Youth Suicide Prevention and the Role of Primary Care

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Objectives

• Review the epidemiology for youth suicide in Utah
• Discuss role of suicide screening
• Discuss suicide risk assessment and treatment planning in the primary care setting
Youth Suicide Epidemiology
Youth Suicides by year

Youth Suicides 10-17; *Jan-July only
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 to 17

Data Source: Utah Death Certificate Database, Utah Department of Health
Utah Student Health & Protection Survey 2017

16% of students in grades 6, 8, 10, and 12 reported that they had seriously considered attempting suicide at some point during the past 12 months

13% made a suicide plan during the past 12 months

7% reported they attempted suicide during the past 12 months

Data Source: Utah Emergency Department Encounters and Hospital Discharge Databases, 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
Method of Suicide: Youth vs. Adults (2013-1016)

Data Source: Utah Death Certificate Database, Utah Department of Health
Suicide Screening
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
Why Universal Screening?

• Risk is fluid

• Universal suicide risk screening in the ED led to a nearly twofold increase in risk detection (Bourdreaux et al., 2016)
How to Screen in Primary Care?

● Utilize Standardized Tools
  o More likely to elicit relevant and consistent information
  o Provides consistent documentation of work
  o Provides opportunity for psychoeducation

● Create a policy for frequency, documentation, and work flow
Screening Standardized Tools

Patient Health Questionnaire (PHQ-9) (page 1 of 1)

Today's Date: ___________________________ Patients Name: ___________________________ Date of Birth: ___________________________

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

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</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 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>

Total each column:

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 Assessment and Interventions
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

### C-SSRS Quick Screen questions (in the last month)

<table>
<thead>
<tr>
<th>Question</th>
<th>&quot;Yes&quot; 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>

### Follow-up questions

4. Have you had these thoughts and had some intention of acting on them?  
   - Intent (without plan)  
   - Intent with 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 (without plan)  
   - Intent with plan

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?  
   - Behavior  
   - >1 year ago: LOW  
   - 1-12 months ago: MODERATE  
   - Past 4 weeks, during current inpatient stay, since last assessment: HIGH
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
  • Play behaviors
• 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 Prevention

<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>
Specific Crisis Interventions

- Safety Plan or Crisis Response Plan
- Counsel of access to lethal means
- Symptom reduction
- Patient and family education
- Motivational interviewing
Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. My mind starts to race and get stuck.
2. I don't want to get out of bed on time. I say I don't feel good.
3. I want to stay away from everyone and get not.

Step 2: Internal coping strategies—Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. Go out outside if I'm home in my rocker chair for 10min.
2. Take my shine or sing a song & socks off & put my feet on the ground.
3. Look at the funny pictures on my phone. I have saved them.

Step 3: People and social settings that provide distraction:
1. Name: Text my friend Nadia
   Phone: 801-535-1234
2. Name: Phone
3. Place: Go to the barn or _
   4. Place: Go to the Jordon trail set up a time to ride, and look at ducks.

Step 4: People whom I can ask for help:
1. Name: My mom
   Phone: 630-123-4567
2. Name: My friend Breanna
   Phone: 435-222-6543
3. Name: My Husband
   Phone: 283-888-5000

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name: Therapist Bob
   Phone: 801-456-3890
   Clinician Pager or Emergency Contact #: Call his office, please
2. Clinician Name: Phone
3. Local Urgent Care Services: The Hospital by my house
   Urgent Care Services Address: 123 Sesame St.
   Urgent Care Services Phone: 801-333-5309
4. Suicide Prevention Lifeline: Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:
1. Ask my husband to move my medications.
2. __________

The one thing that is most important to me and worth living for is:
I love my dog he is there always!
Assessment: High

- Immediate mental health evaluation
  - Telecrisis
  - Integrated Mental Health Provider
  - Mobile Crisis Outreach Teams
  - Emergency Department
  - Evaluate for potential psychiatric inpatient care
- Immediate safety plan or crisis response plan (if patient is able)
- Counsel on access to lethal means
- Family/support system education
- Very close follow-up
Assessment: Low Risk

- Safety Plan or Crisis Response Plan
- Counsel of access to lethal means
- Outpatient referral
- Symptom reduction
- Give emergency/crisis numbers
- Patient and family education
Assessment: Medium Risk

- Same day safety plan or crisis response plan
- Counsel on access to lethal means
- Outpatient referral
- Symptom reduction
- Give emergency/crisis numbers,
- Patient and family education
- Next day caring contact or follow up appointment