Youth Suicide Prevention and the Role of Primary Care

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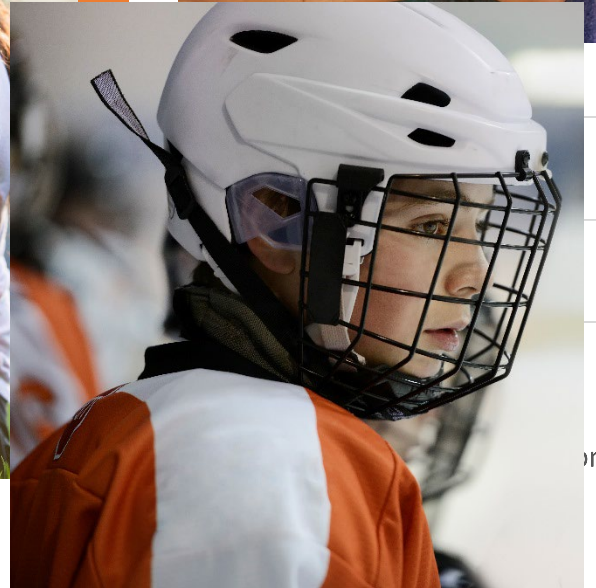
Objectives

- 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



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)

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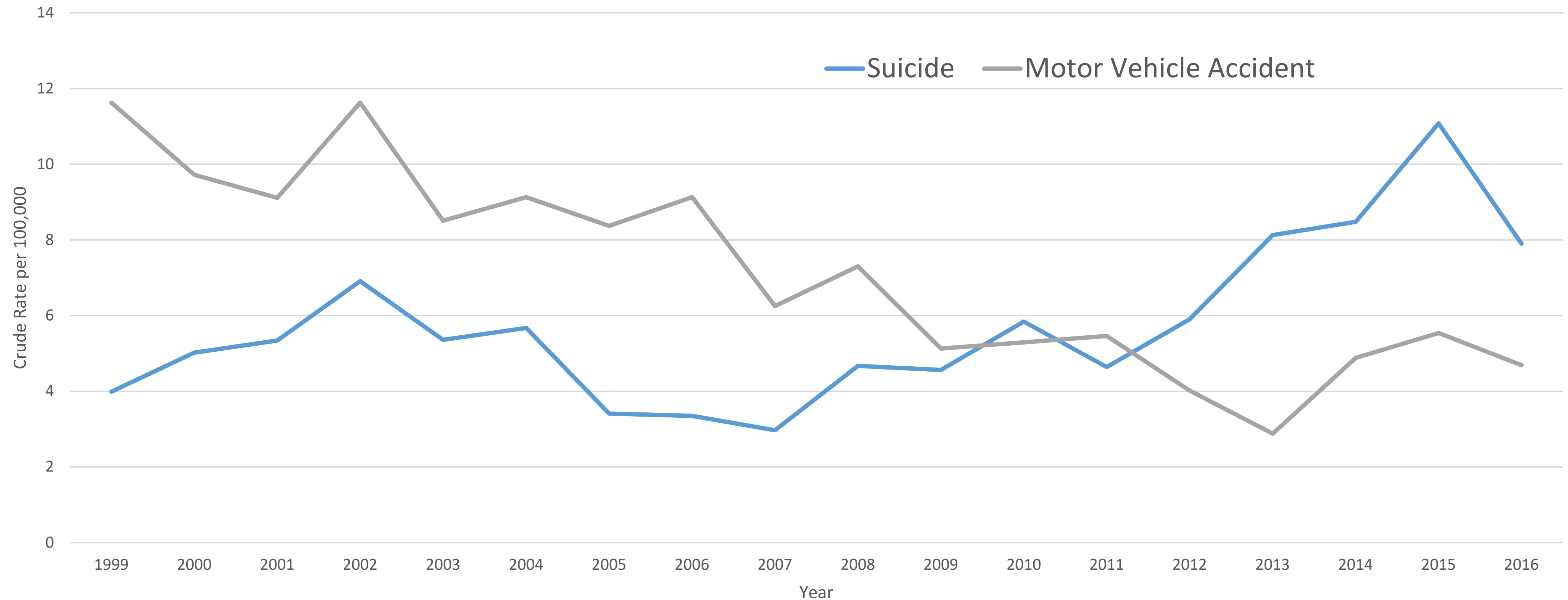
Fatality Rate per 100,000 of Suicides and Motor Vehicle Accidents 1999-2016, Ages 10 to 17



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

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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

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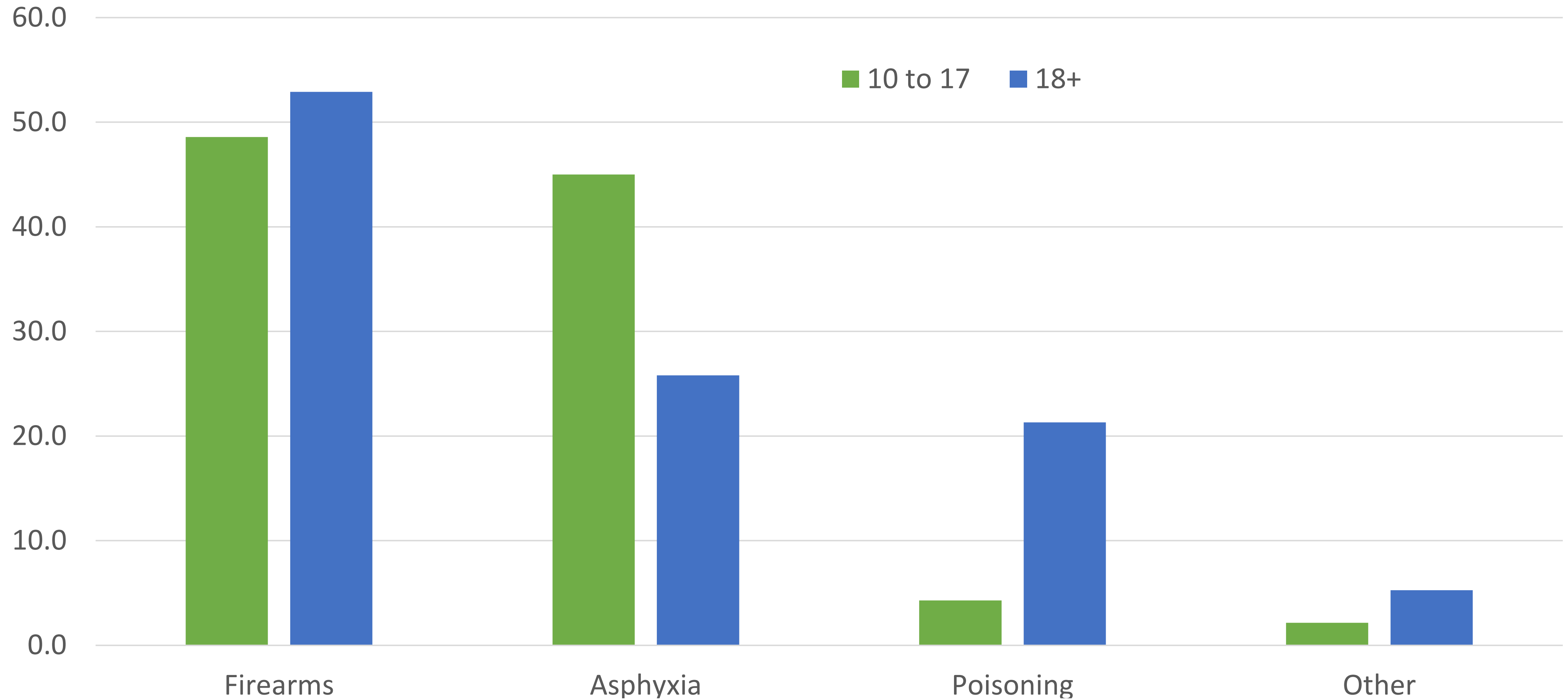
Epidemiology

- 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)



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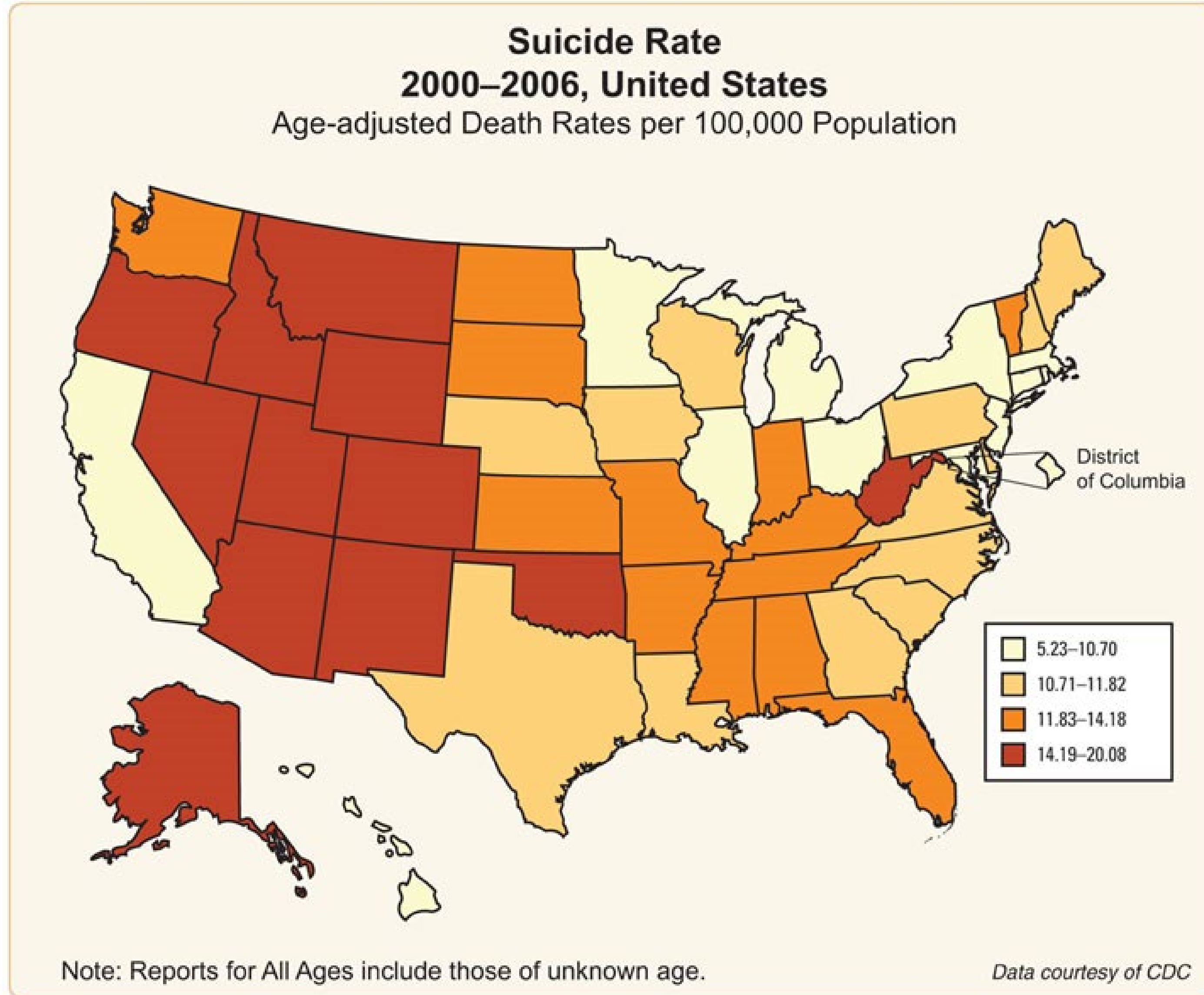
http://www.nimh.nih.gov/statistics/4NAT_MAP.shtml



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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)

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How to Screen in Primary Care?

- Utilize Standardized Tools
  - More likely to elicit relevant and consistent information
  - Provides consistent documentation of work
  - Provides opportunity for psychoeducation
- Create a policy for frequency, documentation, and work flow

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Screening Standardized Tools

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

   If yes, please describe: ____________________

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

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?*

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
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

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

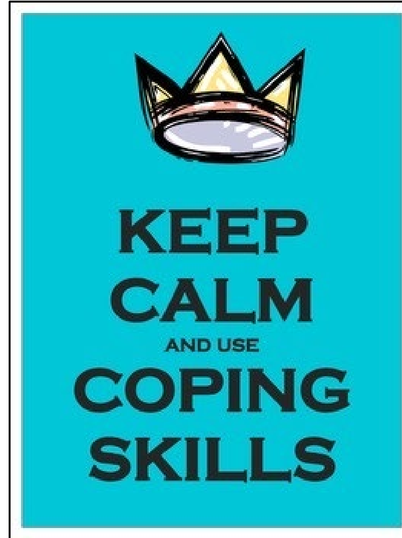
Predisposing Risk Factors

- 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



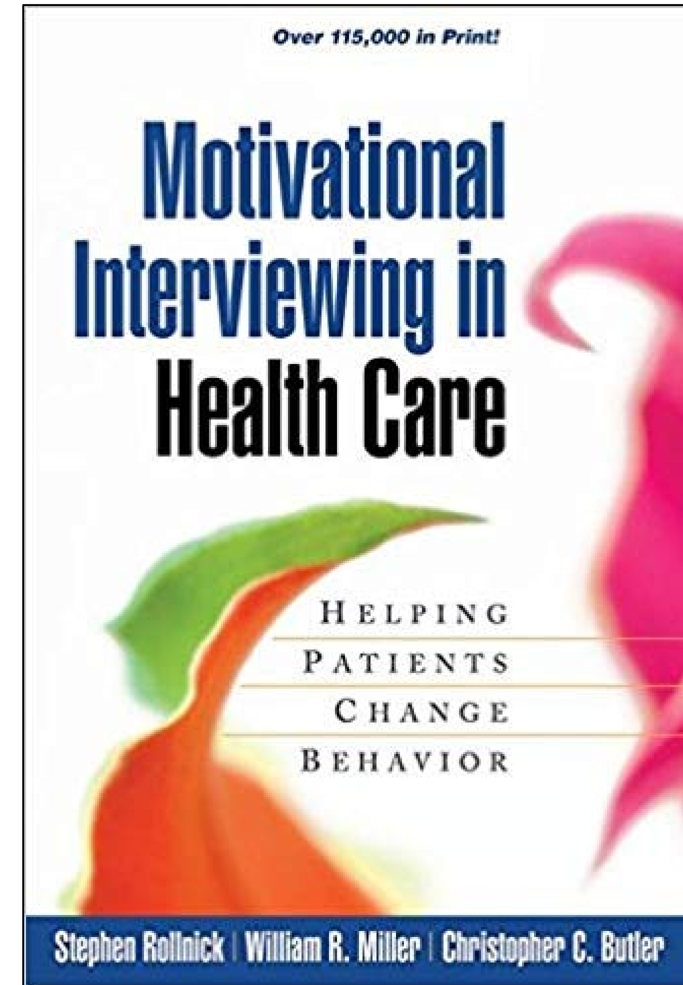
- Ability to cope
- Coping skills
- Beliefs against suicide
- Sense of responsibility to something else (eg family, pets, etc…)
- Positive therapeutic relationships
- Social supports

Risk Assessment Leads to Prevention

Not Simply: Categorical Predictions of 1. Low 2. Medium 3. High	Instead: Judgments to directly inform intervention plans 1. risk status (the patient's risk relative to a specified subpopulation) 2. risk state (the patient's risk compared to baseline or other specified time points) 3. available resources from which the patient can draw in crisis, and 4. foreseeable changes that may exacerbate risk

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 of everyone and ~~get~~ not get back to people who text me.

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 sit outside & if I'm home in my rocker chair for 10 min.
2. Take my shoe or shoes & socks off & put my feet on the ground.
3. look at the funny pictures in my phone I have saved.

Step 3: People and social settings that provide distraction:

1. Name Text my friend Nadia Phone 801-555-1234
2. Name Phone
3. Place Go to the barn or set up a time to ride.
4. Place Go to the Jordan trail 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 Brenna Phone 435-987-6543
3. Name My husband Phone 385 - 888 5888

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Therapist Bob Phone 801-456-7890
   Clinician Pager or Emergency Contact # Call his office press 1
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Urgent Care Services The Hospital by my house
   Urgent Care Services Address 123 Sesame St.
   Urgent Care Services Phone 801-867-5309
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.

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

I love my dog he is there always!

Assessment: High

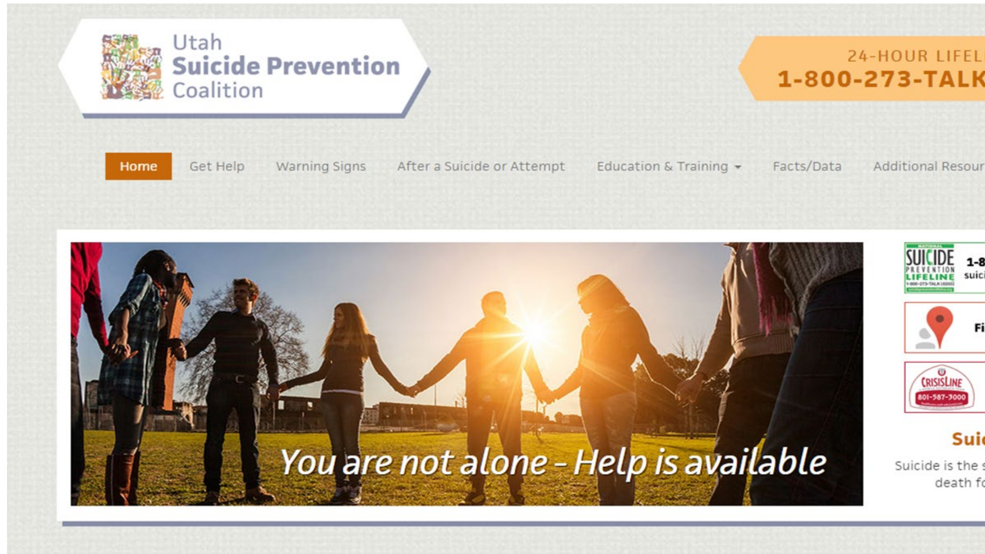
- Immediate mental health evaluation
  - Telecrisis
  - Integrated Mental Health Provider
  - Mobile Crisis Outreach Teams
  - Emergency Department
  - Evaluate for potential psychiatric inpatient care
- Immediate safety plan or crisis response plan (if patient is able)
- Counsel on access to lethal 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



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suicidepreventionlifeline.org

Chat - CrisisLine
Opens 2 - way messaging with a SafeUT CrisisLine counselor.

Call - CrisisLine
Tap this to speak to a SafeUT CrisisLine counselor. The CrisisLine number will appear and you can call immediately.

Submit a Tip
Submit confidential tips to school administrators on bullying, threats, or violence.