Youth Suicide Prevention and the Role of Primary Care

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Outline

• Epidemiology for youth suicide in Utah
• Suicide screening and risk assessment
• Treatment planning for suicide prevention in the primary care setting
Youth Suicide Epidemiology
Utah Youth (10-17) Suicides by year

- 2012: 22
- 2013: 31
- 2014: 33
- 2015: 44
- 2016*: 30
- 2017*: 43
Epidemiology

• Suicide rates rose across the US from 1999-2016 (even more so in Utah)
• Suicide is the leading cause of death among 10-17 year olds in Utah
• For every completed suicide, 50-200 attempts are made
  (Majority of those that attempt do not go on to complete)
Fatality Rate per 100,000 of Suicides and Motor Vehicle Accidents
1999-2016, Ages 10-17

Data Source: Utah Death Certificate Database, Utah Department of Health
Youth Mental Health Needs are High and Growing

Utah Youth Mental Health and Suicide Indicators, 2013-2017

Note: Combined data for Grades 6, 8, 10, and 12.
Method of Suicide: Utah Youth vs. Adults (2013-1016)

Data Source: Utah Death Certificate Database, Utah Department of Health
Epidemiology

• Age: Middle age and elderly have the highest suicide rates
• Gender: Males have higher rates (although females attempt more)
• Method: Firearms most common
• Geography: Intermountain West has highest rates
Suicide Mortality by State - 2017

Suicide Screening and Assessment
Why Screen in Primary Care?

• Approximately two-thirds of patients with depression present to PC with somatic symptoms only (Tylee & Gandhi, 2005).

• 45% of individuals who died by suicide were seen in PC within the month before their death (Abed-Faghri, Boisvert & Faghri, 2010).

• PCPs are by far the largest prescribers of psychotropic drugs (Mark, Levit, & Buck, 2009)

• Recommendations by AAP, Joint Commission
# Patient Health Questionnaire (PHQ-9)

Today's Date: ___________  Patient's Name: ___________  Date of Birth: ___________

Are you currently: □ on medication for depression? □ not on medication for depression? □ not sure? □ in counseling?

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling/staying asleep, sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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?

A. □ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

B. In the past 2 years, have you felt depressed or sad most days, even if you felt okay sometimes?

□ YES □ NO
Suicide Screening vs. Suicide Assessment

Screening:
- Procedure used to quickly identify individuals who may be at risk for suicide

Assessment:
- More comprehensive evaluation to evaluate level of risk and decide on treatment course
- Including standardized tools helps elicit more relevant information, help information be communicated clearly, and create consistency
- Also narrative assessment to elicit conversation, explore attitudes about risk, suicide, desire and ability to safety plan
Columbia Suicide Severity Rating Scale

<table>
<thead>
<tr>
<th>Question</th>
<th>“Yes” indicates</th>
<th>Level of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Wish to be dead</td>
<td>LOW</td>
</tr>
<tr>
<td>2. Have you actually had any thoughts of killing yourself?</td>
<td>Nonspecific thoughts</td>
<td></td>
</tr>
<tr>
<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Thoughts with method (without specific plan or intent to act)</td>
<td>MODERATE</td>
</tr>
</tbody>
</table>

| 4. Have you had these thoughts and had some intention of acting on them? | Intent (without plan)                                  | HIGH          |
| 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? | Intent with plan                                       |               |
| 6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? | Behavior                                               |               |

- Past 4 weeks, during current inpatient stay, since last assessment: HIGH
- 1–12 months ago: MODERATE
- >1 year ago: LOW
Narrative Assessment

• Elicit conversation

• Explore known risk and protective factors

• Explore the level of suicidality
  • Frequency, intensity of suicidal ideation
  • Understanding of death and experiences with death
  • Precipitating events

• Observation
  • Parent child interactions

• Elicit family attitudes about risk, suicide, capability, and desire and ability to follow safety planning
Predisposing Risk Factors

• Psychiatry disorders
• Previous suicide attempt
• Family history of mood disorder and/or suicide
• History of abuse
• Exposure to violence
• Biological factors

Precipitating Risk Factors

• Access to means
• Alcohol and drug use
• Exposure to suicide
• Social stress and isolation
• Hopelessness
Protective Factors

- Ability to cope
- Coping skills
- Beliefs against suicide
- Sense of responsibility to something else (eg family, pets, etc...)
- Positive therapeutic relationships
- Social supports
Risk Assessment Leads to Safety Planning

<table>
<thead>
<tr>
<th>Not Simply:</th>
<th>Instead:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorical Predictions of</td>
<td>Judgments to directly inform intervention plans</td>
</tr>
<tr>
<td>1. Low</td>
<td>1. risk status (the patient’s risk relative to a specified subpopulation)</td>
</tr>
<tr>
<td>2. Medium</td>
<td>2. risk state (the patient’s risk compared to baseline or other specified time points)</td>
</tr>
<tr>
<td>3. High</td>
<td>3. available resources from which the patient can draw in crisis, and</td>
</tr>
<tr>
<td></td>
<td>4. foreseeable changes that may exacerbate risk</td>
</tr>
</tbody>
</table>
Interventions: Safety Planning
Safety or Crisis Response Planning

1. Identifying warning signs
2. Identify coping skills
3. Identify external supports
4. Ensure safe environment / lethal means reduction
5. Arrange follow-up
Adult & Pediatric Safety Plan

As you fill in this form, focus on your own needs and what would be helpful. Your healthcare provider may also review you with questions to discuss ideas.

My Commitment to Be Safe

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

Warning Signs

What are some situations, persons, thoughts, and feelings that trigger my symptoms of depression?

Situations   Thoughts   Feelings

Persons

Coping Skills

What are some coping skills I can use to help myself immediately calm down when I have the thoughts listed above? I will try and think of these skills.

1.  I can tell my friend Naadia: Phone 801-555-1234
    - Go to the barn or
    - Take a horse & ride.

People whom I can ask for help:

- Mom Phone 801-123-4567
- Friend Breana Phone 435-999-1234
- Husband Phone 785-988-5589

Professionals or agencies I can contact during a crisis:

- Therapist Bob Phone 801-456-7890

- Emergency Contact #  Call my office, press 1

Home Treatment

What will my treatment be after I leave the hospital?

- Therapy:
- Medication:
- Others:

What are some specific steps I can take that will help me continue to get better?

Saftey Planner

1. Warning: X

Things to do:

2. Dad's birthday

3. Mom and grandma tell these people:
   - Dad
   - Me
   - My husband to move my medications.

What is most important to me and worth living for is:

my dog, he is there always!
Safety or Crisis Response Planning

1. Identifying warning signs
2. Identify coping skills
3. Identify external supports
4. Ensure safe environment / lethal means reduction
5. Arrange follow-up
Safe Environment / Counseling on Access to Lethal Means

- Goal is to decrease distance between impulsive thoughts and lethal means
- Importance of a collaborative conversation
- Utilizing motivation interviewing techniques
- Developing a specific plan

What’s the difference?

| 😊 | Let’s talk over some storage options to make sure your child can’t access your guns while he’s struggling. |
| 😞 | You should surrender / relinquish / give up / get rid of your guns. |

https://www.train.org/utah/course/1081014/
Sample Safety Plan with High Risk Assessment

- Immediate mental health evaluation
  - Telecrisis
  - Integrated Mental Health Provider
  - Mobile Crisis Outreach Teams
  - Emergency Department
  - Evaluate for potential psychiatric inpatient care

1. Warning signs/ coping skills
2. External supports - family/support system education
3. Ensure safe environment - counsel on access to lethal means
4. Very close follow-up
1. Identifying warning signs / coping skills
2. External supports - give emergency/crisis numbers
3. Ensure safe environment - counsel on access to lethal means
4. Arrange follow-up – outpatient referral, f/u appt to discuss symptom reduction
Sample Safety Plan with Moderate Risk Assessment

1. Identifying warning signs / coping skills
2. External supports – communication plan with parents, emergency crisis numbers
3. Ensure safe environment – counsel on access to lethal means
4. Arrange follow-up - more immediate referral, next day caring contact, quick follow-up appt
Utah Suicide Prevention Coalition

You are not alone - Help is available

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
suicidepreventionlifeline.org

CrisisLine
801-587-3000
healthcare.utah.edu/un/crisis

Utah Suicide Prevention Plan