Session # letter and number

High Stakes: Preparing your Team for Suicide and Psychosis Risk Assessment

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- Mary Peterson, PhD – Department Chair at George Fox University
- Luann Foster, PsyD – Coordinating Supervisor for BHCCT, George Fox University Faculty
- Heather Harris, MA – BHCCT Team Coordinator, George Fox University Pre-Intern

CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

Identify factors and needs in your health system related to psychiatric crisis care

How to develop a program for training and sustaining professionals for crisis risk assessment

How to implement a risk assessment protocol in rural settings using evidence-based methods and outcome data

Bibliography / Reference

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2. Handley, T. E., Inder, K. J., Kay-Lambkin, F. J., Stain, H. J., Fitzgerald, M., Lewin, T. J., ... & Kelly, B. J. (2012). Contributors to suicidality in rural communities: beyond the effects of depression. BMC psychiatry, 12(1), 105.
3. Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. Suicide And Life-Threatening Behavior, 42(6), 640-653. doi:10.1111/j.1943-278X.2012.00119.x
4. Ramberg, I., Di Lucca, M., & Hadlaczky, G. (2016). The impact of knowledge of suicide prevention and work experience among clinical Staff on attitudes towards working with suicidal patients and suicide prevention. International Journal of Environmental Research And Public Health, 13(2), 195. http://dx.doi.org/10.3390/ijerph13020195
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Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Meet our Team

MARY PETERSON, PHD

WHO ARE WE?
THE BEHAVIORAL HEALTH CRISIS CONSULTATION TEAM

What?

Masters' prepared graduate students: After-hours call

Why?

Meeting the needs of a rural health system

Previous risk assessment process

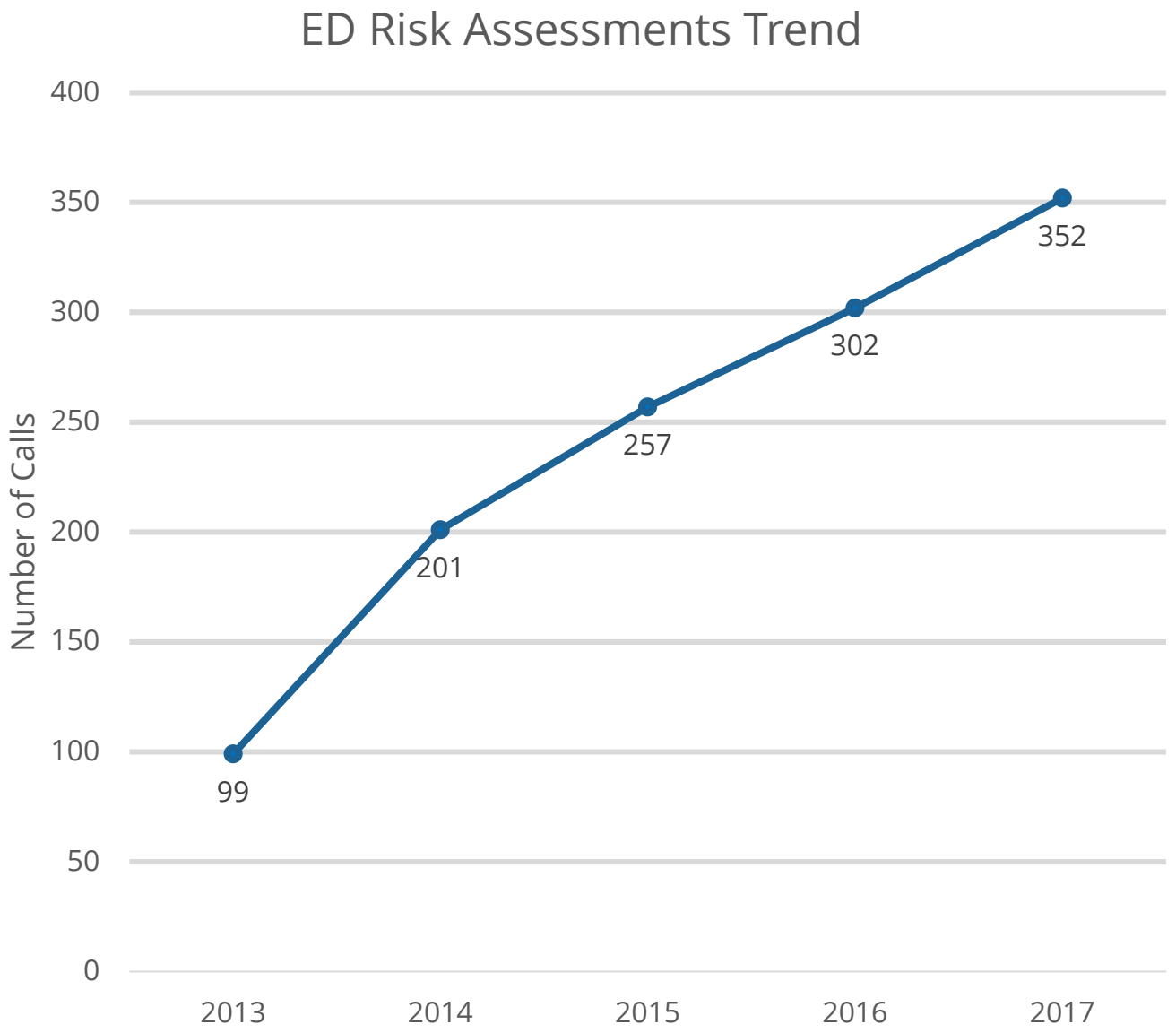
Who do we serve?

Patients

System!

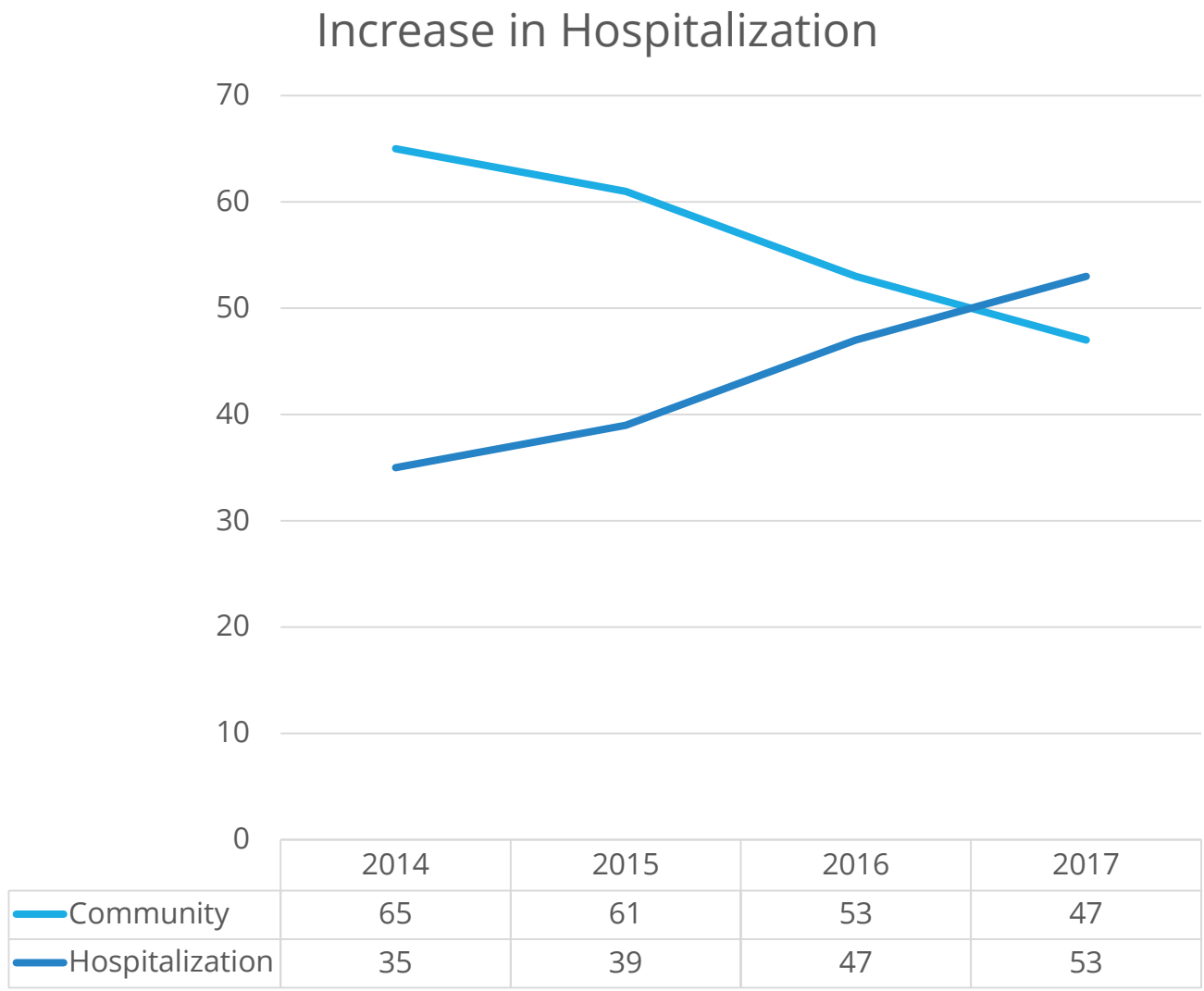
What happened?

- ✓ **ACA**
- ✓ **PCP Shortage**
- ✓ **Social Determinants**



Hospitalization Trends

- **Higher acuity**
- **Significant increase in teens**
- **Heightened Awareness**



	2014	2015	2016	2017
Community	65	61	53	47
Hospitalization	35	39	47	53

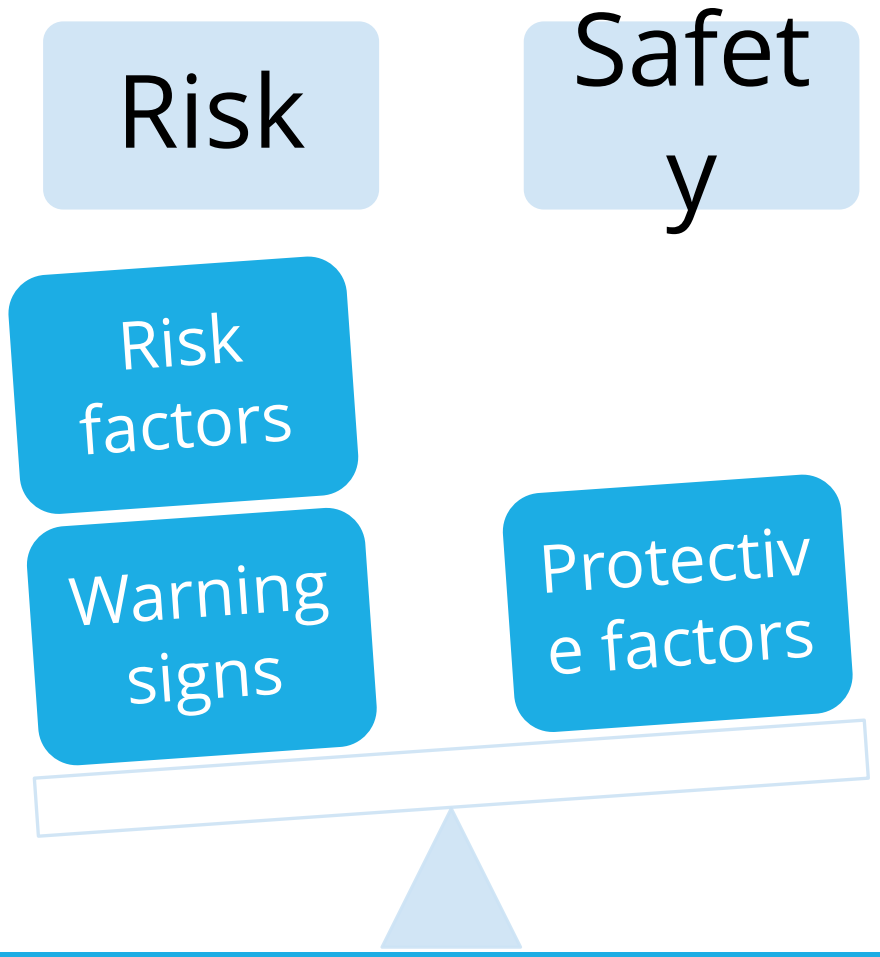
Boots on the Ground

KYLER SHUMWAY, MA

How it Works

1. Hospital ED staff triage
2. Attending requests a consult
3. BHCCT clinician responds:
   - Consults with the medical team
   - Interviews the patient and collaborators
   - Conducts a risk assessment
   - Consults with supervising psychologist
   - Makes recommendations to the medical team
   - Case management
4. Handoff to YCMH (County Mental Health) at end of shift

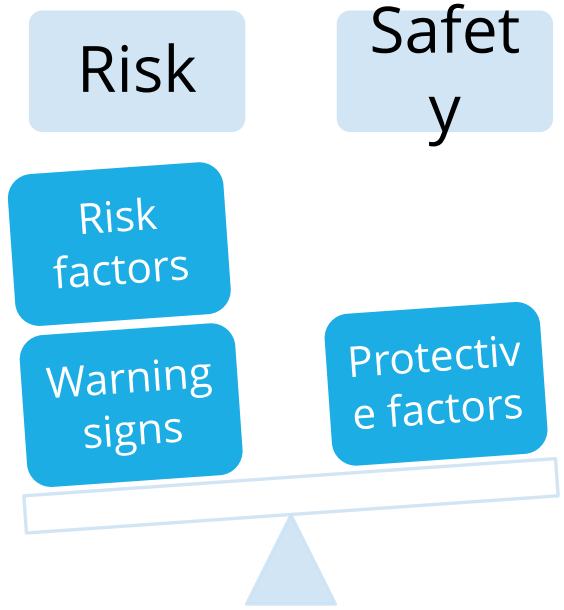
The Balancing Act



The Balancing Act

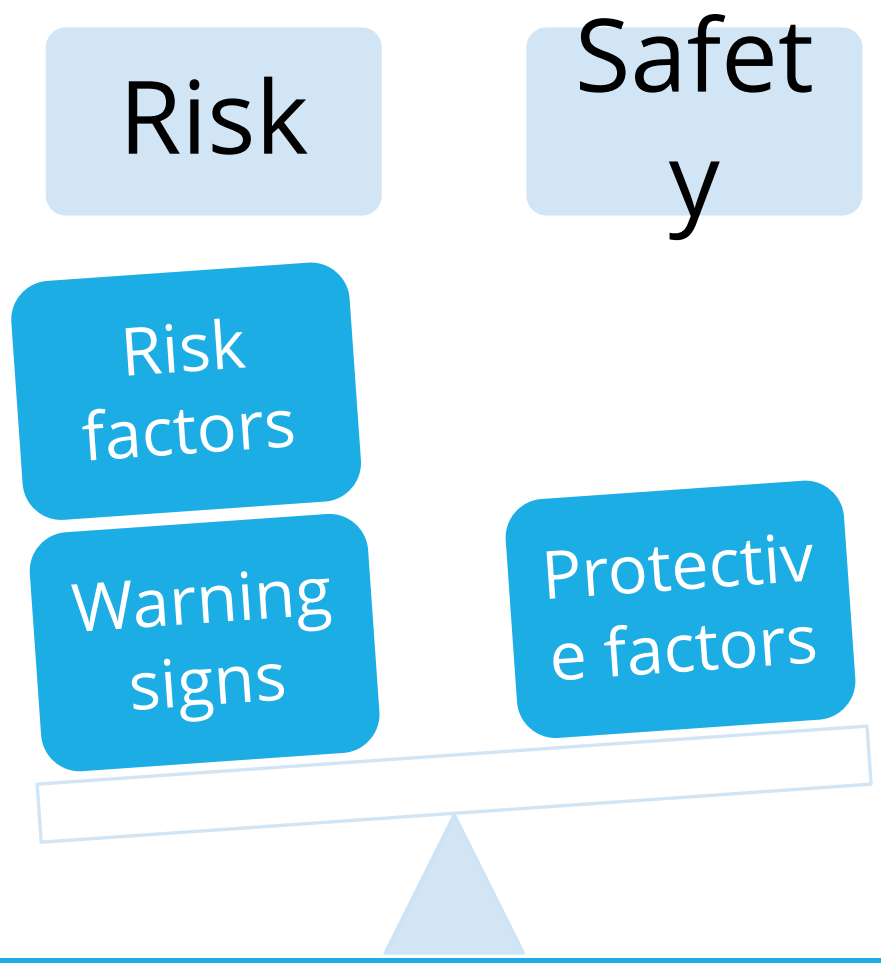
Risk Factors
Access to means
Isolation
>45 years old
Substance abuse
SPMI
Previous attempts
Unemployment

Warning Signs
Recent attempt
Recent loss
Social withdrawal
SI and intent
Relapse



Protective Factors
Social support
Safety plan
Motivated for tx
Faith/Spirituality
PCP
Therapist
Financial security
Openness and honesty

The Balancing Act



Home

- Safety plan
- F/u with PCP and therapist

Respite or Rehab

- Often must be voluntary
- Goodness of fit

Hospitalization

- High acuity
- Stabilization

Time for some audience participation!

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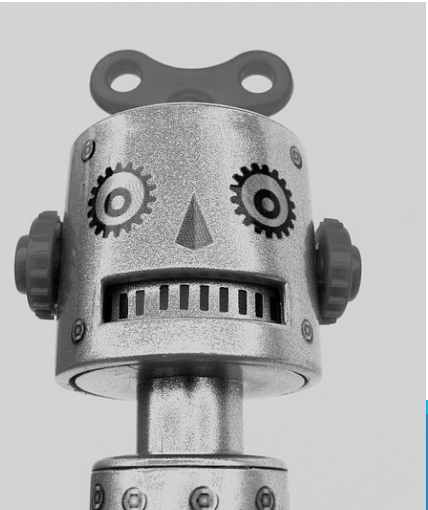

Case Example: Patient 1

Background

A 43 y.o., employed, African American, heterosexual, married, able-bodied male was brought to the ED by his wife after he told her he was having thoughts of suicide.

BAC was measured at 256 at admission, toxicology reports no other substances.

Has a PCP, does not have a therapist, is not religious.

Attending physician requests a consult for risk of harm to self.

In the Room

The patient wife is in the room, tearful.

The patient sits upright in his bed, irritable.

He denies SI/HI, intent, and plan. He denies feeling depressed or anxious. He reports that he said what he did "out of anger." He admits that he drinks daily or every-other-day, "a beer or two." He reports that his motivation is to "go home and forget this happened."

His wife tells you that he has been withdrawing from his friends, and that the two of them have been arguing frequently over the past few months. She reports that her husband drinks to the point of intoxication most nights. She is afraid that he will use his handgun to kill himself.

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Case Example: Patient 2

Background

A 16 y.o., high school student, Latina, single, heterosexual, able-bodied female was sent to the ED by her therapist after she disclosed a plan to end her life that day via hanging herself.

Toxicology reports no substances in her system.

Has a PCP, has a therapist, identifies as Protestant. The therapist left a treatment summary that described a longstanding history of suicide attempts and a diagnosis of PTSD related to sexual abuse perpetrated by a family member in her childhood. The patient lives with a foster family.

Attending physician requests a consult for risk of harm to self.

In the Room

The patient is tearful, laying still in the hospital bed.

She discloses having SI with intent and plan. She reports that she is afraid she might harm herself, but "even more afraid of going back to the inpatient hospital." She is open about her health history. She is motivated to return home so that she does not miss school the next day.

Foster parents arrive after you complete the patient interview. They tell you they think she is "being dramatic" and that the patient "does this all the time."

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Case Example: Patient 3

Background

A 32 y.o., unemployed, White, bisexual, able-bodied male brought himself to the ED after he began to have thoughts of suicide.

Toxicology reports THC in his system.

Has no PCP or therapist, identifies as Atheist. He is currently transient and looking for work and housing. He was previously employed as a construction worker but was laid off 5 months ago. Not married, sexually active with partners he meets through dating apps.

This is his first encounter with your medical system, no previous medical history.

Attending physician requests a consult for risk of harm to self.

In the Room

The patient is eating chips and making jokes with the nurse when you enter.

As you begin your interview, the patient becomes somber and tearful. He discloses having SI with intent, but is disinterested in sharing his plan at this time. He says he has been feeling depressed for "about a week." He tells you that he would like to be placed in an inpatient hospital.

He denies a history of medical issues. He denies having any social supports, as he moved to the area 1 year ago from out of state.

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These choices aren’t easy

Training the Team

LUANN FOSTER, PSYD

Recruiting

Goodness of fit for team candidates

High pressure

Unique opportunity

Orientation and Training

Education

- Evidence-base of practice and our protocol
- Systems and our role

Experience

- Shadowing (Scaffolding)
- Preshadows, Wave 1, 2, 3
- Supervision

Evaluation

- Veteran member
- Supervising psychologist

The Protocol

Key aspects of the protocol

- Presenting problem (What happened today?)
- Risk factors and warning signs
- Substance Use
- Protective factors
- Brief history

Designed to meet the need

The Consult

Succinct Communication:

- Demographics
- Reason for Referral
- Symptoms
- Motivation (for harm vs. for treatment)
- Assessment
- Plan

What is relevant for the pt right now?

Do they meet criteria for hospitalization or no?

If not, what is the appropriate level of care? (referrals)

Student Experiences

HEATHER HARRIS, MA

KYLER SHUMWAY, MA

Critical experiences

Systemic arousal

Distress tolerance

Rapid and effective assessment

Any others that you can think of

Q&A

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

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