Complete at least one CAMS session then make your own determination if clinically appropriate to continue with CAMS and/or refer out or to stop CAMS; then be sure to document that in clinical note also making note at bottom of CAMS form
  - If determined patient needs immediate follow-up and no time; Crisis should be called

Always collaborate and update all team members/care team and always discuss all CAMS in Supervision
Application of CAMS

1) Composite example: Riley

2) Workflow

3) CAMS
   • Drivers
   • Risk factors
   • Stabilization and safety planning

4) Care team
Ongoing Care with Riley

- Continue short term treatment for stabilization using CAMS for continued assessment and management
- May stop CAMS after 3 sessions if overall risk of suicide is 3 or lower
- May continue CAMS if overall risk remains at 3 or higher and/or if patient feels this is beneficial in tracking drivers
- Refer for ongoing care at NCSS where CAMS can be continued if needed, CAMS documentation sent with referral for continuity of care
- One appointment post referral to confirm follow up care in progress and/or check in when pt comes to see their PCP

“...how do you cultivate the ability to have a life that you want to live”? ~David Jobes
Resources

If you or a loved one is experiencing a mental health crisis and need help, call your local 24/7 crisis line:

- Newport area: 800-696-4779
- St. Johnsbury area: 800-649-0118
- Howard Center: 802-488-7777
- LCMHS: 802-888-8888
- NKHS: 802-229-0591
- WCMHS: 802-388-7641
- CSAC: 802-775-1000
- RMHS: 802-622-4235
- HCRS: 802-524-6554
- NCSS: 802-639-6360
- CMC: 802-362-3950

Vermont's Community Mental Health Centers:

- Clara Martin Center [CMC]: claramartin.org
- Counseling Service of Addison County [CSAC]: csacvt.org
- Health care and Rehabilitation Services [HCRS]: hcrs.org
- Howard Center: howardcenter.org
- Lamoille County Mental Health Services [LMCHS]: lamoill.org
- Northeast Kingdom Human Services [NKH]: nkh.org
- Rutland Mental Health Services [RMHS]: rtmh.org
- Northwestern Counseling & Support Services [NCSS]: ncsonline.org
- United Counseling Service of Bennington County [UCS]: ucsvermont.org
- Washington County-Mental Health [WCMHS]: wcmhs.org

Note: Websites here are for information purposes and not intended as a resource or means of contact during an acute crisis.
Mission:
To create health promoting communities in which schools, Institutions of Higher Education, public and private agencies and people of all ages have the knowledge, attitudes, skills and resources to reduce the risk for suicide.

Purpose:
To support state-wide suicide prevention efforts and help local communities implement the recommendations of the Vermont Suicide Prevention Platform using data-driven evidence-based practices.

http://www.vtspc.org
Umatter®

A comprehensive school and community approach to suicide prevention

- *Umatter®* for Schools
- *Umatter®* for Communities
- *Umatter®* for Youth and Young Adults
- *Umatter®* Public Information
CALM: Counseling About Lethal Means
2 hours free online course
Need help?

❖ Talk to a family member, friend, health care provider or faith leader
❖ Call your local mental health agency or crisis team
❖ Text the Vermont Crisis Text Line: VT to 741741
❖ Call the National Suicide Prevention Lifeline: 800-273-TALK (8255)

Resources for help can be found at: www.vtspc.org
Challenges & Opportunities

Thank You 
*for the Work You Do !!*