Behavioral Health Integration Collaborative

"ADDRESSING ADULT SUICIDAL IDEATION IN THE PRIMARY CARE SETTING"

September 1, 2022

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About the BHI Collaborative

*The BHI Collaborative was established by several of the nation's leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.*

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

***American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

TODAY'S SPEAKERS

Virna Little, PSyD, LCSW-r, SAP, CCM

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Suicide Prevention in Primary Care

A Toolkit for Primary Care Clinicians and Leaders

Virna Little, PsyD, Chief Operating Officer, Concert Health

Thanks to ACU (www.clinicians.org) and Centene

Suicide Experiences

Suicide experiences are not uncommon. Each year:

- 10 million American adults think seriously about killing themselves
- 3 million make suicide plans
- 1 million make a suicide attempt

Substance Abuse and Mental Health Services Administration. HHS Publication No. (SMA) 13-4795 2013

Language Matters

Choosing Compassionate & Accurate Language

• • •

Died of/by Suicide *vs* ~~Committed Suicide~~

Suicide *vs* ~~Successful Attempt~~

Suicide Attempt *vs* ~~Unsuccessful Attempt~~

Describe Behavior *vs* ~~Manipulative/Attention Seeking~~

Describe Behavior *vs* ~~Suicidal Gesture/Cry for Help~~

Diagnosed with *vs* ~~they're Borderline/Schizophrenic~~

Working with *vs* ~~Dealing with~~ Suicidal Patients

now matters now

Outline

Role of the primary care provider (PCP) in suicide safe care

Identification of patients at risk for suicide

Assessment of patients at risk for suicide

Safety planning

Office-based interventions for PCPs

Why Focus on Health Care Settings?

- 84% of those who die by suicide have a health care visit in the year before their death.
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.
- Almost 40% of individuals who died by suicide had an ED visit, but not a mental health diagnosis.

Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909-916..

Joint Commission Sentinel Event Alert 56

Sentinel Event Alert

EMBARGOED UNTIL FEB. 24

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[6] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[8] and continues to be high especially within the first year[8,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Baerum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

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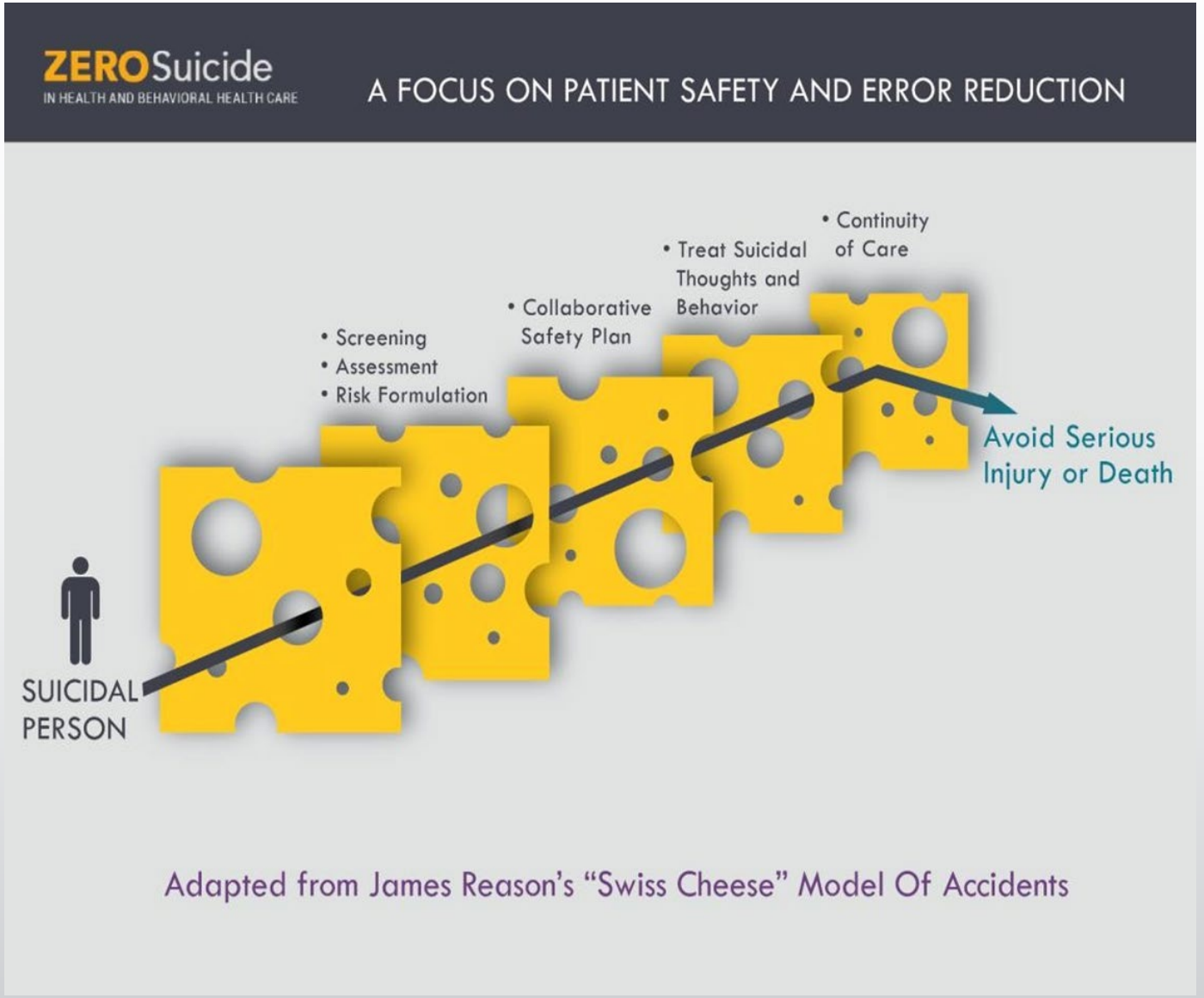
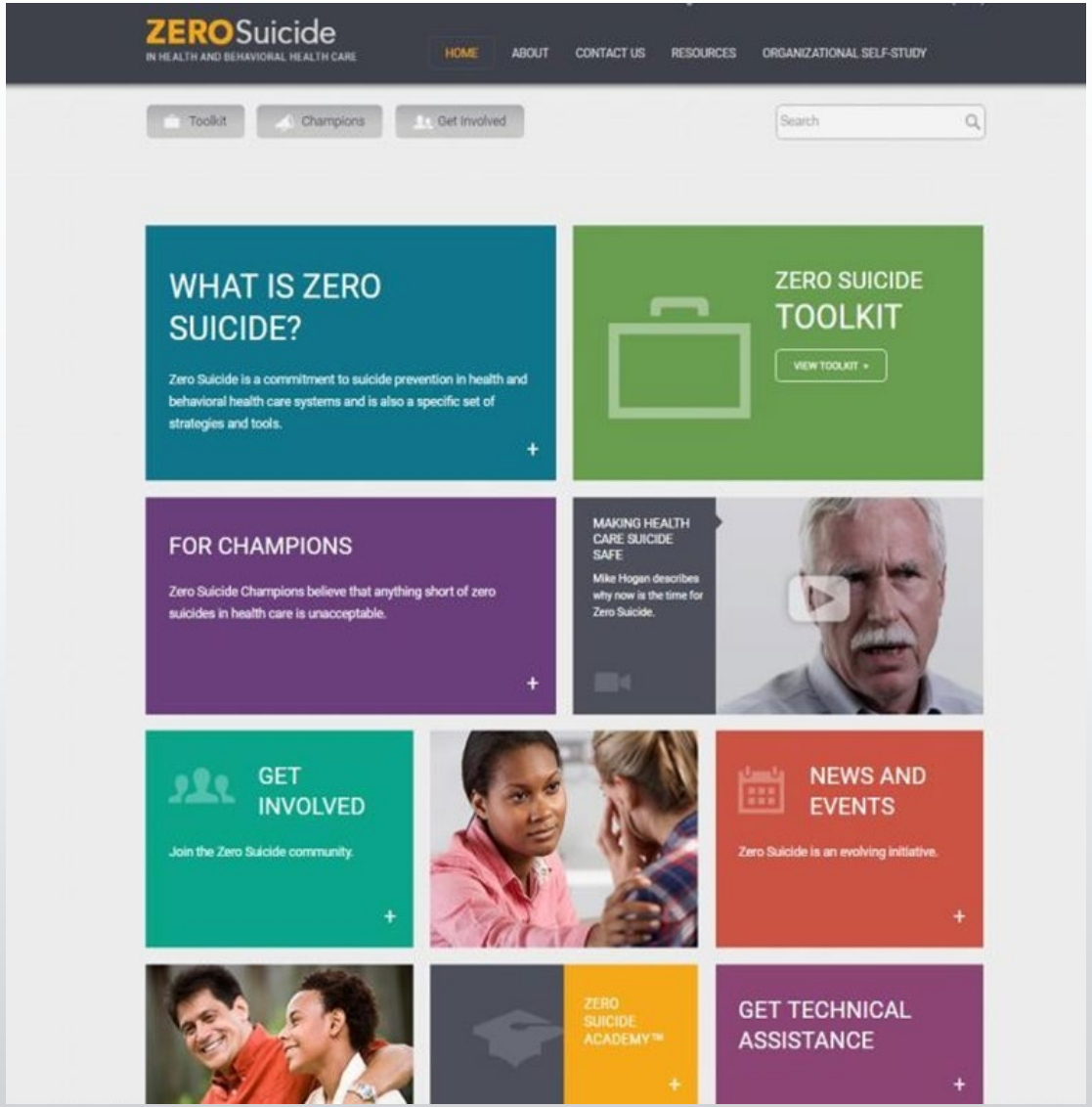
Patient Safety and Error Reduction



Zero Suicide



Access at:

www.zerosuicide.com

What We Hear Sometimes…

- “I don’t have the knowledge to assess or intervene.”
- “With such a short amount of time, I don’t have time to ask or address suicide risk.”

The Minimum How (to do it)

3 things that suicidal people want

In Your Office

- Do not panic.
- Be present listen carefully and reflect
- Provide some hope
  Ex. "You have been through a lot, I see that strength"

LANGUAGE MATTERS!

Identification

- Many offices are screening for depression
- Ask patients directly (ask what you want to know)
- Social determinants play a role
- Many patients don’t have depression
- Substance and alcohol use play a role
- Transitions are a time of risk

Population of Patients at Risk for Suicide

Do you know how many are in your panel, in your practice or organization ?

Are you adding ICD10 codes to your problem list ?

Do you have expectations/standards for BOTH newly identified patients and patients following up for routine primary care ?

What does excellent care for patients at risk for suicide in your organization look like ?

The Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 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
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 asleep, 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're 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
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those 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

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

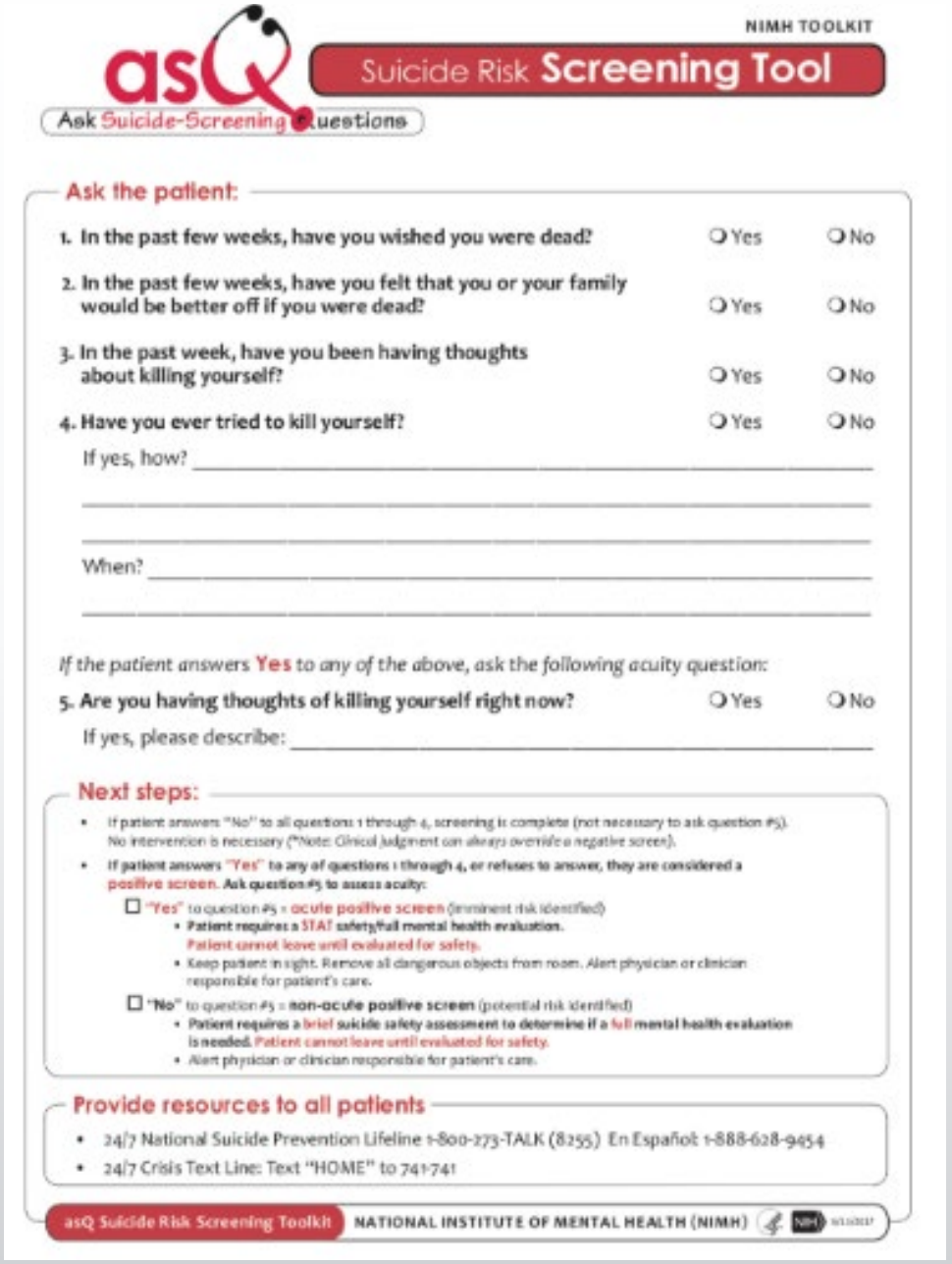
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

If yes, please describe: _____

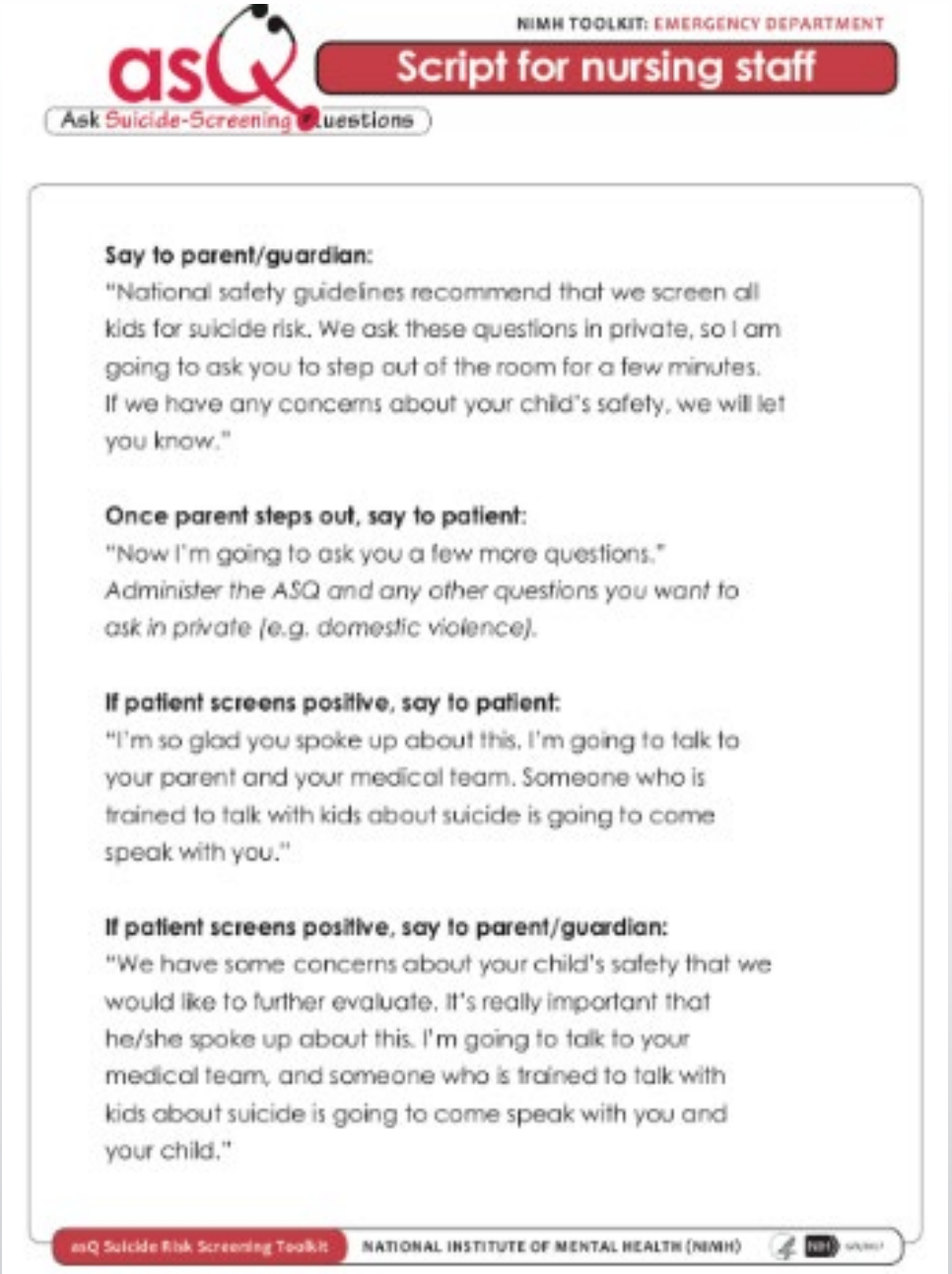
Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)



asQ
Ask Suicide-Screening Questions

NIMH TOOLKIT: EMERGENCY DEPARTMENT

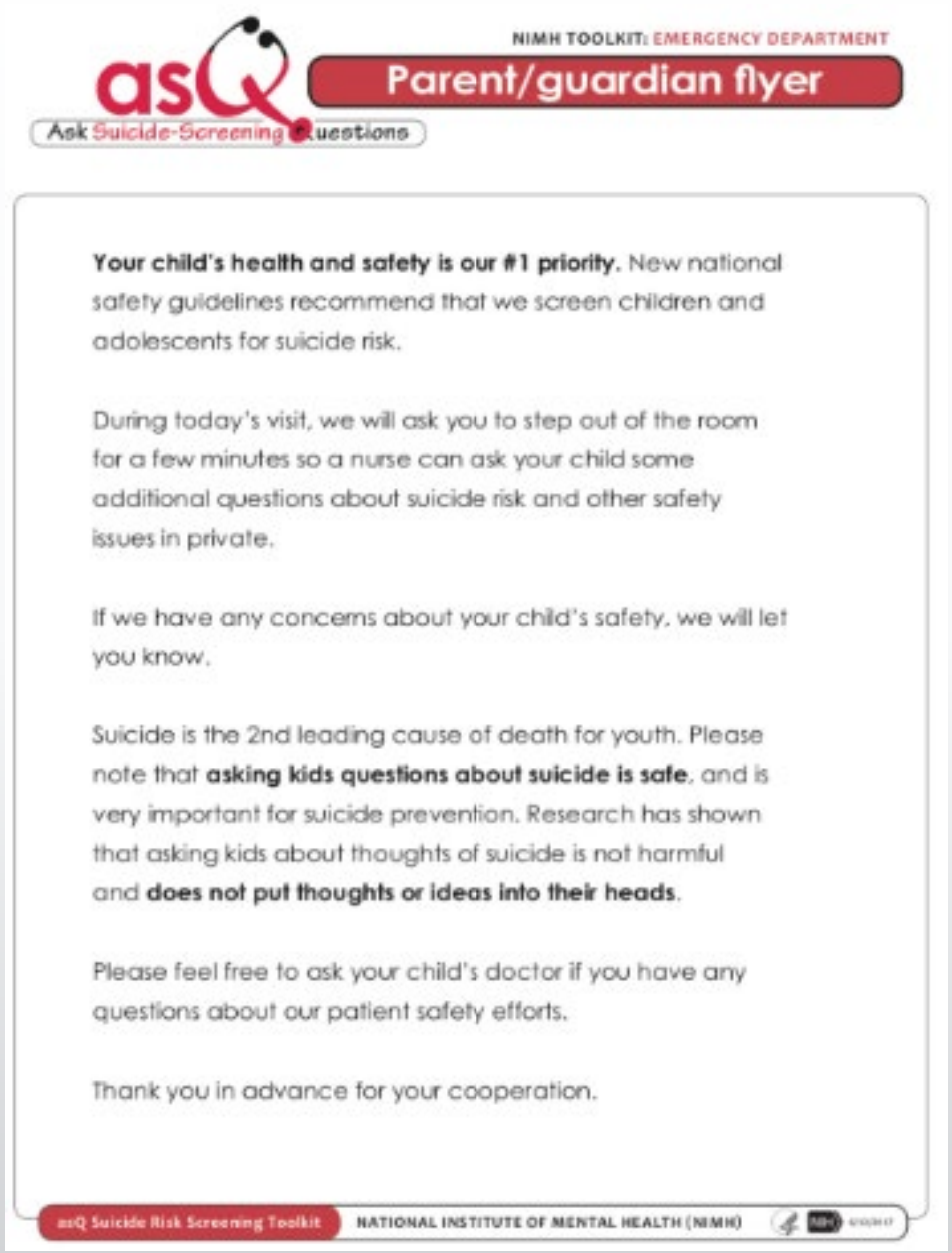
Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"I'm so glad you spoke up about this. I'm going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you."

If patient screens positive, say to parent/guardian:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child."



asQ
Ask Suicide-Screening Questions

NIMH TOOLKIT: EMERGENCY DEPARTMENT

Parent/guardian flyer

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

Appropriate Levels of Care

Not everyone needs an alternate level of care

There is no emergency room magic

Assessing Risk

Can and does happen in primary care settings-appropriate level of care

Helpful to speak the same language and understand the assessment process

The primary care visit focus becomes the risk for suicide

Response Protocol

Ask questions that are in bold.

Ask Questions 1 and 2	Past Month YES	NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual 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. Have you been thinking about how you may do this? *e.g. "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.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. 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. 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.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Schedule follow-up

Address Lethal Means, Safety Planning, Schedule Follow-up

Evaluate Hospitalization, Address Lethal Means, Safety Planning, Schedule Follow-up

Suicidal Ideation

Protective Factors

What are reasons you would not die by suicide today ?

Some common protective factors:

- Kids
- Family/spouse/parents
- Pets
- Religion
- Job

What is Safety Planning?

Safety Planning Intervention consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.

The Minimum WHAT (to do)

BEFORE THEY LEAVE YOUR OFFICE

- Suicide Prevention Lifeline or Crisis Text Line in their phone
  - 1-800-273-8255 and text the word “Hello” to 741741
- Address guns in the home and preferred method of suicide
- Give them a caring message (NowMattersNow.org ⇗ “More”)

NowMattersNow.org Works

Website visits are associated with decreased intensity of suicidal thoughts and negative emotions.

This includes people whose rated their thoughts as “completely overwhelming”

NowMattersNow.org Emotional Fire Safety Plan

Select boxes that fit for you. Add your own. Form is based on research and advice from those who have been there.

Visit nowmattersnow.org/safety-plan for instructions (coming soon). Do not distribute. (V 18.05.27)

ON FIRE

Direct advice for overwhelming urges to kill self or use opioids

— Shut it down —
Sleep (no overdosing). Can't sleep? Cold shower or face in ice-water (30 seconds and repeat). This is a reset button. It slows everything way down.

— No Important Decisions —
Especially deciding to die. Do not panic. Ignore thoughts that you don't care if you die. Stop drugs and alcohol.

— Make Eye Contact —
A difficult but powerful pain reliever. Look in their eyes and say "Can you help me get out of my head?" Try video chat. Keep trying until you find someone.

IN A FIRE

Things I Know How To Do for Suicidal Thoughts and Urges to Use (practice outside of crisis situations)

☐ Visit NowMattersNow.org (guided strategies)	☐ Opposite Action (act exactly opposite to an urge)
☐ Paced Breathing (make exhale longer than inhale)	☐ Mindfulness (choose what to pay attention to)
☐ Call/Text Crisis Line or A-Team Member (see below)	☐ Mindfulness of Current Emotion (feel emotions in body)
☐ "This makes sense: I'm stressed and/or in pain"	☐ "I can manage this pain for this moment"
☐ "I want to feel better, not suicide or use opioids"	☐ Notice thoughts, but don't get in bed with them
☐ Distraction:	☐

Patient Safety Plan

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

Safety Planning

- Can the activity happen all times of the day and all times of the year
- Call someone from the patient's team "Sarah and I would like to speak with you, she has listed you on her suicide safety plan."
- Be creative – Walmart!
- How can we keep you safe today ?

Lethal Means Restriction

- Temporary
- Matter of Fact
- Standard Practice
- Safety Approach (Public Health!)
- Preferred method is important to know and note

Lethal Means

- How much medication is in your home? (neighbors, family)
- Medication boxes, family, individual wrapping, “pill packs”
- Gun locks, boxes, family or surrender for holding
- The time to talk to the pharmacy is now …….

Caring Contact

Henry,
I don't know you well yet, I am glad that you told me a little more about your life. I have lots of hope for you – you've been through a lot. I hope you'll remember that and come back to see us. With care, -Nurse Matt

Caring Messages

We asked over 1000 people. Here are the top results.
Please use and adapt these any way you like for those you care about.

Dear you. Yes you! Remember that one time you felt connected to the universe. No one can take that away from you. It's yours.

— *Ursula Whiteside*

You're a human being, not a human doing. Your worth is intrinsic, and your strength is likely greater than you think it is.

— *John Brown*

Live. If only, at times, because it is an act of radical defiance.

— *Ursula Whiteside*

You may feel you don't matter but you do and see no future. Yet it is there - please let it evolve because the world needs you and your contribution.

— *Kristine Laaninen*

If I could fill the world with more people who feel the world, I would. Understanding suffering is a heavy burden to carry at times for sure - but you are never a burden for feeling it.

— *Nina Smith*

Your story doesn't have to end in this storm. Please stay for the calm after the storm. The possibly a rainbow. Maybe not tomorrow or next week, but you can weather this.

— *Breanna Laughlin*

When things have been rough, I think of things or touch items that give me a sense of pride, joy, encouragement, or hope. Sometimes memories that remind me I'm okay and things often change quickly. I don't know if that would help for you.

— *Daniel DeBrule*

This is part of a poem from Jane Hirschfield, "The world asks of us only the strength we have and we give it. Then it asks more, and we give it."

— *Sara Smucker Barnwell*

I've been there- that place where you'd do anything to stop the pain. It's a dark, suffocating birth canal to a better place...Life changes can suck; but nothing ever changing sucks more.

— *Kathleen Bartholomew*

Please don't stop fighting. You are being prepared for something far greater than this moment.

— *Breanna Laughlin*

Just like winter, the long dark days slowly get shorter until there is more light than dark. Please believe this while you wait to see the light.

— *Debbie Reisert*

Things can be completely dark for some of us somteimes. I don't know where you are at today, or if this message can shine through, but I'm here sending you a tiny bit of light - a light beam.

— *Ursula Whiteside*

This is a favorite line of mine from Desiderata, "You are a child of the universe, no less than the trees and the stars; you have a right to be here."

— *Andy Bogart*

I was trapped in the Dark Place. Drowning in it. Lost in the fog. Sinking in the quicksand. Unable to get out. Slowly, slowly, slowly: I am. You might be able to too. Just get through today.

— *Amy Dietz*

I've found this Franklin D. Roosevelt quote helpful, "A smooth sea never made a skilled sailor." We'll be prepared for something bigger.

— *Ursula Whiteside*

now matters now

Wanting to be rid of pain is the most human of impulses. You are brave to hold that. You are worth so much. Because you exist. And breathe air. Contingent on nothing else.

— *Sara Smucker Barnwell*

Questions ?

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Sun River Health

The care you expect, the respect you deserve

Dan Miller, MD

Chief of GME & Behavioral Health Integration

Allison Dubois, MPH

Executive Vice President & COO

Sun River

- A Federally Qualified Health Center
- Providing comprehensive primary care, behavioral health and oral health services
- Serving 225,000 patients in New York through 43 Health Center locations

Key Takeaways

- Understand the role of primary care providers in suicide safer care
- Ensure you/your team has a comprehensive understanding of utilizing existing workflows to support care for patients at risk for suicide
- Understand the operational considerations and barriers for implementing system wide suicide safer care

BHI Collaborative *"On Demand"* Webinars

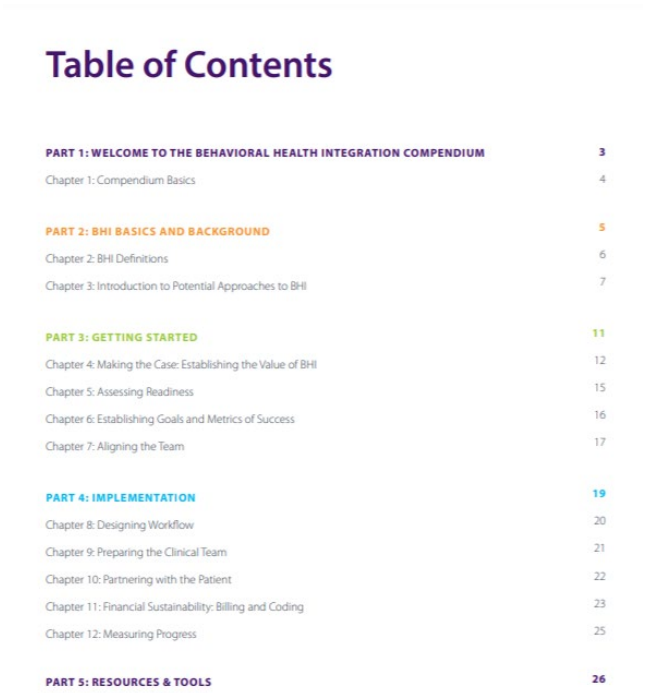
Check out other webinars from the Overcoming Obstacles series such as:

- Practical Strategies for Managing Suicidal Ideation & Reducing Risk
- Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions & Treatment
- The Value of Collaboration and Shared Culture in BHI
- Advancing Health Equity through BHI
- Implementation Strategies for Virtual BHI

Watch all these webinars and more on the Overcoming Obstacles YouTube playlist now!

Collaborative Resource – *BHI Compendium*

The BHI Compendium serves as a tool to learn about behavioral health integration and how to make it effective for your practice and patients.



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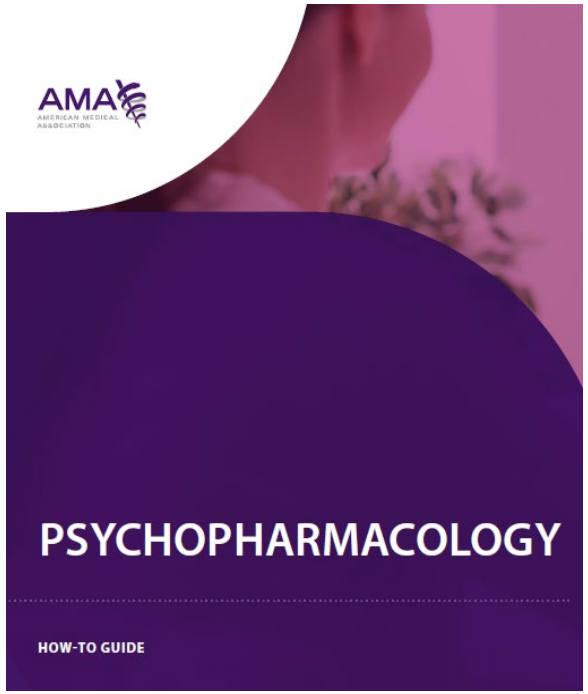
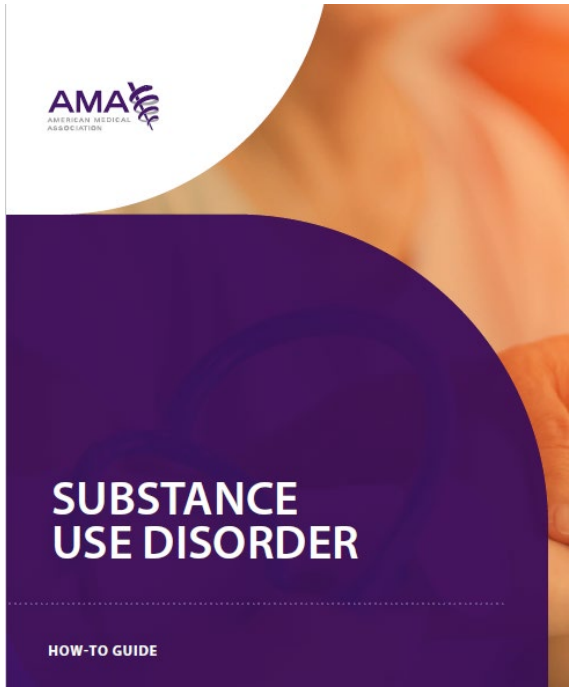
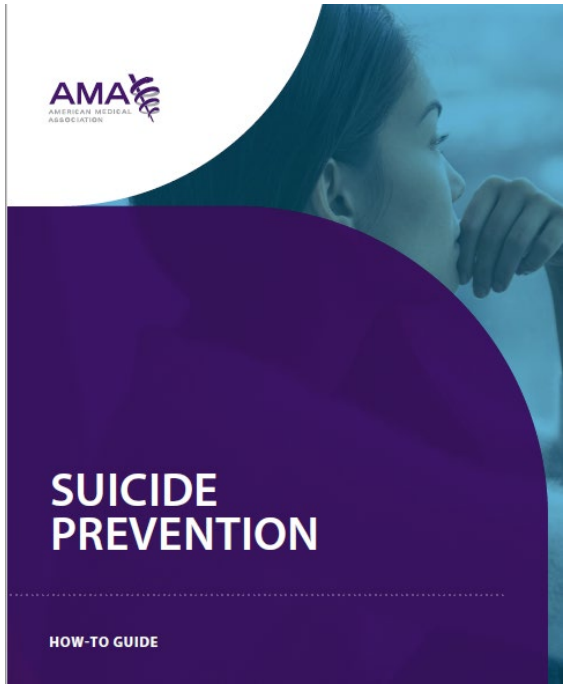
Download Now
to learn how to make the best decisions for the mental health of your patients.

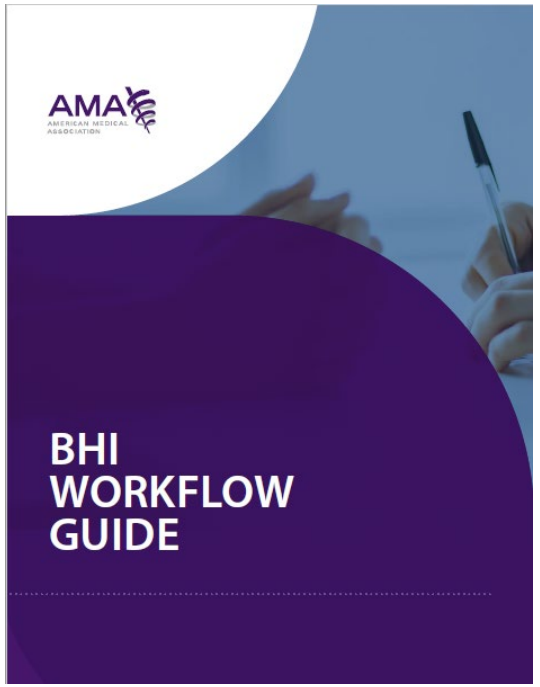
AMA Resources – *How-To Guides*

Access AMA's BHI practice guides for practical strategies, actionable steps and evidence-based resources on four specific areas of effective integrated care: pharmacological treatment, substance use disorder, suicide prevention, and workflow design.










Thank you for joining!