TBI-BH ECHO

Traumatic Brain Injury – Behavioral Health ECHO

UW Medicine | Psychiatry and Behavioral Sciences

TBI and Suicidal Ideation; addressing risk

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UW Medicine
UW SCHOOL OF MEDICINE

Project ECHO

TBI-BH ECHO

Speaker disclosures

✓ No relevant conflicts of Interest

The following series planners have no conflicts of interest:

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Objectives

At the end of the presentation participants will be able to

1. Implementing a screening program in practice
2. The importance of training providers to complete evaluations of risk of death by suicide
3. Key elements of Continuous Quality Improvement

Suicide Terminology

- **Self-harm -** Suspected or confirmed- the intentional, direct injuring of body tissue, done without the intent to take one's own life.
- **Suicide Plan -** Intentional harm of one's self with the what, when, where, and how.
- **Suicide Attempt -** A self-injurious act with some intent to die. (there does not have to be injury or harm, just the potential for injury or harm)
- **Suicide Behavior -** Span of activities related to behaviors and thoughts of suicidal thinking, attempts, and completions.
- **Suicidal Ideation -** Thinking and having thoughts of engaging in suicidal behavior

Acceptable Terminology	No Longer Acceptable Terminology
Died by suicide	Committed suicide
Suicide death/Suicided	Successful attempt/suicide
Suicide attempt/Attempt to end his/her life	Unsuccessful attempt/suicide
Person living with suicidal thoughts or behavior	Suicide ideator or attempter
Suicide/Ended his/her/their life	Completed suicide
Expresses suicidal ideation	Manipulative, cry for help
Working with	Dealing with suicidal crisis
Non-fatal attempt at suicide	Failed attempt at suicide

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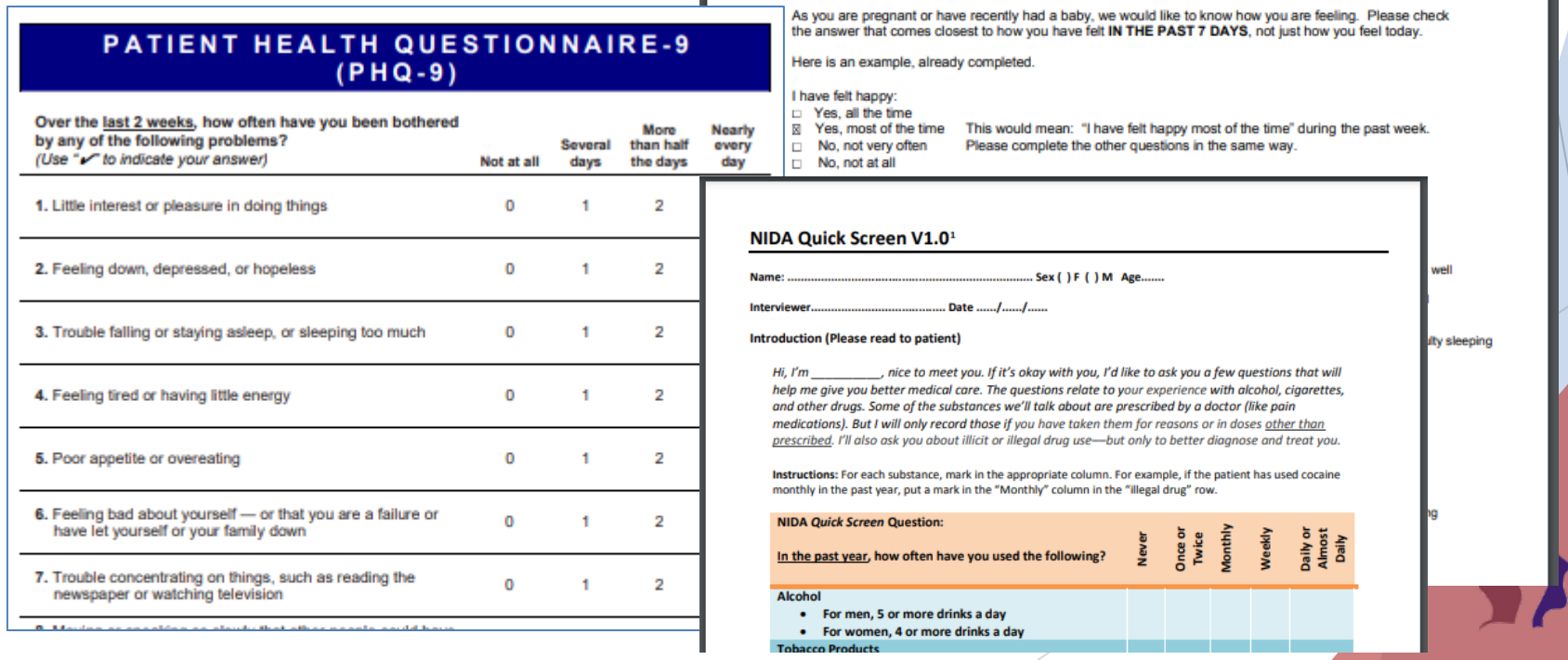
Initial risk assessment

- Screening
  - PHQ 9th item
- Risk severity
  - Columbia Suicide Risk Assessment
- Treatment Plan
  - Depression, referral
- Follow up
  - Within one week

Screening

- Universal screening using validated tools
  - Primary Care visits
  - Specialty visits



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

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	
2. Feeling down, depressed, or hopeless	0	1	2	
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	
4. Feeling tired or having little energy	0	1	2	
5. Poor appetite or overeating	0	1	2	
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

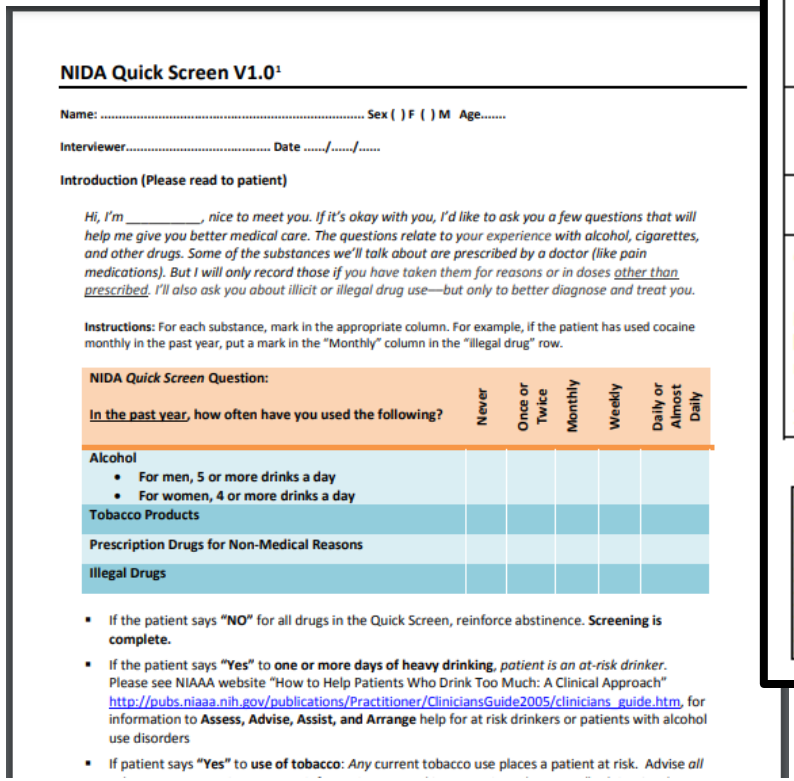
Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					

Risk Severity

- Validated Tools
- SBIRT
- Emergency protocols



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Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker.* Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all*

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Primary Care

Ask questions that are in bold and underlined.	Past month YES	NO
Ask Questions 1 and 2		
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 might 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 some intention 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	
If YES, ask: *Was this within the past 3 months?*	Past 3 Months	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Columbia Suicide Severity Rating Scale (CSSRS)

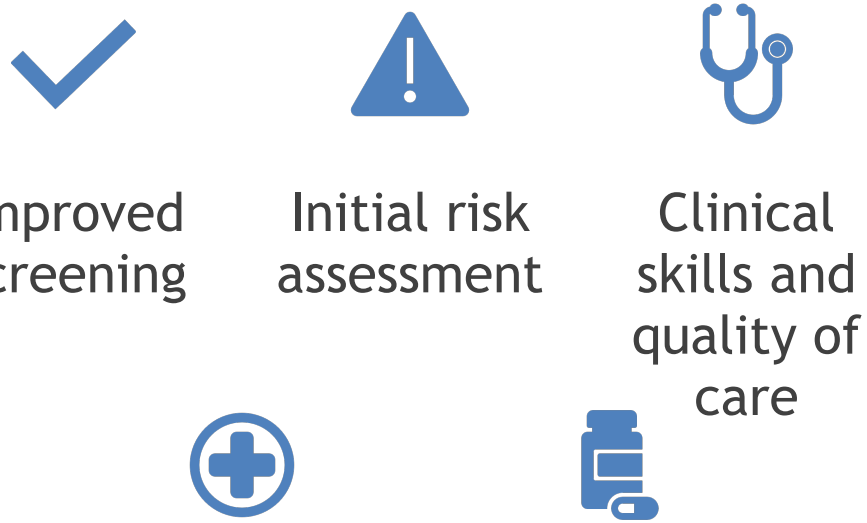
- Available in 103 different languages; successfully implemented across many settings
- RA version - 3 pages long
  - checklist of all risk and protective factors that may apply
  - formal assessment - intended to help establish a person's immediate risk of suicide and is used in acute care settings

Columbia-Suicide Severity Rating Scale (C-SSRS) | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

Coordinated Care

- Create a team approach
  - The staff you have
  - Navigation, follow up, brief psychotherapy, consultation
- Proactive follow up
  - Repeat symptom scores
- Connect with community services
- Use a registry

Clinical interventions and approaches



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QI Recommended Targets

- Suicide risk reduction

1. Screening rates
2. Risk evaluation
3. Follow up
4. Treatment
5. Response

What data will guide improvement?

- # patients screened
- # patients evaluated
- # with treatment
- % response
- Metrics of your choice

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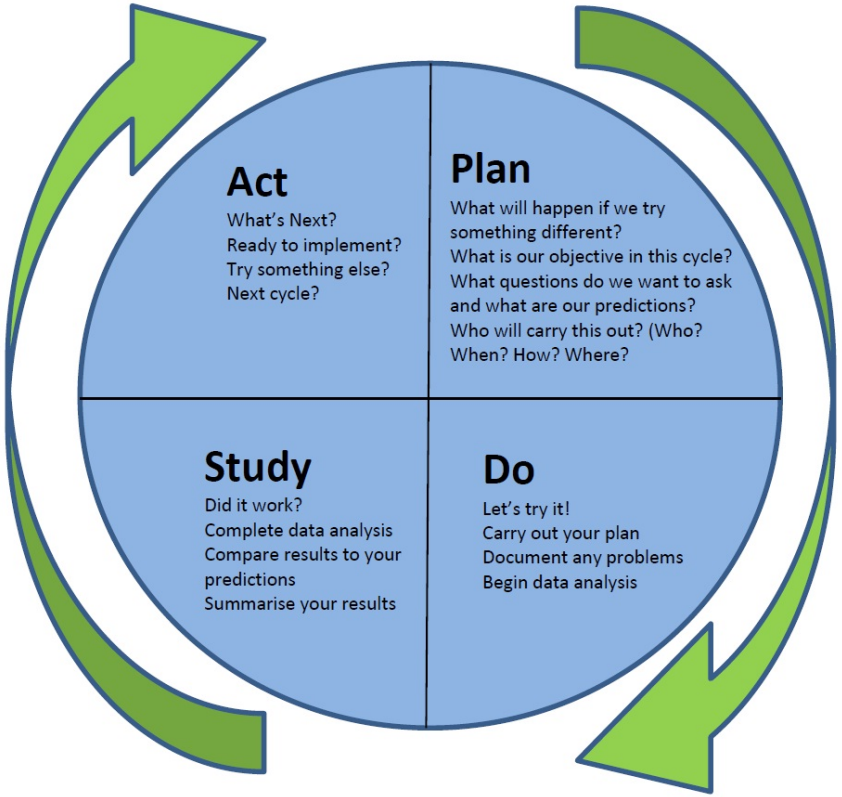
PDSA's are: Simple, Effective and…

PDSA addresses the crux of change: the translation of ideas and intention into action.

Learning as quickly as possible whether an intervention works and making adjustments accordingly.

Collaborative Care itself can be thought of as a series of PDSA's, quickly adjusting treatment in order to get people better.

Practice change to improve outcomes



- Quality improvement methods for practice change
- Data driven practice change – screening, follow-up, coordinated care

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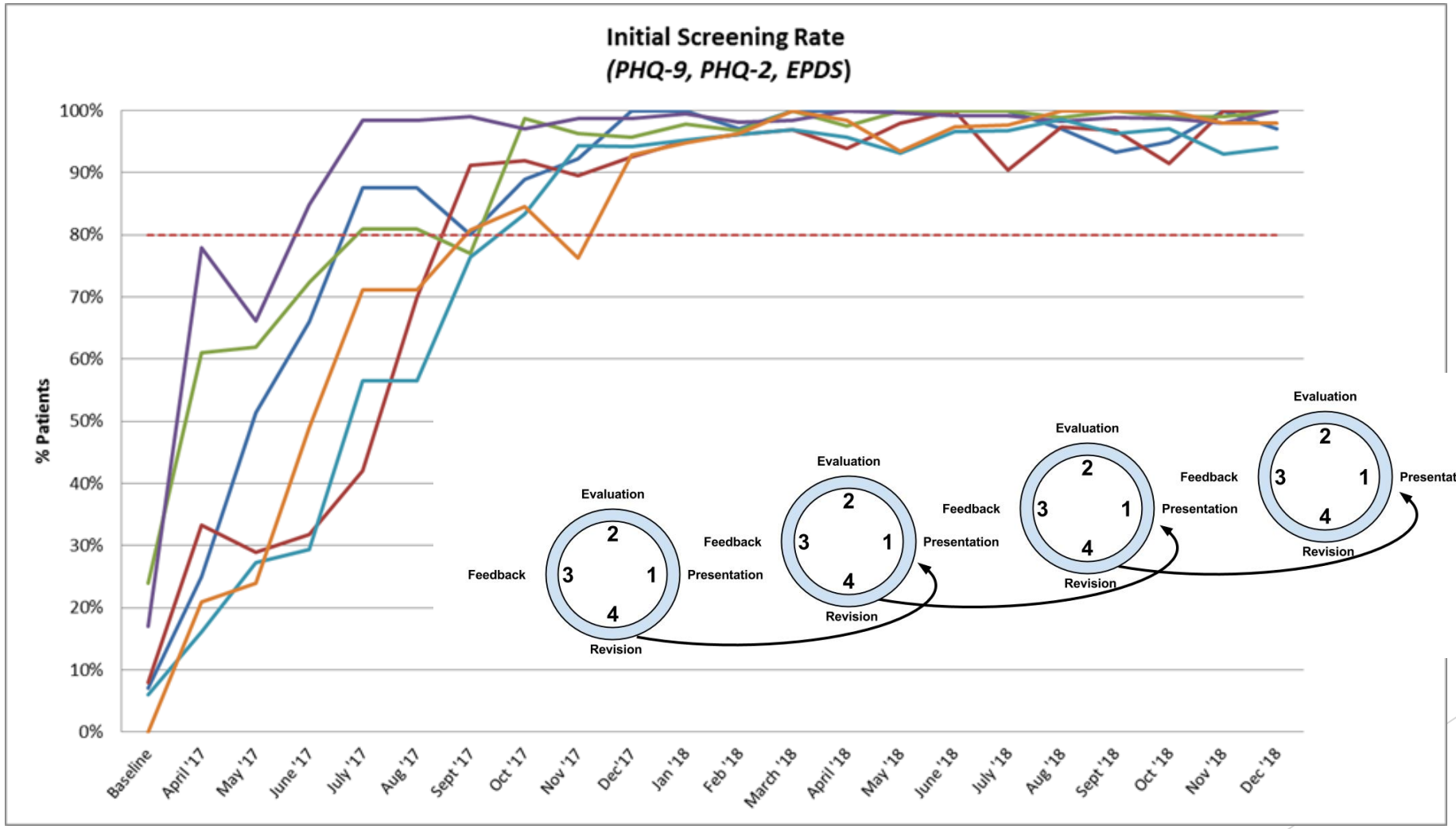
MInD-I Screening Rates



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Case presentation

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Case #1

- 38 yo Latinx woman with TBI following car accident, Medicaid insurance, three children
- recurrent severe depression (PHQ9 score = 18), manifested in suicidal ideation, apathy, low energy
- She is a single mother
- Never been treated for depression or suicide risk
- Past history of depression with no self harm attempts or history of psychosis or mania
- Current SI with plan to use a handgun that is loaded and by her bedside
- Very concerned about how to be sure her older children are cared for if she is hospitalized

Clinical Question

Group clinical questions?

What additional pharmacologic and psychotherapy approaches should be considered?

What suicide risk monitoring should be done - type and cadence?

Case #2

- 29 year old man with TBI
- Presents to discuss insomnia; struggling with worries about work that isn't able to do since his injury. Worked int eh maritime industry with ship renovation and refitting.
- PHQ-9 was 14 with last question indicating thoughts that life is not worth living

Clinical Question

Group clinical questions?

What would be the approach to help this patient?

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All Patients Safe

- Interactive, online suicide prevention training
- Both the three-hour and six-hour version of the course meet WA State's licensure requirements for health care provider suicide training
- Includes perinatal suicide risk
- Currently free for WA State providers and client-facing staff

https://www.apsafe.uw.edu/about

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