Welcome!

Adolescent CoCM Training
March 20, 2023

The Collaborative Care Model

The Collaborative Care program is a joint effort with MCCIST, Mi-CCSI, BCBSM and MICMT that through their collaborative efforts develop and deliver training curriculum and support practice implementation throughout the state of Michigan.

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

MI-CCSI
Center for Clinical Systems Improvement

Blue Cross Blue Shield Blue Care Network of Michigan
Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

MICMT
Michigan Institute for Care Management & Transformation

Thank you to
Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan has contracted with the Michigan Collaborative Care Implementation Support Team (MCCIST) and the Michigan Center for Clinical Systems Improvement (MiCCSI) to provide training and implementation on the evidence-based treatment model of Collaborative Care to primary care practices throughout the state of Michigan.

We would like to thank BCBSM for their attention, initiation and support of this important work.

Blue Cross Blue Shield of Michigan

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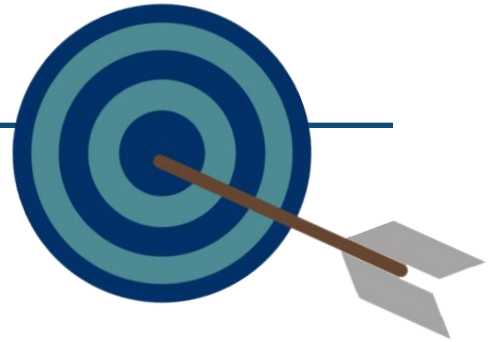
Aim of This Training



- **This is the introductory training to prepare you to launch the Adolescent CoCM Program**
  - Implementation is a process and will require more preparation beyond today
- **For some, this will be review; for others it will be new material**
  - Scope of experience/practice depends on roles and responsibilities at your PO/Practice
- **Continued support beyond this training to support the Adolescent CoCM Program**
  - Additional training and resources will be available to advance your skills and support your PO/Practice
  - Reach out to your training partners as questions come up in the implementation process

Learning Objectives

- Describe depression, anxiety, and other common co-morbid psychiatric disorders that occur during adolescence
- Explain the basic treatment options for depression and anxiety
- Perform a basic suicide risk assessment
- State primary attributes of adolescent brain development
- Identify the ways that these attributes impact interactions between youth and adults in a clinical setting
- Identify personal biases in adolescent care and interaction
- List three of the care management processes relative to the Collaborative Care Model (CoCM)
- Review techniques for effective engagement with adolescents and their caregivers
- Examine the special considerations needed when working with adolescents and their caregiver through the CoCM process
- Describe strategies for care coordination in a planned proactive manner
- Review various psychotherapy techniques and when to consider referral to specialty mental health providers for adolescents
- Explain the importance of self-care in the treatment of anxiety and depression in adolescence

Learning Outcome

- Participants will be able to apply the Collaborative Care Model with the adolescent population, focusing on patient caseload, suicide assessment, and treatment of depression and anxiety.

Training Schedule

Day 1 – An Introduction to CoCM with Adolescents

8:00am – 8:15am	**Introductions**
8:15am – 8:30am	Eligibility Recommendation and Case Load Size
8:30am – 10:00am	Overview of Adolescent Depression and Anxiety
10:00am – 10:10am	Break
10:10am – 11:10am	Treatment of Adolescent Depression and Anxiety
11:10am – 11:20am	Break
11:20am – 12:20pm	Suicide Assessment in Adolescents
12:20pm – 12:30pm	Conclusion and Evaluation

Presenters:

Dayna LePlatte-Ogini, MD	Clinical Assistant Professor, Michigan Medicine Department of Psychiatry
Heidi Rollings, MD	Program Director, Pine Rest Christian Mental Health Services: Assistant Clinical Professor of Psychiatry, Michigan State University
Karla Metzger, LMSW	Program Director, MCCIST
Erin Hughes-Krieger, LMSW	Training and Implementation Specialist, MCCIST
Debbra Snyder, MS, LLP, CAADC, CCS	Project Manager, MCCIST
Sarah Fraley, LMSW	Training and Implementation Specialist Lead
Karen Gall, LMSW, ACTRP	Training and Implementation Specialist, MCCIST
Sarah Bonnough, LMSW	Training and Implementation Specialist

Virtual Etiquette

Provide feedback

- Be an active participant by asking questions and responding to questions through the chat feature and responding to polls

Video and Audio:

- Unless distracting, please turn video ON. This is crucial for building trust and engagement.
- Test your video and audio before the meeting begins.
- Try to look at the camera when talking (to mimic the feeling of in-person eye contact).
- Adjust your camera if it is too high or low.
- Closed captioning is activated but individual users may deactivate this feature if they prefer by selecting “Hide Subtitle” under the “CC Live Transcript” tab

Environment:

- Be aware of your backgrounds to not be distracting.
- Position yourself in the light.
- Find a quiet place to join or mute yourself as necessary.

Disclosure

The Michigan Center for Clinical Systems Improvement (MiCCSI), Michigan Institute for Care Management and Transformation (MICMT), and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

This presentation is being recorded

Disclaimer

Each physician organization and/or practice is solely responsible for all billing practices and medical care and services delivered to its patients and all decisions related to such medical care and services. Neither MICMT, the Regents of the University of Michigan, or MI-CCSI shall be responsible for any delivery of medical care or other services to any patient, or any decisions, acts or omissions of persons in connection with the delivery of medical care or other services to any patient.

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Who’s here with us today?

What patient population are we focusing on?

- Patients ages 12 years old through young adulthood transitions as appropriate for clinic type
- Patients with depression and/or anxiety (can have comorbidities such as ADHD and/or some substance use)
- Adolescents willing and able to engage in ongoing communication (often weekly at beginning)
- Guardian/support person willing to engage (sometimes weekly at beginning), especially for 12–14-year-olds. For older adolescents may not need same level of family support but should be part of level of care determination. Understanding your clinic's policies surrounding minors and confidentiality/consent is key.

Adolescents who might not be appropriate for CoCM

- Unable to communicate
- Parents (or support persons) not willing to engage in frequent contact with BHCM (not following through with higher level of care) do not just default to CoCM if higher LOC needed. Patients who need a higher level of care and/or are in the care of CMH (consider duplication of services).
- Input from Psychiatric Consultant key/PCP comfort level
  - Significant developmental disability (Severe autism)
  - Significant self or other harming behavior
  - Bipolar disorder
  - Psychosis or delusional disorders
  - Eating disorder (significant symptoms)
  - Significant substance use disorder
  - Obsessive compulsive disorder

Therapy Referrals?

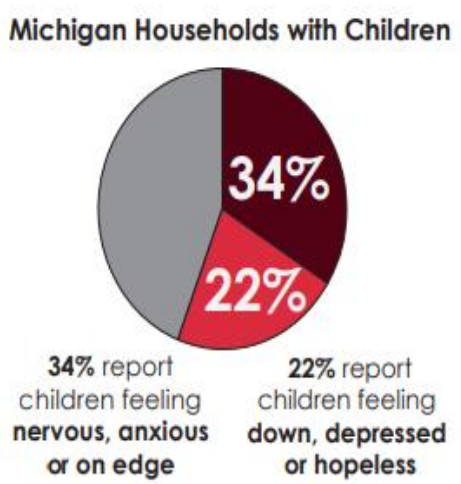
Adult vs. Adolescent CoCM

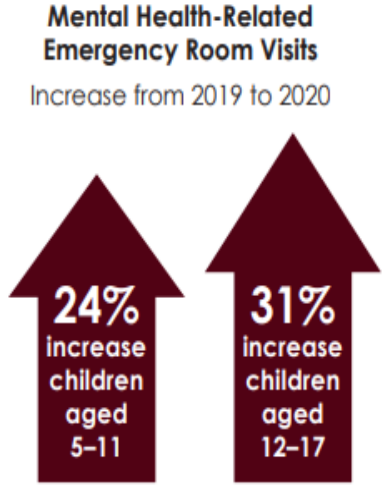
- More time commitment for BHCM.
- Not just assessing the adolescent, also assessing the family/guardian/systems. Intergenerational approach is key to success.
- Coordination between multiple systems: schools, therapy providers, courts, etc..
- Many of these adolescents will benefit from therapy. Psychiatric consultant can recommend evidence- based psychotherapy.
- Based on anecdotal evidence, a full-time BHCM focused solely on CoCM should be able to manage a caseload of 30-60 adolescents at a time (depending on complexity and what other support staff may be available).

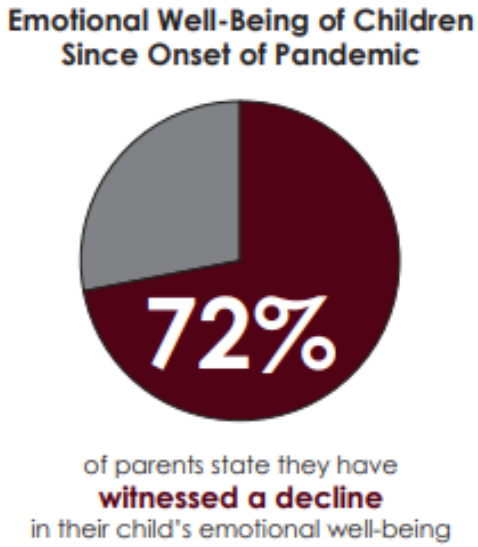
A Brief Review of Depression, Anxiety, and other Common Co-morbid Disorders in Adolescence

There is a need for more mental health...

- Prior to the pandemic, there were already several challenges with regards to access to mental health needs
- Pandemic has intensified the mental health needs







Pandemic and Mental Health of Adolescents

- Most common presentations
  - Anxiety
  - Depression
  - Disturbances in sleep
  - Disturbances in appetite
  - Impairment in social interaction
- The pandemic may continue to have increased long term adverse consequences on adolescent mental health
- Important to intervene and monitor

Meherali S, Punjani N, Louie-Poon S, et al. Mental Health of Children and Adolescents Amidst COVID-19 and Past Pandemics: A Rapid Systematic Review. *Int J Environ Res Public Health*. 2021;18(7):3432. Published 2021 Mar 26. doi:10.3390/ijerph18073432

Blue Cross Blue Shield Data

- Self harm and suicide increased in 2020 significantly
  - 28% increase in self harm
  - 11% overall for suicide
- Self harm and suicide increased in the 10–14-year range as well as in the 15–18-year range
  - Suicide attempts up 45% among 10-14-year-olds
  - Suicide attempts up 20% among 14–18-year-olds

A Case - Mary

16-year-old female with no past psychiatric history presents to her primary care providers office with her mother given concerns about low mood. Patient has been more isolative, tearful, and irritable. She has poor sleep. She refuses to go to soccer practice and prefers to go home to nap after school. She previously was very active with her soccer team and was going to be the team captain but now she may be kicked off the team given her lack of participation recently. She describes feelings of hopelessness and worthlessness. Her grades have dropped, and she has been in significant conflict with parents around her failing grade in English. She often goes to bed without dinner and parents believe she has lost some weight. She describes feeling stressed with school and the pandemic. She reports having a passive wish to die. No suicidal plans.

Does this presentation sound familiar?

Depression in Young People – Prevalence

- 2% in children
- 4-8% in adolescents (Avenevoli et al., 2015)
  - 12-month period 11.0%
  - Severe impairment 3.0% (life); 2.3% (12 months)
- Male-female ratio of 1:1 during childhood
- Male-female ratio of 1:2 during adolescence
- 20% of females by the age 18
- 1 in 4 adolescents have experienced a depressive episode by age 18
- 5-10% have sub-syndromal symptoms of MDD
  - Significant psychosocial impairment
  - Increased risk of suicide and developing MDD

Birmaher et al. 1996, Wichstron 1999

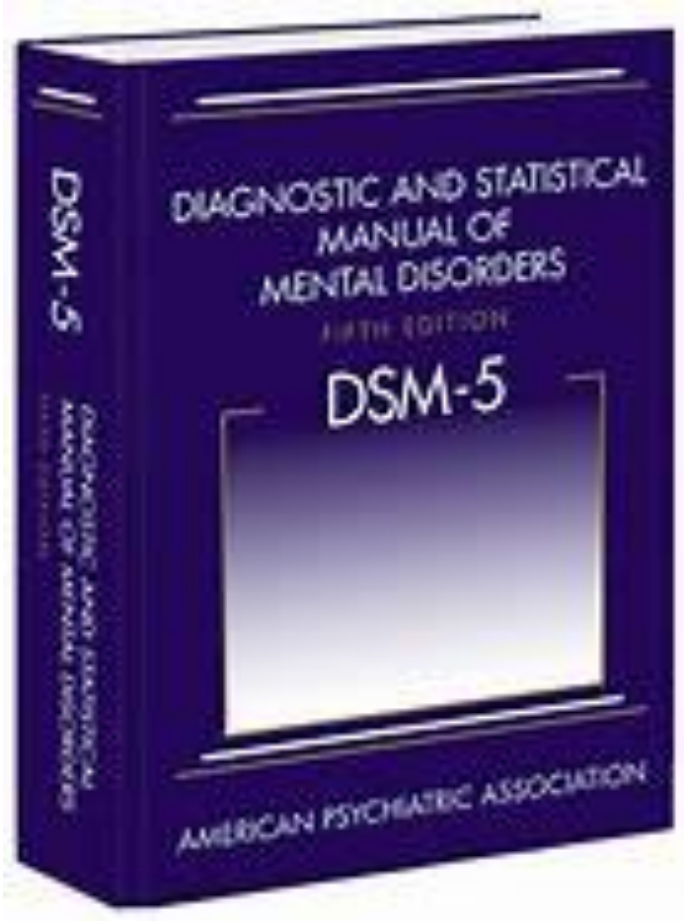
Co-morbidity is the Norm

- 40-90% of youth with depressive disorders have a co-morbid disorder and up to 50% have 2 or >
- Most common co-occurring mental health diagnoses:
  - Anxiety
  - Disruptive behavior disorders
  - ADHD
  - Substance Use Disorder
  - Autism Spectrum Disorder

Long-term Consequences of Depression on...

- School
- Work performance
- Substance abuse
- Suicide attempts
- Legal difficulties

DSM-5


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION

Who is at risk for depressive disorders?

- Parent or sibling with depression
- Negative outlook or poor coping strategies
- Chronic medical issues
- Previous depressive symptoms or depressive episodes
- Family stressors or dysfunction including conflict with caregiver
- Exposure to early adverse events (abuse, neglect, loss of loved one)

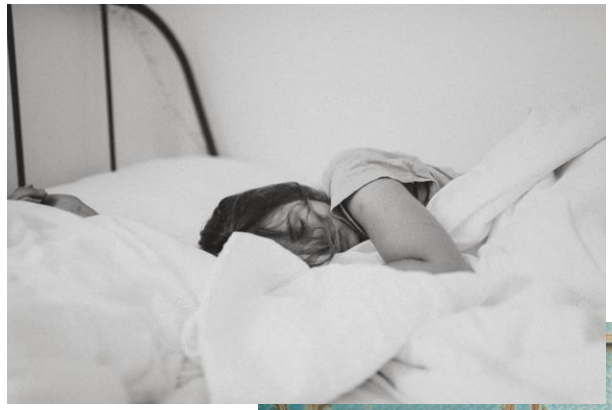
Depressive Disorders

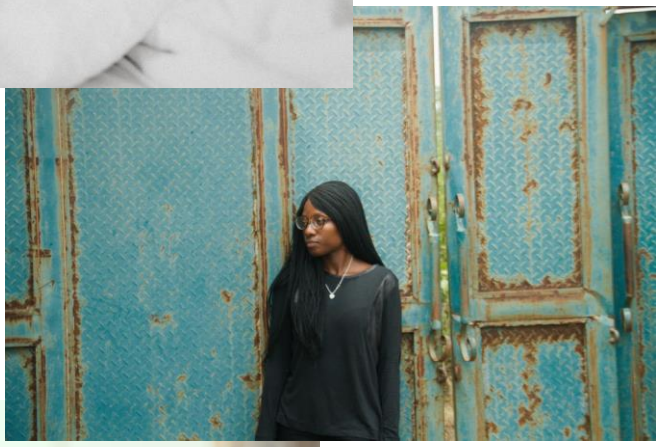
- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder (MDD)
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder

MDD

Depressed mood or anhedonia + 5 or more of the following for 2 weeks:

- S = Sleep
- I = Interest (anhedonia)
- G = Guilt/Hopelessness/Worthlessness
- E = Energy
- C = Concentration
- A = Appetite
- P= Psychomotor agitation/retardation
- S = Suicidal thoughts (thoughts of death)





Let’s Go Back To Our Case…..

- Does Mary Have MDD?
- What more would you like to know?

Recall Mary…

- 16-year-old female
- Symptoms:
  - Low mood and tearful
  - Isolative
  - Irritable
  - Poor sleep
  - Hopelessness
  - Worthlessness
  - Passive wishes to die

- Functional struggles: less engagement in activities (soccer), napping after school, facing removal from extra-curricular activities with less engagement, academic decline, conflict with parents, not eating at dinner with weight loss, unable to manage stress

A little more about Mary…

With further questioning she has a long history of being a worrier.

She frequently worries about things that she probably should not be worried about. She describes having a phobia of flying.

No clear description of panic attacks. She also reports concerns about bullying at school. Last year she was in a serious car accident with her father. They both survived but she is still somewhat scared about driving long distances.

Anxiety disorders and depressive disorders are highly prevalent conditions that frequently co-occur

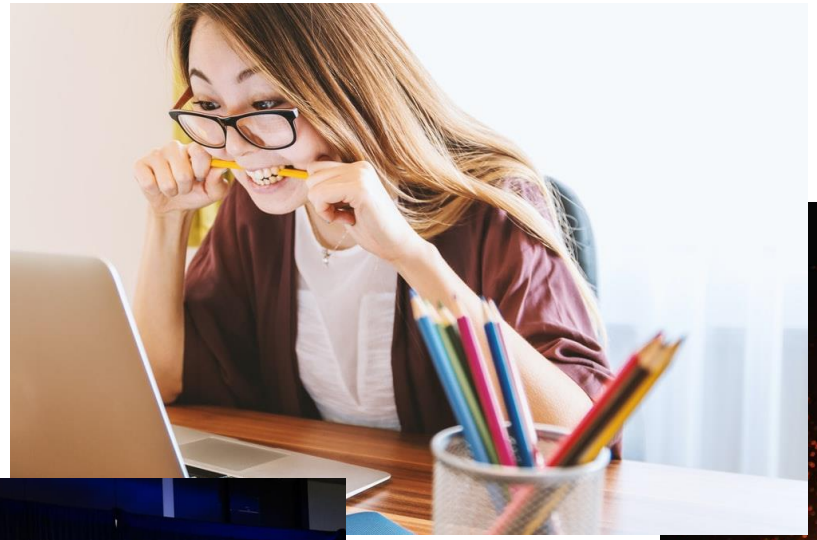
What is Anxiety?

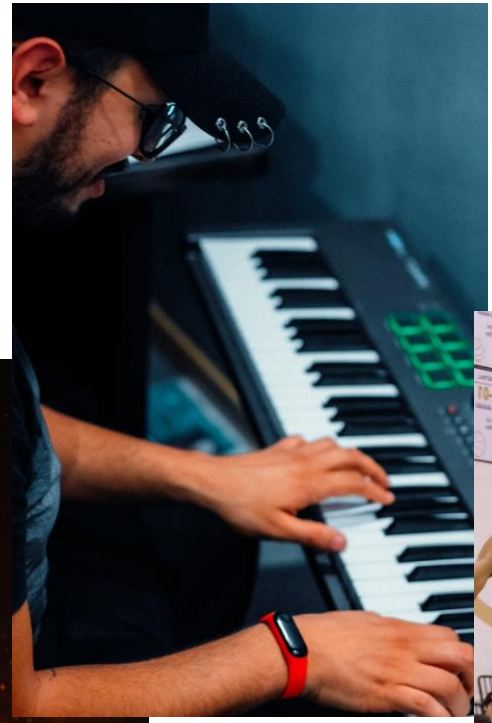
- Worry: anxious apprehension and thoughts focused on the possibility of negative future events
- Fear: response to threat or danger that is perceived as actual or impending

Anxiety Can Be Normal

Important to distinguish normal, transient, developmentally appropriate worries and fears from anxiety disorders

Anxiety Is Not All Bad





Anxiety As A Disorder

- Persistent
- Excessive
- Intense
- Frequent
- Distressing
- Not helping
- Disruptive
- Overwhelming
- Difficult to control

Interferes with daily functioning and interpersonal relationships

Again, Comorbidity is The Rule

- Obsessive Compulsive Disorder
- Separation Anxiety Disorder (SAD), Social Anxiety, and Generalized Anxiety Disorder (GAD)
  - Less common to have pure anxiety
- Mood Problems
- Externalizing Disorders
- Greater risk of developing substance abuse and conduct problems

Anxiety is Common

- Most common psychiatric illness of childhood
  - Prevalence estimates ranging from 10% to 30%
  - 12-month prevalence in adolescence 25% to 32%
- More common than asthma, diabetes, cardiovascular disease, and cancer

Achenbach TM, Howell CT, McConaughy SH, Stanger C SOJ Am Acad Child Adolescent Psychiatry. 1995 Mar;34(3):336-47.

AUMerikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J SOJ Am Acad Child Adolescent Psychiatry. 2010 Oct;49(10):980-9. Epub 2010 Jul 31.

Overview

- OCD
- Non- OCD Anxiety
  - Generalized Anxiety
  - Separation Anxiety
  - Specific Phobia
  - Panic Disorder
  - Selective Mutism
- Tools for assessment
- Treatment
- School refusal
- PTSD

OCD

Presence of obsessions, compulsions, or both:

- Obsessions:
  - Recurrent/persistent thoughts, urges, or images
  - Intrusive
  - Unwanted
- Compulsions:
  - Repetitive behaviors or mental acts
  - Aimed at preventing or reducing anxiety/distress

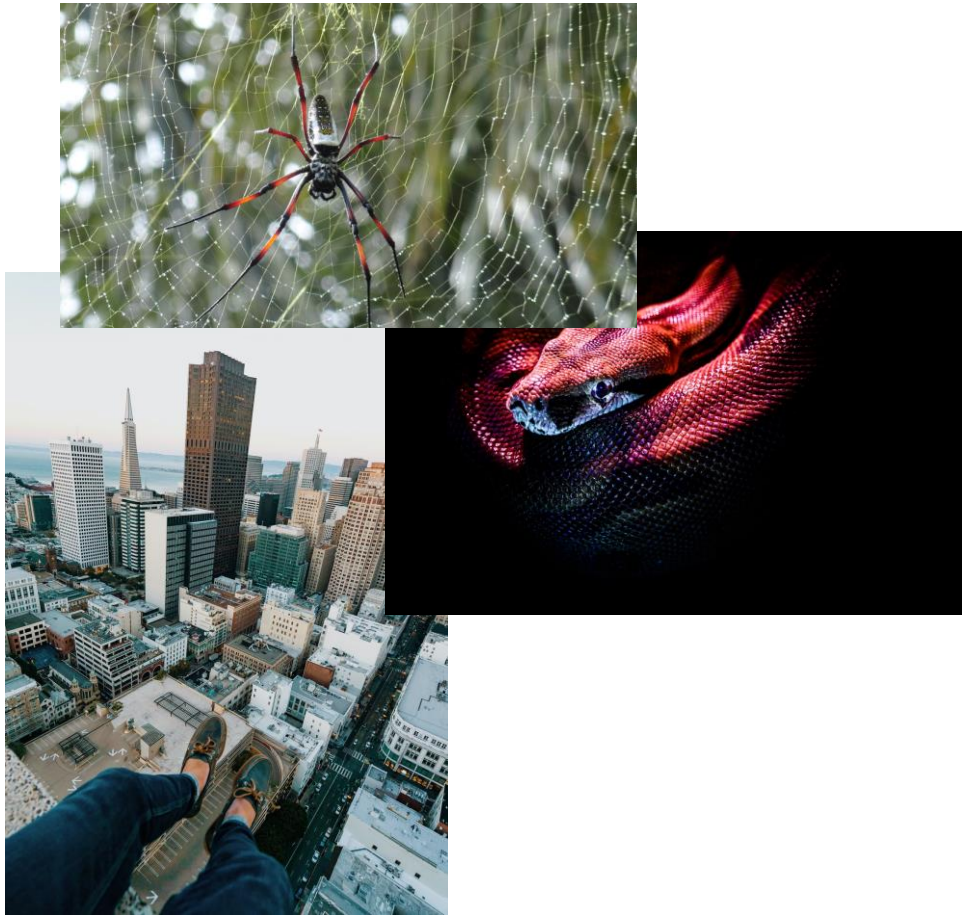
OCD

The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Generalized Anxiety

- Excessive anxiety and worry
- Occurring more days than not for at least 6 months, about a number of events or activities
- The anxiety and worry are associated with three (or more) of the following six symptoms:
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

Specific Phobia



- Marked fear or anxiety about a specific object or situation
- The phobic object or situation almost always provokes immediate fear or anxiety
- The phobic object or situation is actively avoided or endured with intense fear or anxiety
- The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more

Panic Attack

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light-headed, or faint
- Chills or heat sensations
- Paresthesia (numbness or tingling sensations)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or “going crazy”
- Fear of dying

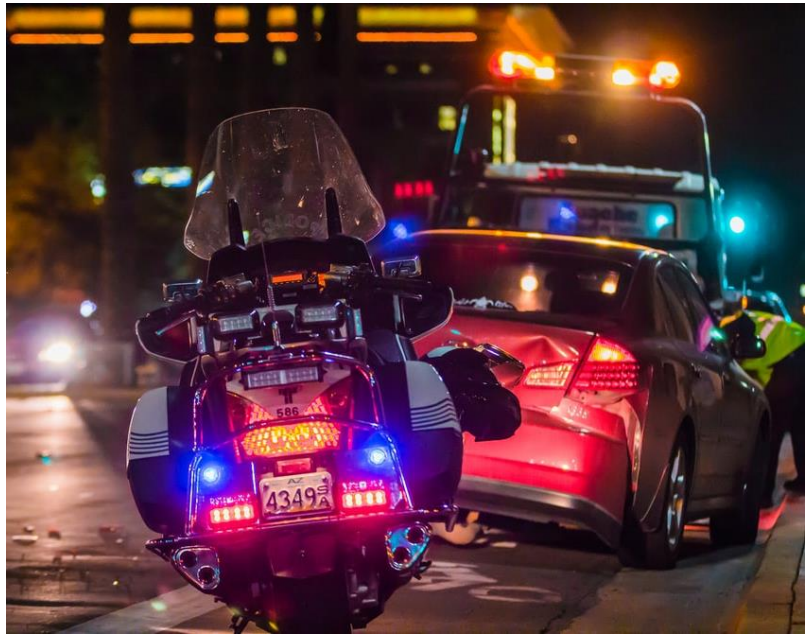
Panic Disorder

- Recurrent unexpected panic attacks
- At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
  - Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”)
  - A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)

Trauma

Trauma: an intense event that threatens safety or security of an individual

Toxic Stress: reoccurring negative experiences that threaten safety or security



Pandemic Related Stress

- Still learning more about this…
  - Fear of infection
  - Overburdened health care system
  - Uncertainty
  - Work and school related stress
  - Financial hardship
  - Social isolation
  - Excessive news and social media exposure
  - Multiple losses
  - Cannot ignore the increased awareness of racism
- All of this has an impact on adolescents coming into our clinics
- Could compromise an adolescent's sense of safety and make them more vulnerable to mental health disorders

A Few Resources

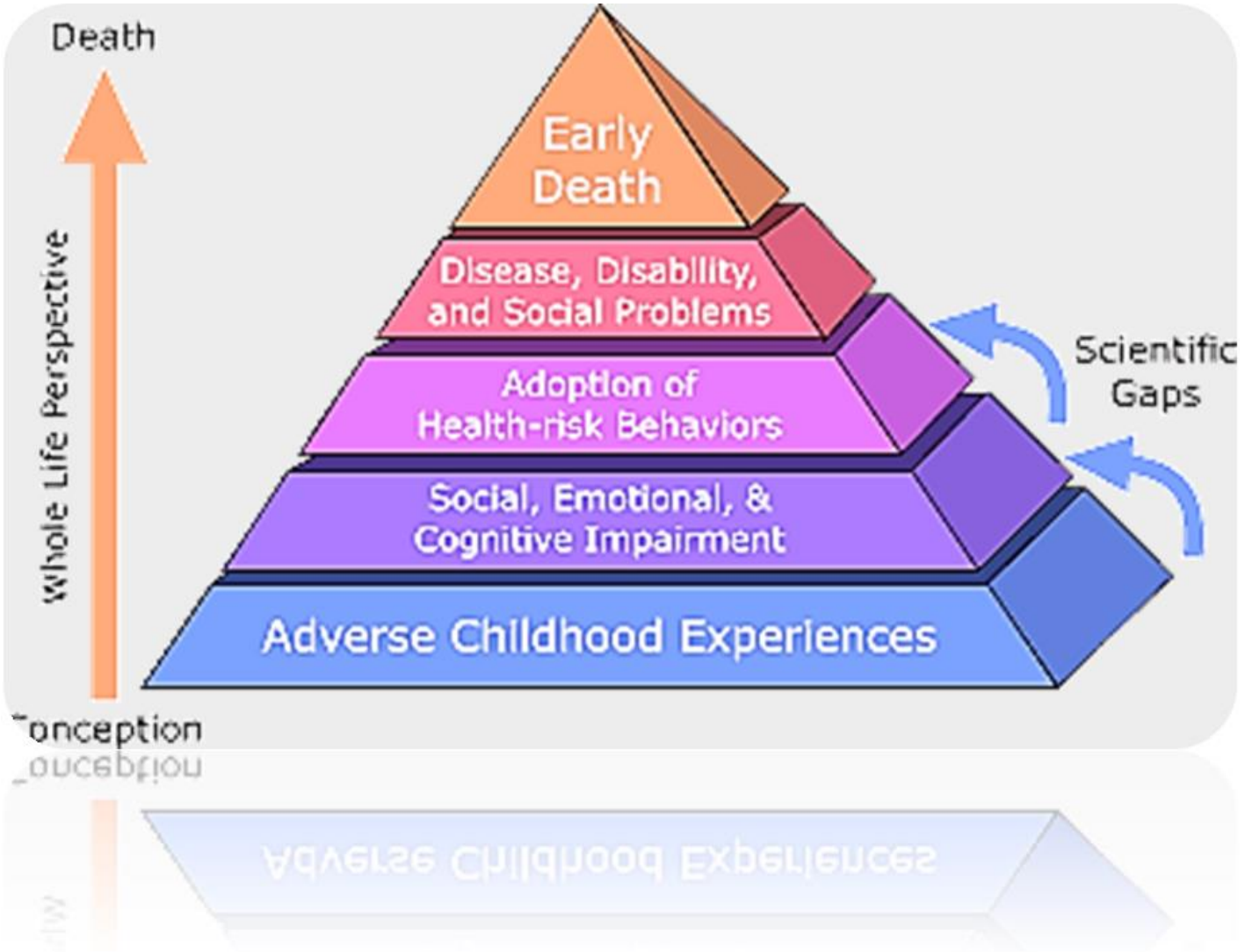
- AACAP Natural Disaster Resources
- American Psychological Association: COVID-19 Information & Resources
- National Center for PTSD
  - COVID-19: Resources for Managing Stress - PTSD: National Center for PTSD (va.gov)
- Internal Society For Traumatic Stress Studies
  - ISTSS - Public Resources
- Center for Traumatic Stress Studies: COVID-19 Pandemic Resource Pages

A Few Resources Related to Racism

- AACAP's Antiracism Resource Library
- AACAP's Asian American and Pacific Islander Resource Library
- AACAP's Virtual Forum on "Healthcare Disparities through the Lens of Diversity during the COVID-19 pandemic"
- Dr. Carlson interviewed Dr. Patrice Harris on Health Equities and Disparities in the COVID-19 era, as part of AACAP's SCREENSIDE CHATS series
- AACAP's Racism Resource Library
- JAACAP: Our Vision: An Anti-Racist Journal

Adverse Childhood Experience Study

- The ACEs Study is an ongoing collaborative research project between the CDC and Kaiser Permanente (17,000 subjects)
- Explore impact of childhood experiences and long-term health outcomes
- A series of 10 questions; each question worth 1 point for positives


Death
Whole Life Perspective
Conception
Early Death
Disease, Disability, and Social Problems
Adoption of Health-risk Behaviors
Social, Emotional, & Cognitive Impairment
Adverse Childhood Experiences
Scientific Gaps

Trauma in Collaborative Care

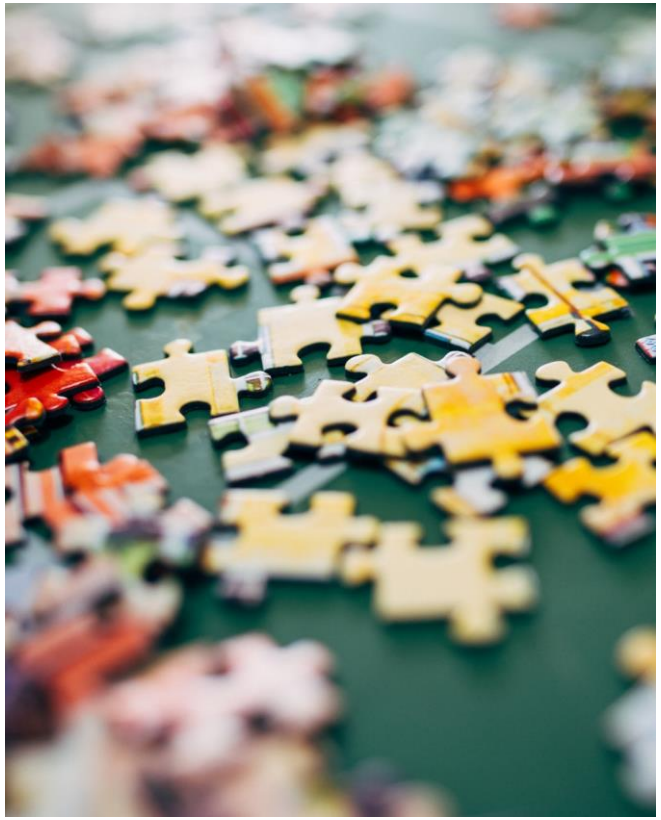
- Trauma and toxic stress can change a person's experience of the world
- Changes biology and brain architecture
- Ask about it
- Ask about it again
- Supportive relationships protect young people from the impact of trauma and toxic stress
- Remember to think about trauma informed interventions when needed
- Refer to a therapist trained in trauma informed interventions

School Refusal

- Not a DSM diagnosis
- Symptoms associated with several diagnoses
- Does not include youth who are not attending school because of truancy or conduct disorder
- Clinical picture can vary
- Behavior may be negatively reinforced (may be avoiding bullying or reading out loud, etc.) or positively reinforced (allowed to engage in pleasurable activities when refusing to go to school)
- Treatment may vary based on presentation and should include involvement from family and school

Gathering the Story

- From the adolescent
- From the adult (parent, guardian, etc..)
- Other collateral informants (when possible)
- Individual time with both the adult and patient
  - Clinic demand and schedules can make this tough for PCP
- Past Treatment
- Family History
- Medical History



Metrics for Anxiety

- Generalized Anxiety Disorder-7 (GAD-7) - recommended
- Child Behavior Checklist
- Obsessive Compulsive Inventory – revised
- The Leyton Obsessional Inventory
- OCD Self Report Questionnaire
- Children’s Yale-Brown Obsessive-Compulsive Scale
- Multidimensional Anxiety Scale For Children

Metrics For Depression

- PHQ-A (modified for adolescents)
  - Ages 11-18
  - Higher the number the more severe the symptoms
  - Good to look at individual items to get a better feel for the adolescent
- Pediatric Symptom Checklist
  - More of an overview
  - Ages 4-17
  - Does not include a question pertaining to suicide
  - Online free with scoring instructions
- All free, validated and can be downloaded

PHQ-9 modified for Adolescents (PHQ-A)

Name: Mary **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?				X
2. Little interest or pleasure in doing things?		X		
3. Trouble falling asleep, staying asleep, or sleeping too much?		X		
4. Poor appetite, weight loss, or overeating?			X	
5. Feeling tired, or having little energy?			X	
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				X
7. Trouble concentrating on things like school work, reading, or watching TV?		X		
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?	X			
9. Thoughts that you would be better off dead, or of hurting yourself in some way?		X		

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

X 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 X Very difficult ☐ Extremely difficult

Mary's PHQ-9 Total Score 14

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+ 2 +	6 +	6
Total Score *(add your column scores)* = 14				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Back to Mary

- She admits to trying marijuana with a friend twice
  - No current use
- She has tasted alcohol and did not like it
  - No current alcohol use
- She has also tried nicotine at times with the same friend who introduced her to cannabis
- No other substance use

CRAFFT

- **C**ar, **R**elax, **A**lone, **F**orget, **F**riends, **T**rouble.
- The CRAFFT is an efficient and effective health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21
- The CRAFFT is the most well-studied adolescent substance use screener available and has been shown to be valid for adolescents from diverse socioeconomic and racial/ethnic backgrounds
- CRAFFT
- See link above for more details http://crafft.org

"Addiction is a disease of adolescence“

-Volkow

- Adolescence is a crucial period of both susceptibility to the rewards of drugs and the vulnerability to the long-term effects of drug exploration
- Important to screen
- 50% of all lifetime SUD’s onset occurred prior to age 18 and 80% prior to age 24 (Compton et al, 2007)
- Substance use initiation almost always occurs in adolescence (Johnston et al., 2015)

Youth Screening, Brief Intervention, and Referral to Treatment (YSBIRT)

- Evidence-based practice to prevent and reduce risky substance use among adolescents ages 12 - 18
- YSBIRT.org aims to equip the primary care field with the resources and support necessary to implement SBIRT in their practices
- Implementation guide or change package is available on their website
- There are training opportunities to enhance SBIRT education and readiness
- Webinar will be available in future trainings

Another Case Example……

Lisa

17-year-old female presents to the office with the abrupt onset of fear and discomfort. Her heart is racing. She is sweating. She is trembling. She is short of breath. She felt like she was going to die.

She was taken the ER and her work entire medical workup was negative. It happened again about a week later (out of the blue) and Lisa's parents rushed her to the ER. Her work-up was again negative.

She was encouraged to follow-up with her PCP and find a therapist for her anxiety.

Lisa gets entered into the Collaborative Care Program at her PCP's office

- What is the diagnosis?
- What are the next steps?
- She has another episode: how can you coach her parents? How can you help Lisa?

Note: Presentations can be similar with pseudo-seizures, GI distress, and/or other somatic symptoms disorders

Some Recommendations for Lisa

- Regular, short-interval visits with PCP
- BHC can work to establish a collaborative, therapeutic alliance with patient and family
- Compassionate listening
- Educate patient and caregivers about diagnosis and coping skills
  - Education alone can help reduce anxiety
- Set treatment goals
  - With some somatic symptom disorders the goal might be functional improvement rather than cure
- Identifying and removing possible triggers
- Improve sleep
- Physical activity
- CBT
- Mindfulness-based therapy
- Consider SSRI (or whatever psychiatry consult describes as next best step for medication management)

Break

Treatment

- Psychotherapy
- Medications
  - Get comfortable
- Combination
- Self-Care
- Follow-up

Therapy

- Overall important aspects:
  - “Fit,” adherence to appointments and attending with good frequency (recommend weekly to every other week especially initially), parent/guardian involved to reinforce concepts and perhaps identify their own goals
- Encourage psych consultants to recommend specific types of treatment

Psychodynamic Therapy

- Reduce maladaptive defense mechanism
- Resolve past psychological trauma
- Accept the realistic limitations of one’s family and one’s own abilities

Interpersonal Therapy

- Short term, focused on present social function
- Targets interpersonal deficits, role conflicts, grief, and difficult transitions
- Additional data about the youth in single-parent family homes

Dialectical Behavior Therapy (DBT)

- Not just borderline
- Can be helpful for many teens especially with certain symptoms/problems:
  - Confusion about self
  - Emotional instability
  - Interpersonal problem
  - Parent/Teen problem
  - Impulsivity

Four Elements of DBT

- Distress tolerance
- Mindfulness
- Emotional regulation
- Interpersonal effectiveness

Cognitive Behavior Therapy (CBT)

- Seeks to identify and change maladaptive beliefs, attitudes and behaviors
- Negativistic expectancies, cognitive distortions, social skills deficits
- Attempts to improve the quality of one's interaction with the environment
- Data from JAMAICA Gerber et al, JAMA 2009
  - CBT helps prevent next episode
  - Emphasizes the role of parental depression in child's depression
  - Briefly highlight the value of adult getting help

ClBeck et. Al, 1979; Lewinsohn et al, 1994)

Group Therapies

- Explore with consulting psychiatrist
- May include social skill groups, DBT program with groups, executive functioning/ADHD symptom management
- More structured/intensive programming like a partial hospitalization program

Psychopharmacology with Adolescents

POLL: Psychopharm

- How do you feel about Psychopharm?
  - A. I am pretty familiar
  - B. I know a little bit but I want to know more
  - C. I do not know anything

General Recommendations

- Start low - Go slow - And keep going
- Help youth and family have realistic expectations
- Continue to make slow, steady increases until arriving at the effective dose
- Ensure the patient is taking them regularly

Lessons Learned From Landmark Studies

TADS

- The Treatment For Adolescents with Depression Study (TADS), 2004
- Randomized Controlled Trial (RCT)
- Highlights the value of combination treatment
- “Findings revealed that 6 to 9 months of combined fluoxetine + CBT should be the modal treatment from the public health perspective as well as to maximize benefits and minimize harm for individual patients.” (March, Vitelli, 2009, American journal of Psychiatry

TORDIA

- Treatment of SSRI-Resistant Depression in Adolescents (TORDIA), 2008
- “Switching to a combination of CBT and another antidepressant resulted in a higher rate of clinical response than switching to another medication without CBT.” (Brent, Emslie, Clarke, et al., 2008 Journal of Consulting and Clinical Psychology)
- 9 or more sessions best results
- CBT with problem-solving and social skills treatments, more likely had a reduction in depression
- No suicides in the study
- SNRI: a bit more activating than the SSRIs

Psychotropic Medication Classes

SSRIs

- Increases serotonin concentrations

SSRIs

- Generally reserved for moderate to severe symptoms
- Most common pharmacotherapy for youth with depression
- Caution in youth with bipolar disorder (may induce a manic episode)

FDA Approved

- Depression: Fluoxetine “Prozac” and Escitalopram “Lexapro”
  - Fluoxetine 8 years old and older
  - Escitalopram 12 years old and older
- OCD: Fluoxetine “Prozac”, Fluvoxamine “Luvox”, Sertraline “Zoloft”, Clomipramine
- Anxiety: duloxetine
  - However, the evidence is stronger for SSRI’s
- NOTE: For adolescence, it is common to use many psychotropic medications off-label both for depression and other mental health disorders

Medication	FDA-approved indication	Indication age range	Starting Dose	Dose range
Citalopram (Celexa)	Depression	Adults	10-20mg	10-40mg
Escitalopram (Lexapro)	Depression	12 years to adult	2.5-5mg	2.5-20mg
	GAD	Adults		
Fluoxetine (Prozac)	Depression	8 years to adult	5-10mg	10-60mg
	OCD	7 years to adult		
Fluvoxamine (Luvox)	OCD	8 years to adult		
Sertraline (Zoloft)	Depression	Adults	12.5-25mg	12.5-200mg
	OCD	6 years to adult		

SSRI Contraindications

- Youth with evidence of extreme irritability, agitation, or explosiveness on prior trials of SSRIs
- Children with evidence of bipolar disorder
  - Elevated, expansive, decreased need for sleep, pressured speech, explosiveness that is episodic in nature
  - Many children with “bipolar” have relational issues, trauma, or more chronic characterological issues
- Caution for patients taking triptans: can place youth at risk for serotonin syndrome

SLOW

- Dose Increase:
  - Typically, 2-6 weeks, may even see some benefit at 8 weeks
  - Allow several weeks at target dose before assessing full response to medication

SNRIs

- Increases serotonin and norepinephrine concentrations

Duloxetine (Cymbalta) and Venlafaxine (Effexor)

- Limited data
- Works in a similar way to SSRIs
- In adults, helpful for pain (diabetic peripheral neuropathic pain, fibromyalgia, chronic musculoskeletal pain)
- Remember to monitor BP
- Given effects on norepinephrine, may be more energizing/activating and should be given in the morning
- Venlafaxine “Effexor:” can have more pronounced withdrawal if a teen stops this or is not taking regularly

Other Antidepressants

Wellbutrin "Bupropion"

- Limited data
- No RCTs
- Off label use for MDD and ADHD
- May exacerbate tics
- May not be as helpful with anxiety as SSRIs
- Do not use with eating disorders
- Do no use if history of a seizure disorder

Tricyclic Antidepressants (TCAs)

- Precursor to the safer SSRIs
- Examples: amitriptyline, desipramine, doxepin, nortriptyline
- In adults use for MDD, anxiety disorders, and pain syndromes
- Often used medically for children for headaches, pain syndrome, functional GI conditions, enuresis
- More side effects
  - Drowsiness, dizziness, dry mouth, and constipation, GI distress
  - Irritability or angry outbursts
  - Sudden unexplained death in some case studies (Biederman 1991, Riddle et al.1993, Varley and McClellan 1997)
  - Possibility of cardiac toxicity, follow EKGs: use extreme caution in individuals with high suicide risk
- Not a lot of evidence to support the frequent use of TCAs as a monotherapy for adolescents – depression/anxiety
- EKGs – given concerns for cardiac side effects, consider EKG monitoring especially when used with > 1 treatment that can elevate QTc interval

Common Drug Interactions

- Triptans (watch for serotonin syndrome when used together with SSRI's)
- Fluoxetine "Prozac" – more interactions with P450
- Check EKG if used with other medications that may increase QT interval and risk for Torsades de Pointes

Black Box Warning in Antidepressants 2004

- No suicides occurred in any of these studies
- FDA measured suicidal thinking and behavior by using "Adverse Event Reports"
- “Adverse events" 3% of all children/adolescents taking medication, compared to 2% of those taking placebo
- Most of these events were an increase in suicidal thoughts; None were suicide completions
- Since the FDA issued the black box warning, there has been a decline in antidepressant use, but an increase in completed suicides
- Further analyses of clinical trials data revealed that there is overall improvement in suicidality in subjects treated with antidepressants, with only a few subjects reporting worsening or new onset suicidality

Increased risk can be managed

- Careful monitoring
- Development of a safety plan
- Combination of medication + therapy
- For moderate to severe levels of depression, there is benefit in the use of medication
  - Higher rate of relief
  - More completed relief

Conclusion About Black Box Warning

“Spontaneously reported SAEs appear to be more common with antidepressant treatment than placebo. Nevertheless, given the greater number of patients who benefit from antidepressant treatment, particularly the SSRIs, than who experience these SAEs, as well as the decline in overall suicidal ideation on rating scales, the risk-benefit ratio for SSRI use in pediatric depression appears to be favorable, with careful monitoring."

- Boris Birmaher, Child Manual of Child and Adolescent Psychopharmacology 2nd edition

Antidepressant Discontinuation

- Maintain patient on medication for 9-12 months once remission in symptoms is reached
  - Helps to prevent relapse
- Typically discontinue over a 4–6-week period
- Tend to do it spring/summer or periods of low stress
- If multiple episodes of depression, may be best to stay on the medication

Bipolar Disorder

Always monitor for bipolar symptoms when there is a concern for depression

- Although the topic is still somewhat controversial, evidence suggests that it is often diagnosed when not present, and yet many cases also go undiagnosed
- Marked progress has been made in validating and honing assessment strategies and experts agree there is validity of DSM based diagnoses
- Ask about hypomanic/manic symptoms
- Consider using screening tools
- If there is a concern for bipolar disorder, refer for further evaluation by a psychiatric provider as this is beyond the scope of collaborative care program

Hypomanic/Manic Symptoms DSM 5

- A distinct period (1 week or > or hospitalized) of abnormal and persistent elevated, expansive or irritable mood with increased goal-directed activity or energy
- Symptoms all day or nearly all day during this time
- During mood state and increased energy/activity need 3 or > (4 or > if only irritable mood) sx:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
  - Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
  - Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

More Descriptions...

- Distinct change/acute onset
  - Significant change from baseline
- More episodic
- Persists
- Pathological elation/euphoria
  - Too silly, inappropriately silly/giddy
- Decreased need for sleep
- Hyper sexuality
- Activity, speech, flow of ideas - "overdrive"
- Extravagant plans
- Delusional thinking and sometimes hallucinations

How to Screen

- Talk with parent, guardian, and/or other caregivers
- Family history
- Screening instruments directed more specifically at mania/hypomania
  - Parent-completed versions of the General Behavior Inventory (P-GBI)
  - Child Mania Rating Scale (P-CMRS)
  - Young Mania Rating Scale (P-YMRS)
- Child Interview
  - Language? Psychosis? Suicidal Behavior? Abuse? Illicit substance use?
  - Racing thoughts? Flight of ideas?

Mary's Management

- BHCM checked in on her every 1-2 weeks after assessment and entry in CoCM
- BHCM helped her create CoCM goals related to her depression:
  - Isolate from others less
  - Engage in enjoyable activity weekly
  - Attend therapy
- CM additional assisted with the following while a therapy referral was pending:
  - Behavioral activation: set daily routines with a visual weekly planner and activities for each day adding in 1 enjoyable activity a week
  - Sleep Hygiene: assisted with identifying a set sleep/wake up time and put iphone away 1 hour before this time
  - Provided her with a list of apps that she could use: Mary really enjoyed CALM app for sleep and meditation

Mary's Management

- Mary started Fluoxetine and this was titrated up to 30mg
- Metrics increased briefly but they did improve a couple of months later
- She connected with a therapist for more long-term care in the community
- PCP continues to prescribe Fluoxetine and no further titration given improvement in symptoms

Resources

- Remember to be aware of our immediate resources
- This may vary depending on your location
- MC3 is available across the state
  - Mc3.depressionscenter.org

What is MC3?

- The MC3 program offers psychiatry support to primary care providers in Michigan who are managing patients with behavioral health problems. This includes children, adolescents, young adults through age 26, and women who are contemplating pregnancy, pregnant or postpartum (up to one year)
- Psychiatrists are available through same-day phone consultations to offer guidance on:
  - Diagnostic questions
  - Medication recommendations
  - Appropriate psychotherapy
- Your local MC3 Behavioral Health Consultant is also available to provide recommendations for local resources

Psychopharmacology Reference Cards

MC3 Psychopharmacology Reference Cards

ttps://mc3.depressioncenter.org/wp-content/uploads/2020/09/pharmacards-MC3peri-online.pdf

MC3 Perinatal Psychopharmacology Reference Cards

MC3 – Psychiatry support for Michigan primary care providers (depressioncenter.org)

MC3 Reference Card

- https://mc3.depressioncenter.org/wp-content/uploads/2020/03/pharmacards-online-11-19.pdf
- https://mc3.depressioncenter.org/pharma-cards
- https://depressiondecisionaid.mayoclinic.org/index
- https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/wa/wa-depression-care-guide.pdf

SLEEP

Sleep – Inadequate Sleep Has Consequences

- Inattentiveness
- Reduction in executive functioning and poor academic performance
- Obesity
- Mood disturbances including increased suicidal ideation
- Higher risk of engaging in health risk behaviors
  - Alcohol and substance abuse
- Increased rates of car crashes
- Occupational injuries
- Sports-related injuries

Owens JA, Weiss MR. Insufficient sleep in adolescents: causes and consequences. Minerva Pediatric. 2017 Aug;69(4):326-336. doi: 10.23736/S0026-4946.17.04914-3. Epub 2017 Feb 17. PMID: 28211649.

Get More Information About Sleep

- Understanding patient's sleep habits and alertness can help with intervention
- BEARS
- Sleep Log

BEARS

- Bedtime problems
- Excessive daytime sleepiness
- Awakenings during the night
- Regularity/duration of sleep
- Snoring/difficulty breathing

Sleep Hygiene

- Establish a regular sleep/wake time
- Use the bed for sleep
- Create a relaxing bedtime ritual
- Avoid long naps
- No caffeine within 6 hours of bedtime
- No alcohol or drugs
- Exercise but not within 4 hours of bedtime

Hypnotic Use: General Principles

- Systematically assess for etiology of sleep disturbance
- Always combine with behavior plan
  - Results in sustained improvement
  - Minimizes side effects
  - Avoids giving “wrong message”
- Address unhealthy sleep practices
- Establish treatment goals
- Have an exit strategy
  - In some cases, may want to start planning discontinuation at initiation

Medications for Insomnia

- Antihistamines
- Melatonin
- Benzodiazepines
- Non-benzodiazepine receptor agonists
- Melatonin receptor agonist
- Histamine receptor agonist
- Orexin receptor agonist
- Alpha agonist
- Antidepressants
- Antipsychotics
- Anticonvulsants

NONE APPROVED IN CHILDREN/ADOLESCENTS

Melatonin

- 1-5mg at bedtime (may want to try to give it earlier in the evening)
- Max 9-10mg
- Limited data about supplements
- No RCTs
- Hard to give good guidance
- More data coming out about ASD population and ADHD population
  - Rossignol, 2011
  - Tjon et.al, 2003, Weiss et all, 2008, Van der Heijden et. Al 2007

Trazodone "Desyrel"

- Serotonin type 21 receptor blocker and weak serotonin reuptake inhibitor
- Mainly used adjunctive and helps with transition
- Use with caution in males - priapism

Mirtazapine "Remeron"

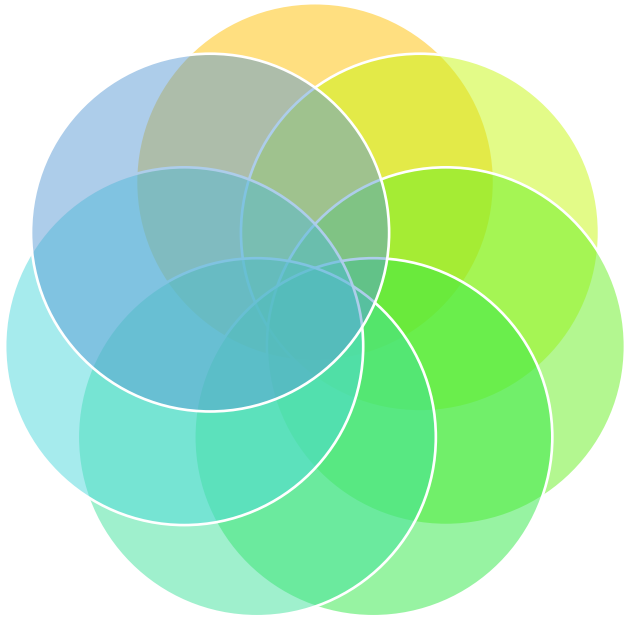
- Serotonin and adrenergic receptor blocker
- Side effects:
  - Weight gain
  - Increased appetite
  - Somnolence

Self-Care

Routine

Journal

Sleep



Carve out the time

Exercise

Appreciate nature

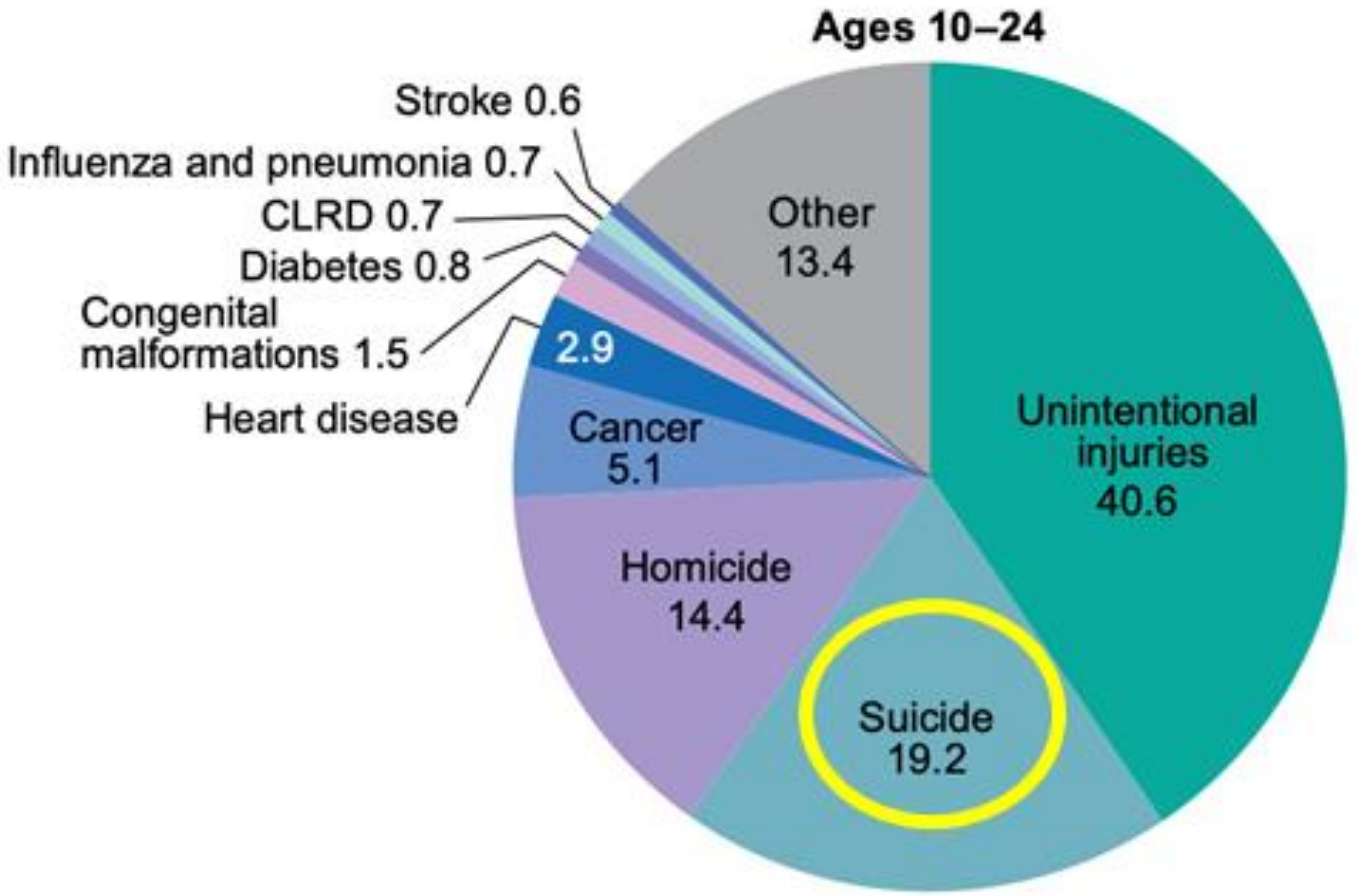
Creative expression

Break

Suicide Assessment and Safety Planning

Suicide Statistics

Nearly 1 in 5 adolescent deaths is suicide[1]



CLRD: chronic lower respiratory disease

10 Leading Causes of Death by Age, United States 2018

Age Groups

Ranking	10-14	15-24	25-34	35-44	45-54	55-64	65+
1	Unintentional injury (692)	Unintentional injury (12,044)	Unintentional injury (26,614)	Unintentional injury (22,667)	Malignant Neoplasms (37,301)	Malignant Neoplasms (113,947)	Heart Disease (526,509)
2	**Suicide (596)**	**Suicide (6,211)**	**Suicide (8,020)**	Malignant Neoplasms (10,640)	Heart Disease (32,220)	Heart Disease (81,042)	Malignant Neoplasms (431,102)
3	Malignant Neoplasms (450)	Homicide (4,607)	Homicide (5,234)	Heart Disease (10,532)	Unintentional Injury (23,056)	Unintentional Injury (23,693)	Chronic Low Respiratory Disease (135,560)
4	Congenital Anomalies (172)	Malignant Neoplasms (1,371)	Malignant Neoplasms (3,684)	**Suicide (7,521)**	**Suicide (8,345)**	Chronic Low Respiratory Disease (18,804)	Cerebrovascular (127,244)
5	Homicide (168)	Heart Disease (905)	Heart Disease (3,561)	Homicide (3,304)	Liv		
6	Heart Disease (101)	Congenital Anomalies (354)	Liver Disease (1,008)	Liver Disease (3,108)	Diabetes		
7	Chronic Low Respiratory Disease (64)	Diabetes Mellitus (246)	Diabetes Mellitus (837)	Diabetes Mellitus (2,282)	Cerebro		
8	Cerebrovascular (54)	Influenza & Pneumonia (200)	Cerebrovascular (567)	Cerebrovascular (1,704)	Chr Respiratory Disease (3,807)	**Suicide (8,540)**	Influenza & Pneumonia (48,888)
9	Influenza & Pneumonia (51)	Chronic Low Respiratory Disease (165)	HIV (482)	Influenza & Pneumonia (956)	Septicemia (2,390)	Septicemia (5,956)	Nephritis (42,232)
10	Benign Neoplasms (30)	Complicated Pregnancy (151)	Influenza & Pneumonia (457)	Septicemia (829)	Influenza & Pneumonia (2,339)	Influenza & Pneumonia (5,858)	Parkinson's Disease (32,988)

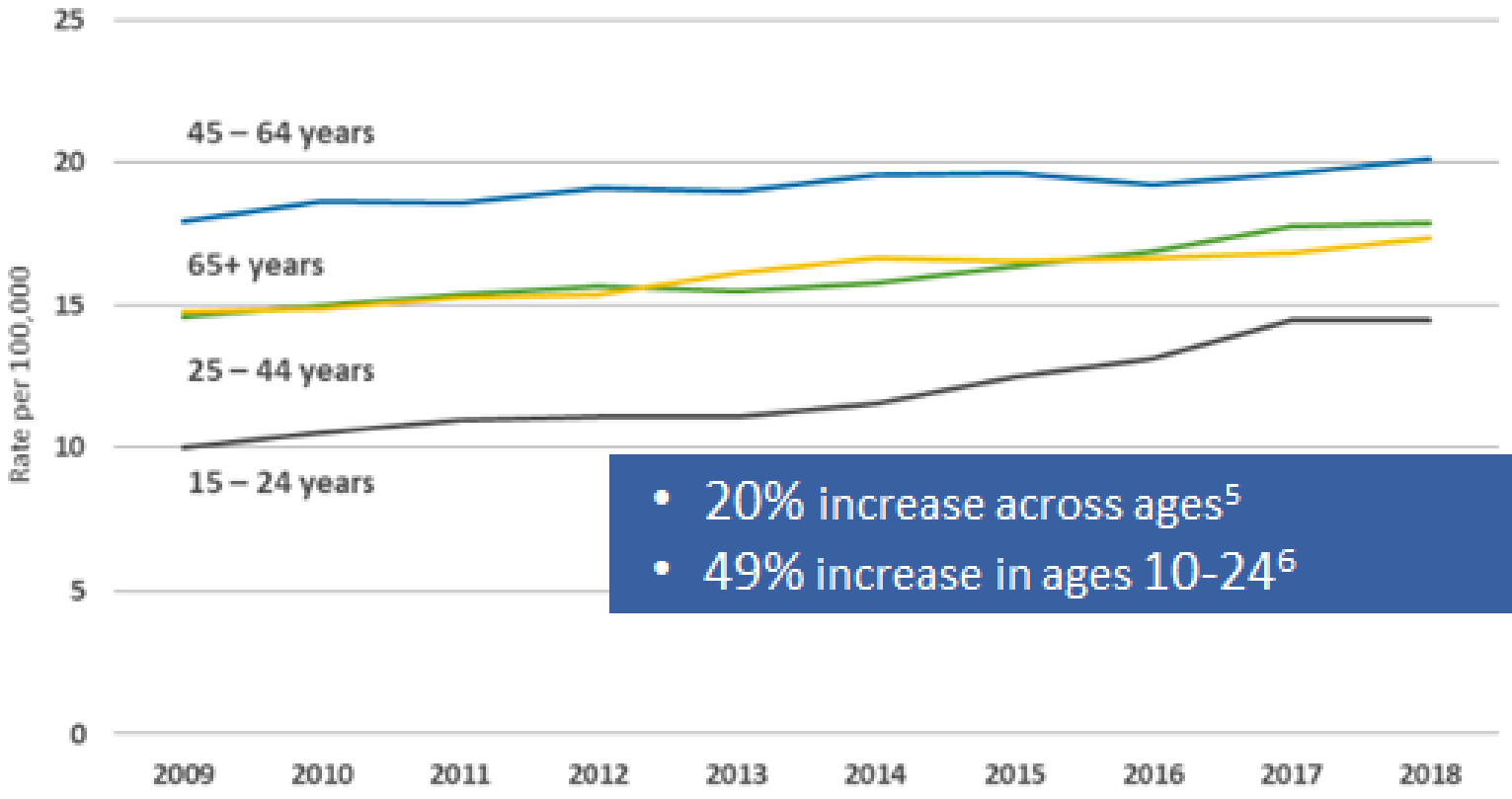
2nd leading cause of death for ages 10-34 years[1, 3]

www.sprc.org

Source: CDC, 2020

Adolescent Suicide Deaths: A Growing Problem[2]

Suicide Rates by Age, United States 2009-2018



- 20% increase across ages[5]
- 49% increase in ages 10-24[6]

www.sprc.org

Source: CDC, 2020

Risk Factors

- History of non-suicidal self-injury or prior suicide attempts [11-12]
- Recent discharge from psychiatric hospital
  - Highest in first 3 months and when suicidality was reason for admission[13]
- Family history of suicidal behavior[12, 14]

80-90% Of teens who died by suicide meet criteria for a psychiatric diagnosis, per psychological autopsies [12]

54% Of individuals who died by suicide in the US did not have a known mental health diagnosis[15]

- Substance abuse, mood disorder, anxiety, and disruptive/conduct[16-21]

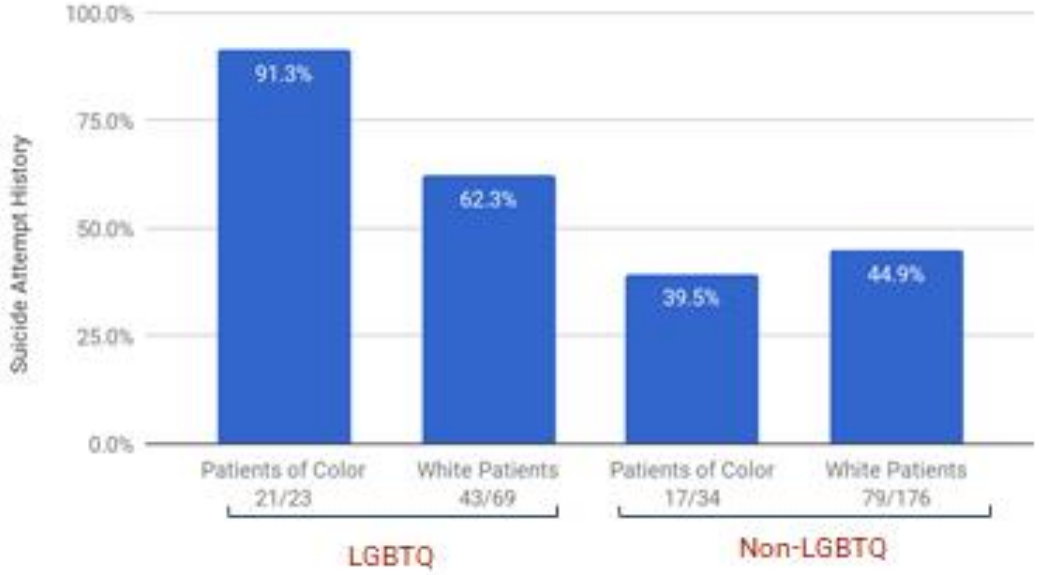
Of youth with Major Depressive Disorder or Dysthymia:[22]

- Up to **85%** will have suicidal ideation
- Up to **32%** attempt suicide by early adulthood
- **2-7%** die by suicide

LGBTQ+ Individuals

- Family rejection or negative family reaction
  - 8x greater risk of attempted suicide vs adolescents with minimal or no family rejection[23]
- For 12–14 year-olds, LGBT individuals were 25% of suicide decedents[24]
- Transgender adolescents have 6x greater odds of suicide attempts than peers[25]
  - Pine Rest adolescent inpatient study: 5x greater odds than other adolescent patients[26]
  - No difference from other patients when they report high adult support[26]

Suicide Attempt History among Psychiatrically Hospitalized Youth[26]



Suicide risk screening

What is it?

- An assessment for current/recent suicidal ideation and/or suicidal behavior

What is it not?

- An assessment for depression, anxiety, or any other psychiatric construct
- A fool-proof way to identify 100% of young people at risk

Suicide deaths are preceded by healthcare visits for 0-19 year-old youth

- 38% of suicide decedents saw a healthcare provider in the 4 weeks prior to their death[28]
  - Only 16% saw a mental health provider
- 77% of suicide decedents visited a healthcare provider in the 52 weeks prior to their death[28]
  - Only 32% saw a mental health provider
- Universal screening (medical and psychiatric populations) identifies youth at risk for suicide[29-33]

Screening Tips

- Important to select one and have this standardly used by all providers
- Identify who will perform the safety screening and follow up questions and safety planning
- Outline clear process in the clinic for low, intermediate and high-risk patients
- Algorithms can be helpful
- Use a validated tool such as the Ask Suicide Screening Questions (ASQ) or Columbia Suicide severity Rating Scale (C-SSRS)

Ask Suicide Screening Questions (ASQ)

- NIMH
- Developed in 3 pediatric Emergency Departments
  - Children's National Medical Center, Washington, DC
  - Boston Children's Hospital, Boston, Massachusetts
  - Nationwide Children's Hospital, Columbus, Ohio
- Strong psychometric properties in youth [Horowitz et al. 2010, Horowitz et al. 2020, DeVylder et al. 2019, Aguinaldo et al. 2021]
  - Usable by medical, non-psychiatric healthcare workers
  - Takes less than 2 minutes
  - Positive screen: "yes" to any of the top 4 items
  - Validated in Emergency Departments, inpatient med/surg units, primary care, and specialty outpatient clinics

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? _____

   _____

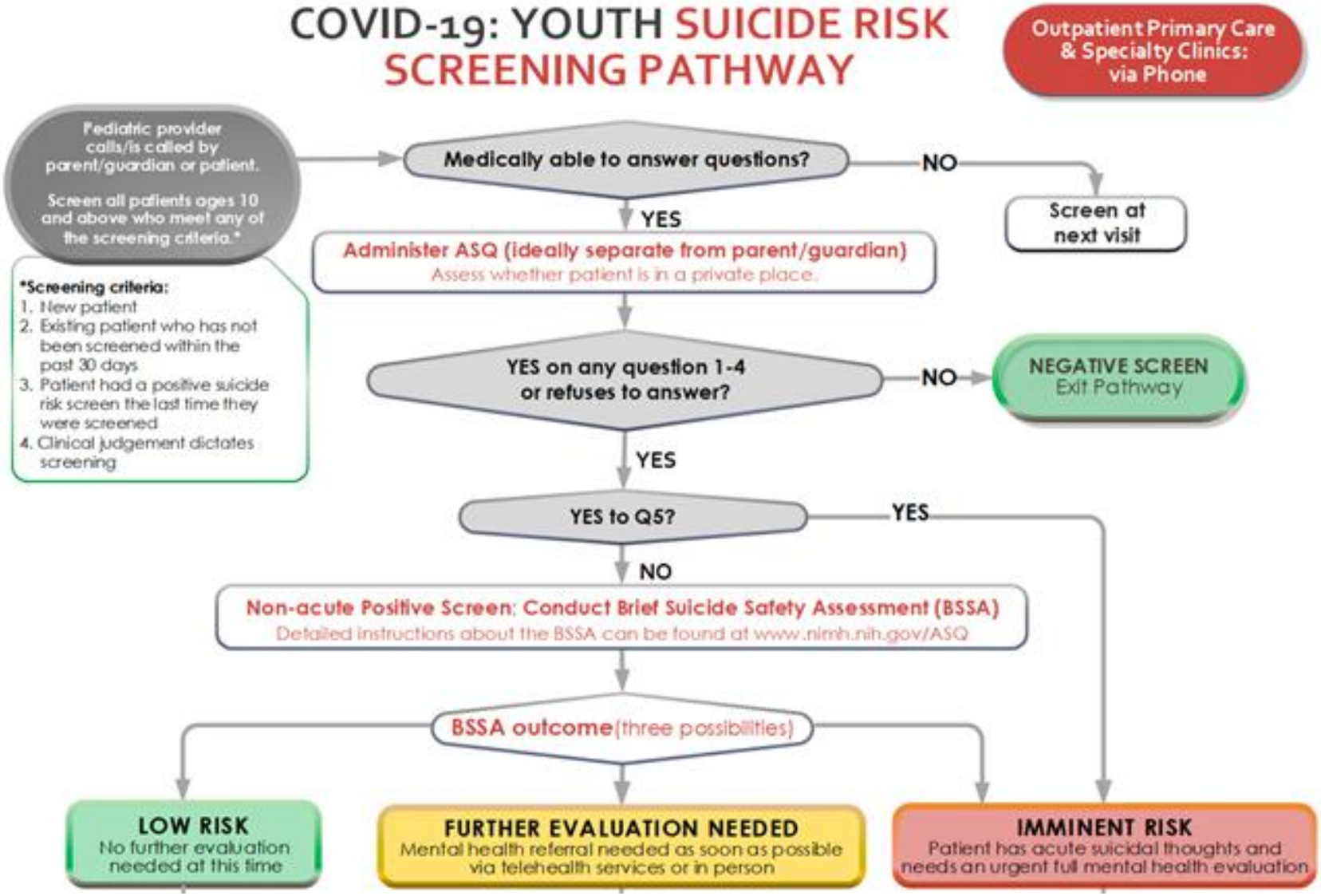
If the patient answers **Yes** *to any of the above, ask the following acuity question:*

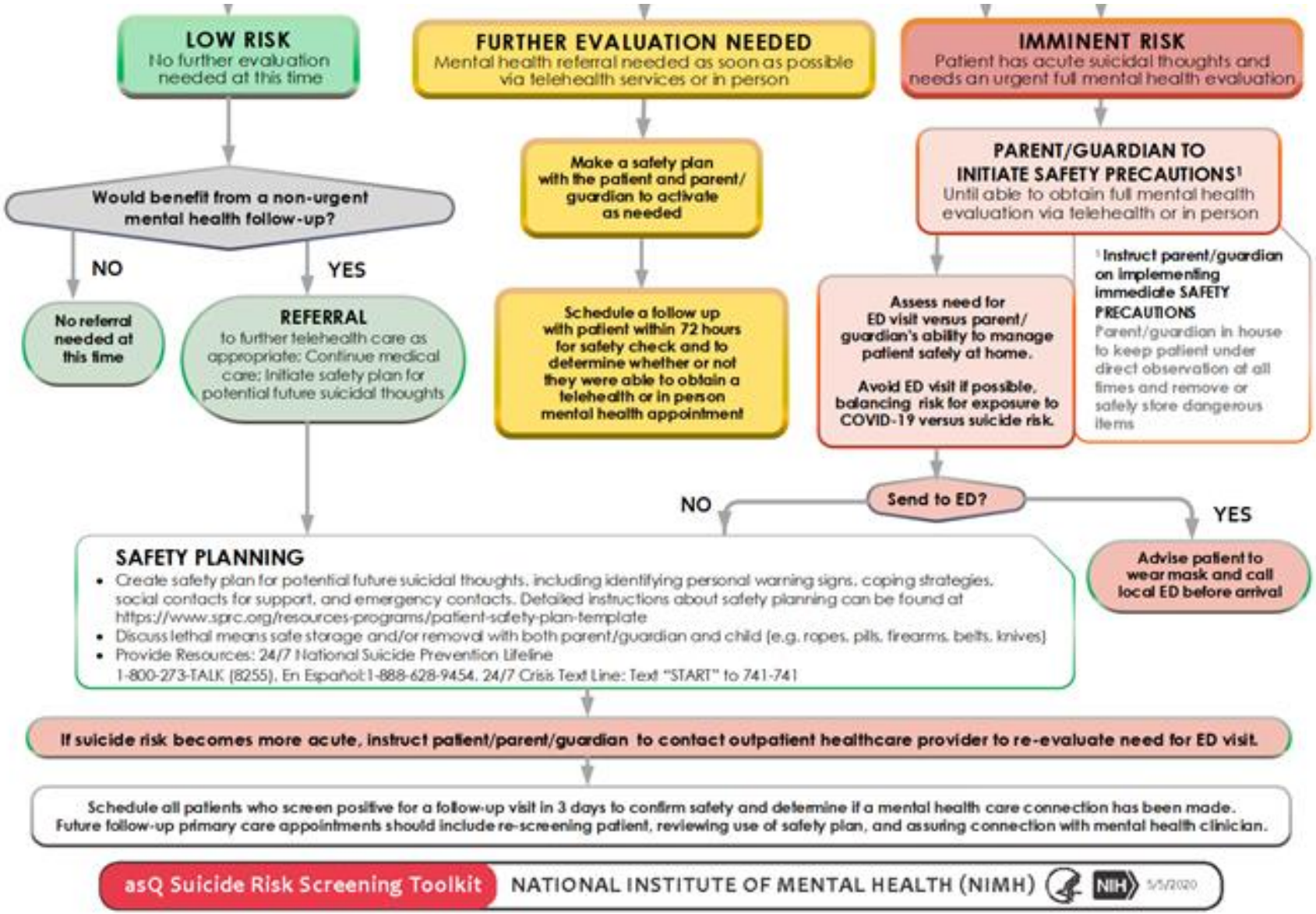
5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

Ask Suicide Screening Questions (ASQ)

- Tool kit is available online: http://www.nimh.nih.gov/asq
  - Information Sheet
  - Screening Tool (available in 14 languages)
  - Toolkit Summary
  - Patient Resource List
  - Training/Educational Videos
  - Brief Suicide Safety Assessment Guide and Worksheet
  - Nursing Scripts
  - Parent/Guardian Flyers
  - Suicide Risk Screening Pathways (flow charts)
  - Covid-19 Suicide Risk Screening Pathways (flow charts)

COVID-19: YOUTH SUICIDE RISK SCREENING PATHWAY




LOW RISK
No further evaluation needed at this time
FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible via telehealth services or in person
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further telehealth care as appropriate: Continue medical care; Initiate safety plan for potential future suicidal thoughts
Make a safety plan with the patient and parent/ guardian to activate as needed
Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a telehealth or in person mental health appointment
PARENT/GUARDIAN TO INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation via telehealth or in person
[1] Instruct parent/guardian on implementing immediate SAFETY PRECAUTIONS
Parent/guardian in house to keep patient under direct observation at all times and remove or safely store dangerous items
Assess need for ED visit versus parent/ guardian's ability to manage patient safely at home.
Avoid ED visit if possible, balancing risk for exposure to COVID-19 versus suicide risk.
Send to ED?
NO
YES
Advise patient to wear mask and call local ED before arrival
SAFETY PLANNING
• Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
• Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
• Provide Resources: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255), En Español:1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to re-evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ Suicide Risk Screening Toolkit
NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
NIH
5/5/2020

Columbia Suicide Severity Rating Scale (C-SSRS)

- Developed by researchers from Columbia University, University of Pennsylvania, and the University of Pittsburgh with support from NIMH in 2007, termed "The Columbia Protocol"
- In 2012, the FDA declared The Columbia Protocol the standard for measuring suicidal ideation and behavior in clinical trials
- The Columbia Protocol (also known as C-SSRS) is widely used and extensively validated
  - Available in more than 140 country-specific languages; used in clinical trials, schools, faith communities, hospitals, military, first responders
  - Assesses suicidal ideation and suicidal behaviors (even aborted and interrupted attempts)
  - No mental health training required
  - Reduces unnecessary referrals
  - Appropriate for all ages
  - Many versions available on the website: https://cssrs.columbia.edu

Columbia Suicide Severity Rating Scale (C-SSRS)

- What does it assess?
  - Whether and when they have thought about suicide (ideation)
  - What actions they have taken — and when — to prepare for suicide
  - Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition

"It's about saving lives and directing limited resources to the people who actually need them. " Dr. Kelly Posner Gerstenhaber, Founder and Director, The Columbia Lighthouse Project

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**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 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?***	**Lifetime**	
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.		
If YES, ask: *Was this within the past 3 months?*	**Past 3 Months**	

C-SSRS Algorithm

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

- Yellow = low risk
- Orange = moderate risk
- Red is high risk
- Real world examples of algorithms available on https://cssrs.columbia.edu

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."

From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ **Initiate local psychiatric admission process** ☐ **Stay with patient until transfer to higher level of care is complete** ☐ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** ☐ Multiple risk factors and few protective factors	☐ **Directly address suicide risk, implementing suicide prevention strategies** ☐ **Develop Safety Plan**
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ **Discretionary Outpatient Referral**

What to do After Completing the Screen

- You must act on a positive screen
- Interventions should be changed to reflect your individual setting's resources and policies.
- Remember- *keep it simple, trust your intuition, and be thoughtful*
  - High risk category: Safety precautions and full mental health evaluation or ED referral.
  - Moderate risk category: Need more information to determine disposition-> brief suicide safety assessment and triage appropriately.
  - Low risk category: Probably not an acute risk. Outpatient referral to mental health if deemed beneficial.
  - All patients: Give safety resources, counseling on access to lethal means

A Word About the PHQ-2 and PHQ-9

- Depression screening is not the same as suicide risk screening
  - Recall that not all suicide decedents had a diagnosable depression at time of death[16-18]
- PHQ-2 as a predictor (data in adults)
  - 14% of 157 patients at a Federally Qualified Health Center with suicidal ideation would have been missed using the conventional clinical cutoff of 3 on the PHQ-2[44]
- PHQ item 9: "Any thoughts of being better off dead or of hurting yourself in some way?"
  - Very high false positive rate (data in adults)
    - Of 841 patients in a National Network of Depression Centers Clinical Care Registry study, 13% were positive on eC-SSRS while 41% were positive as assessed by PHQ-item 9[45]
    - Of 330 cancer patients endorsing item-9, only 33% reported thoughts of suicide[46]
    - Of 110 heart disease patients endorsing item-9, only 20% reported thoughts of suicide[47]
- PHQ-9 item 9 is still a predictor for suicide[48]

Common Concerns Regarding Suicide Screening

- What do parents and patients think about it?
  - Vast majority think it's a good idea! [Horowitz et al. 2010, Ballard et al. 2012, Ross et al. 2016, Tipton et al. 2020]
- I heard that asking about it puts the idea into their heads
  - Studies demonstrate that it doesn't. [Dazzi et al. 2014]
- What about training?
  - Once you have picked a screener and plan, it can be easy to select the appropriate staff to get training and the ones presented today have free trainings
- What about the time commitment?
  - Universal screening with 2 validated tools shown today did not increase ED wait times or overburden the healthcare system [Horowitz et al. 2010, DeVylder et al. 2019, Latif et al. 2020, Roaten et al. 2018]

Example of Practice Suicide Protocol

- Purpose: the practice has a systematic approach to ensure quality care for all patients at risk for suicide. These guidelines are carried out by the patient care team.
- Suicidal Patients
  - Identifying patients with suicidal ideation
  - All patients ≥11 years are screened for depression at every well visit and any encounters for depression medication management (PHQ-4/PHQ-9)
    - The treating physician will investigate any positive responses regarding thoughts of suicide or self-harm, including asking Columbia Screening questions (see PDF)
    - The CM will develop a written safety plan with the patient

Example Safety Protocol (continued)

- Patient screening as actively suicidal and physically at the practice
  - The CM will work with the patient and parent in the office to contact 24/7 on-call services to screen the patient over the phone. (Pine Rest: 800-678-5500; Forest View: 800-949-8439)
  - If the parent is not at the visit with the patient, the physician or CM will contact the patient's family to ask that they come to the practice or meet the patient at the location of their behavioral assessment/treatment
  - If necessary, particularly if 24/7 assessment indicates need for immediate care and psychiatric bed not available, the CM will direct the family to HDVCH Emergency Room
- Suicidal Call In from patient
  - If a patient calls and is actively suicidal or a parent is concerned that child is actively suicidal the CM will take the telephone call and perform an assessment (including Columbia questions). The phone nurse will stay on the line with the patient/parent until the CM can take the call. The family will be directed to contact 24/7 on – call services if indicated

PRACTICE NAME

Patient Safety Plan Agreement

Patient name: _____ Date of Birth: _____

1. I agree to take my medications only as prescribed.
2. I will make my environment safe by:

   _____

   _____

   _____

3. My warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

   _____

   _____

   _____

4. Emergency Contact Numbers:

   Counselor: _____ Number: _____

   Family/Friend Name: _____ Number: _____

   Family/Friend Name: _____ Number: _____

   National Suicide Prevention Hotline: 1-800-273-8255

   Call 911

5. I agree to attend my regularly scheduled appointments.
6. The one thing that is most important to me to live for is:

   _____

Patient Signature: _____
Date: _____

Witness Signature: _____
Date: _____

Additional interventions to reduce suicide

- Link youth to services and support to decrease suicide attempts[Doupnik et al. 2020]
- School, community, and healthcare based interventions[Calear et al. 2016]
- Help youth identify supportive adults
  - Youth with identified adult mentors are less likely to die of suicide over at least 10-14 years [King et al. 2019]

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Resources to provide patients

- Consider having this attached to safety plans
- Available to all patients in CoCM
- **National Suicide Prevention Lifeline 24/7:** 800-273-TALK (8255)
- **Crisis Text Line 24/7:** text GO to 741741
- **Trevor Project:** http://www.thetrevorproject.org
  - Text START to 678-678, call 1-866-488-7386 or chat online
- **Great Lakes Mental Health Technology Transfer Center Network**
  - MHTTCN Region 5 Suicide Prevention_05_16_19_2.pdf
- Resources for your clinic: add in **local CMH crisis lines, emergency rooms**

Additional interventions to reduce suicide

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A Word on Lethal Means Restriction

- **90%** of attempts are survived
  - 80-95% of survivors don't later die by suicide [Lewiecki et al. 2013]
- **40%** of attempters contemplated <5 minutes [Lewiecki et al. 2013]
- **6%** of suicide attempts involve guns [Miller et al. 2012]
  - 90% of attempts using a firearm are fatal [Lewiecki et al. 2013]
- Restricting access to lethal means decreases suicide rates by those methods [Mann et al. 2005]

Means Matter

- Many suicide attempts occur with **little planning during a short-term crisis**
- **Intent isn't all** that determines whether an attempter lives or dies; **means also matter**
- **90%** of attempters who survive **do NOT go on to die by suicide later**
- Firearms used in youth suicide **usually belong to a parent**
- **Reducing access to lethal means saves lives**

More Resources Related to Gun Safety/Means Restriction

- **ASK Campaign |** www.askingsaveskids.org
  The ASK (Asking Saves Kids) Campaign was created in collaboration with the American Academy of Pediatrics. Across the country, it has successfully inspired an estimated 19 million households to ask if there are guns where their children play. Join these parents and pledge to ASK this life-saving question at /pledge. You can also learn about more ways to get involved in ASK, and how you can spread the ASK message in your community.

- **Ceasefire Oregon Education Foundation |** http://coef.ceasefireoregon.org/
  This foundation works to "reduce gun violence by educating the public and providing opportunities to dispose of unwanted firearms." Includes information about the ASK (Asking Saves Kids) campaign.

- **Gun Shop Project |** https://www.hsph.harvard.edu/means-matter/gun-shop-project/
  This outlines the Gun Shop Project, created by the Firearm Safety Coalition in New Hampshire. It includes guidelines and resources to support suicide prevention efforts for gun shops and firing ranges. Resources include a public education piece on gun safety rules, posters and tip sheets.

More Resources Related to Gun Safety/Means Restriction (cont.)

- **Kids Health |** http://kidshealth.org
  Includes information on Gun Safety for both kids and parents. To find the specific pages, type “guns” in the Search box.
- **Means Matter |** www.meansmatter.org
  This site, from the Harvard School of Public Health, includes basic information about means reduction, taking action, lethal means counseling, and helpful links.
- **Project ChildSafe |** www.projectchildsafe.org
  This is a national program that “promotes safe firearm handling and storage policies among all firearm owners…” You can download a brochure (in English or Spanish) that details safe handling and storage guidelines, access an infographic on various gun storage options, or take a quiz to test your firearm safety knowledge.

To learn more about talking to patients about reducing access to lethal weapons, consider the *free* CALM training.

Counseling on Access to Lethal Means(CALM)

Learn how to:

(1) Identify people who could benefit from lethal means counseling,
(2) Ask about their access to lethal methods, and
(3) Work with them—and their families—to reduce access.

https://zerosuicidetraining.edc.org

QUESTIONS?

On-going Webinars:

Listings and registration on MICMT's website:

https://micmt-cares.org/collaborative-care-model-cocm-1

Evaluation:

You will receive an email with the evaluation link.

Please complete as soon as possible to give us your feedback and to receive your attendance credit for CME/CE Credit.

Thank you!