Youth Suicide Prevention and the Role of Primary Care

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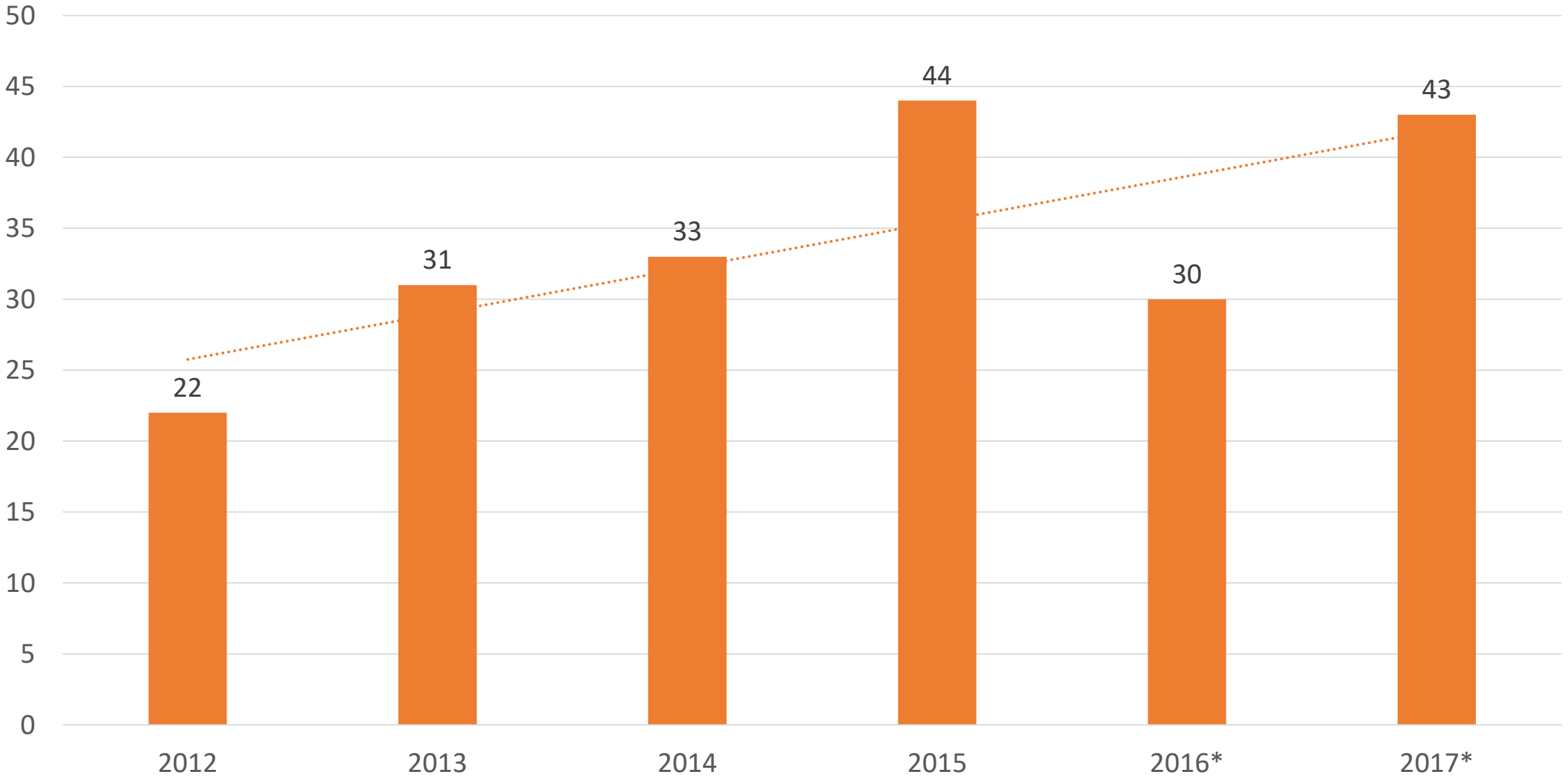
Outline

- 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

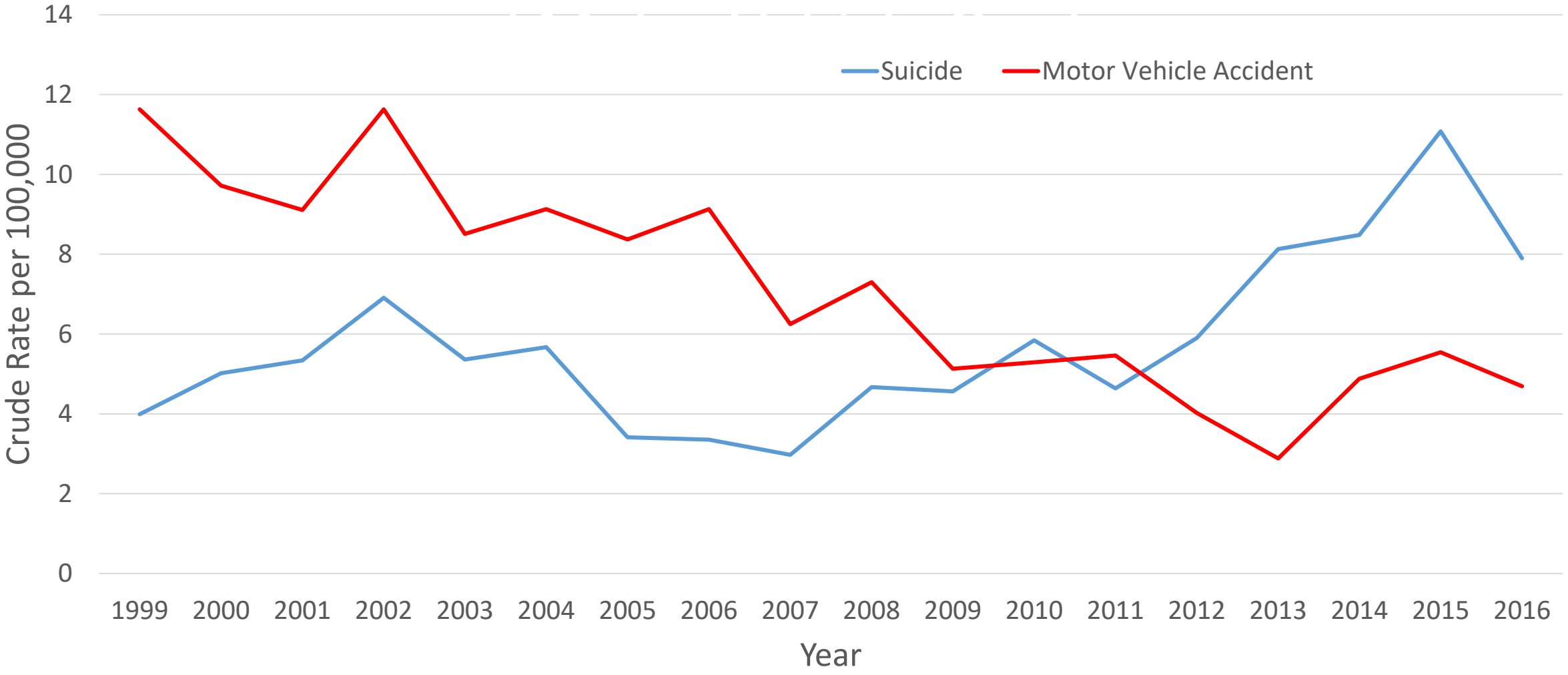


Epidemiology

- 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

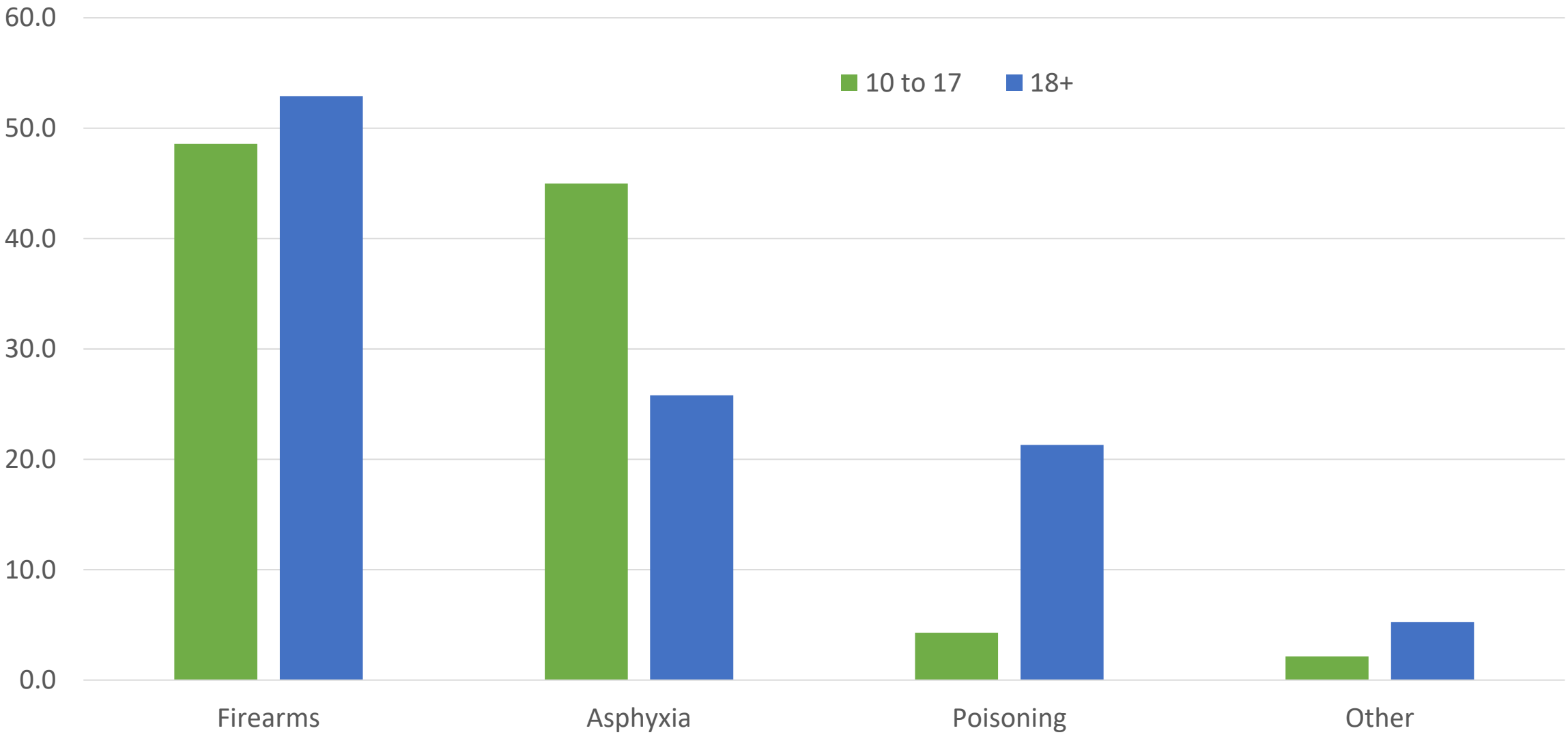
Youth Mental Health Needs are High and Growing

Utah Youth Mental Health and Suicide Indicators, 2013-2017

Note: Combined data for Grades 6, 8, 10, and 12.

Source: 2017 Prevention Needs Assessment Survey results. State of Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Method of Suicide: Utah Youth vs. Adults (2013-1016)

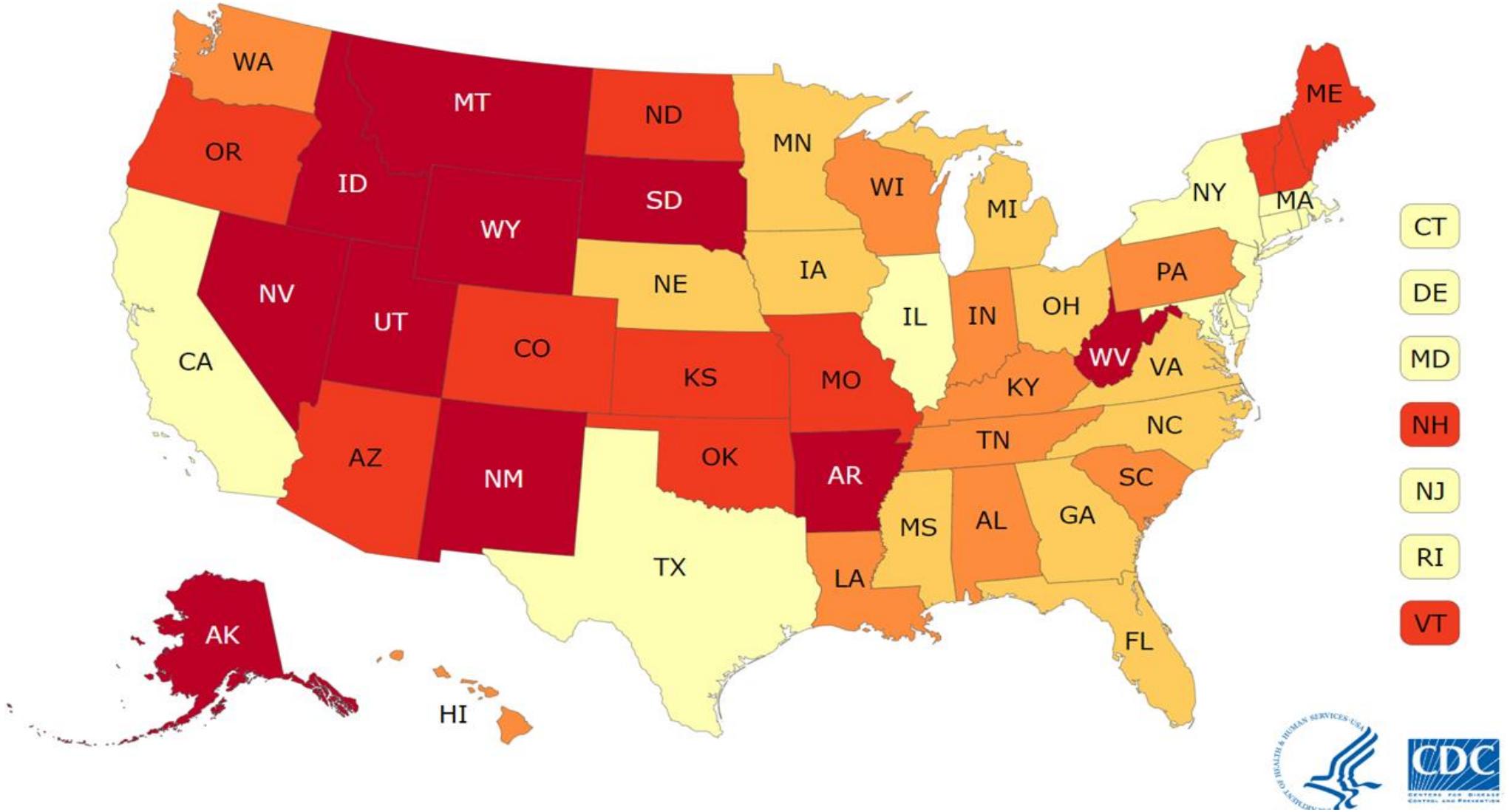


Data Source: Utah Death Certificate Database, Utah Department of Health

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



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

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) *(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 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

▸ ALGORITHM: SUICIDE ASSESSMENT AND PREVENTION – CLINIC CARE

PREVENTION at Intermountain and in Utah *(see page 10)*

Patient screens positive for suicide on PHQ-9 *(1–3 to question 9)* *or* clinical suspicion of suicidal ideation or behaviors present (a)

SCREEN for suicide risk using the C-SSRS Quick Screen *(see page 2)* **(PCP or MA)**

ASK Question 1 (b):
Have you wished you were dead or wished you could go to sleep and not wake up?

ASK Question 2:
Have you actually had any thoughts of killing yourself?

yes to 1, no to 2

no to 1, yes to 2
OR yes to both

ASK Question 3:
Have you been thinking about how you might kill yourself?

ASK Question 4:
Have you had these thoughts and had some intention of acting on them?

ASK Question 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?

ASK Question 6 (b):
Have you ever done anything, started to do anything, or prepared to do anything to end your life?

ACTIONS based on positive patient response (g) *(respond based on highest level of risk)*

If yes to 1 and no to 2

LOW risk
- Consider referral to MHI or BH provider **(c)**
- Consider patient education **(d)**

Note: Patient response to question 6 may increase risk and result in additional steps.

If yes to 3

MODERATE risk
- Assess risk factors **(e)** and either facilitate evaluation for inpatient admission or complete Safety Plan with follow-up within 24–48 hours
- Educate patient **(d)**

If yes to 4 and/or 5

HIGH risk
- Facilitate immediate evaluation **(f)**
- Educate the patient **(d)**

If yes to 6

HIGH risk
If in the past 4 weeks:
- Facilitate immediate evaluation for inpatient care **(e)**
- Educate patient **(d)**

MOD risk
If 1–12 months ago:
- Assess risk factors and refer to MHI or BH provider **(c)**
- Educate patient **(d)**

LOW risk
If ≥1 year ago:
- Consider referral to MHI or BH provider **(c)**
- Consider patient education **(d)**

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

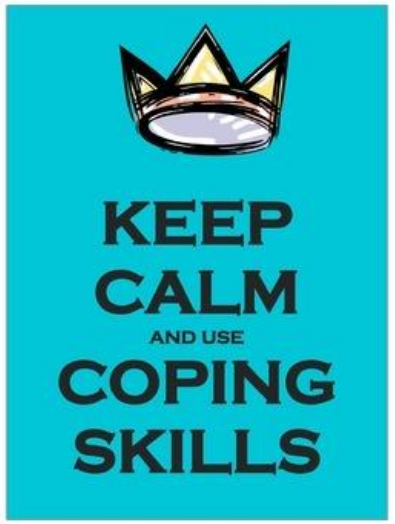
Predisposing Risk Factors

- 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

Not Simply:	Instead:
Categorical Predictions of 1. Low 2. Medium 3. High	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

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

DOCUMENT

Adult & Pediatric Safety Plan

As you fill in this form, focus on your own needs and what would be helpfu
Your healthcare provider may also review with you 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 depr

Situations

Thoughts

Persons

Feelings

Coping Skills

What are some **coping skills I can use to help myself immediately calm down** when I have the
listed above? I will stop and think of these skills. (Deep breathing, etc.)

- I can/will:
- I can/will:

What are some **coping skills I can use to help me get control?**
(Activities that can distract me while I develop strength to cope with stress and pressure, such as t

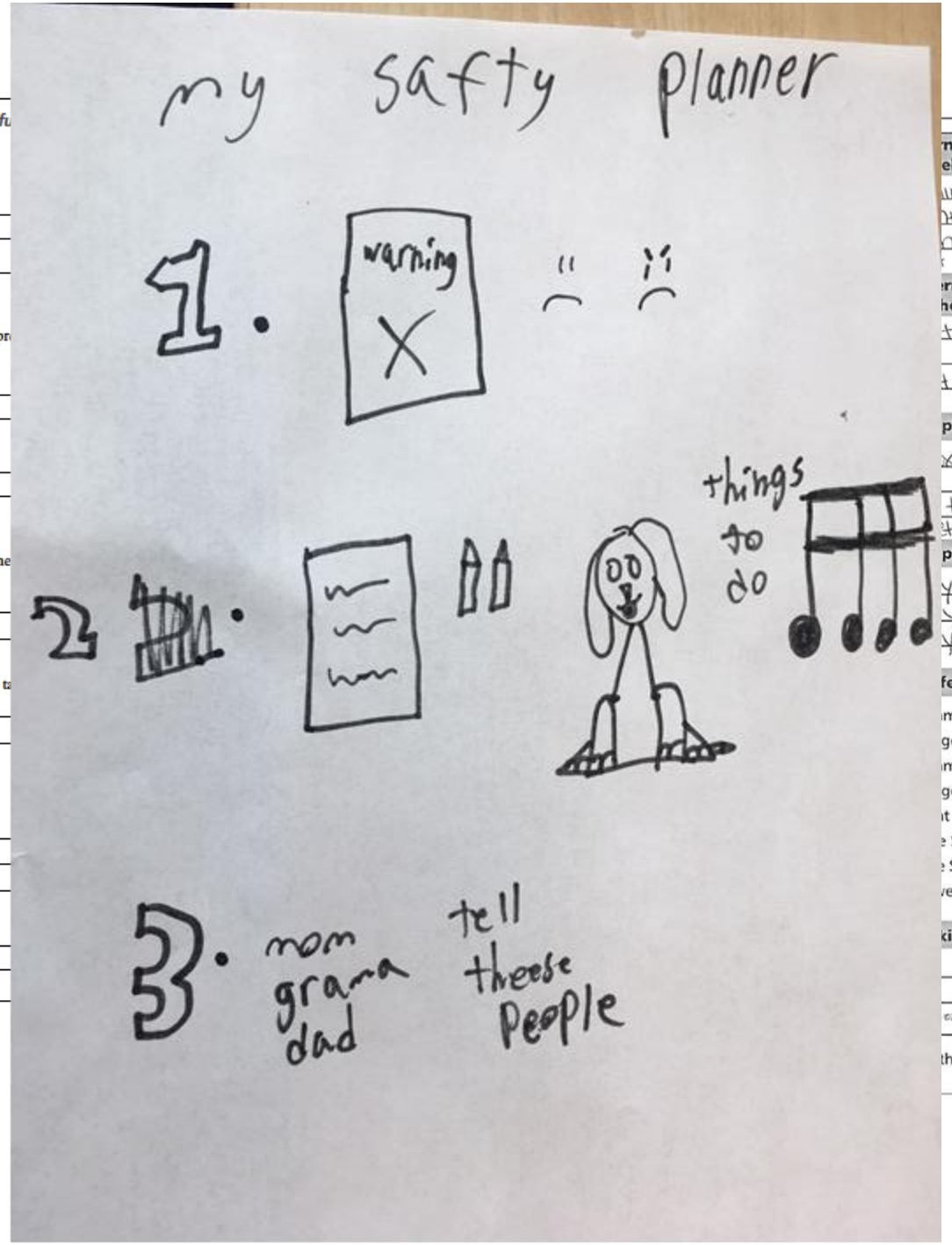
- I can/will:
- I can/will:

Home Treatment

What will my treatment be after I leave the hospital?

- Therapy:
- Medications:
- Other:

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



Patient Safety Plan Template

ning signs (thoughts, images, mood, situation, behavior) that a crisis may be eloping:

nd starts to race and get stuck.
t want to get out of bed on time? I say I don't
nt to stay away of everyone and get not back to people who text me.

rnal coping strategies – Things I can do to take my mind off my problems hout contacting another person (relaxation technique, physical activity):

t outside? If Im home in my rocker chair for 10 m
my shoe or shoes & socks off & put my feet
the funny pictures in my phone I have. Saved

ple and social settings that provide distraction:

xt my friend Nadia Phone 801-555-1234
Phone
to the barn or 4. Place Go to the Jordan trail
t up a time to ride. and look at ducks.

ple whom I can ask for help:

y mom Phone 630-123-4567
y friend Brenna Phone 435-987-6543
y husband Phone 385-[redacted]5889

fessionals or agencies I can contact during a crisis:

me Therapist Bob Phone 801-456-7890
ger or Emergency Contact # Call his office press 1
me Phone
ger or Emergency Contact #
t Care Services The Hospital by my house
e Services Address 123 Sesame St.
e Services Phone 801-867-5309
vention Lifeline Phone: 1-800-273-TALK (8255)

king the environment safe:

my husband to move my medications.

that 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

DOCUMENT

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

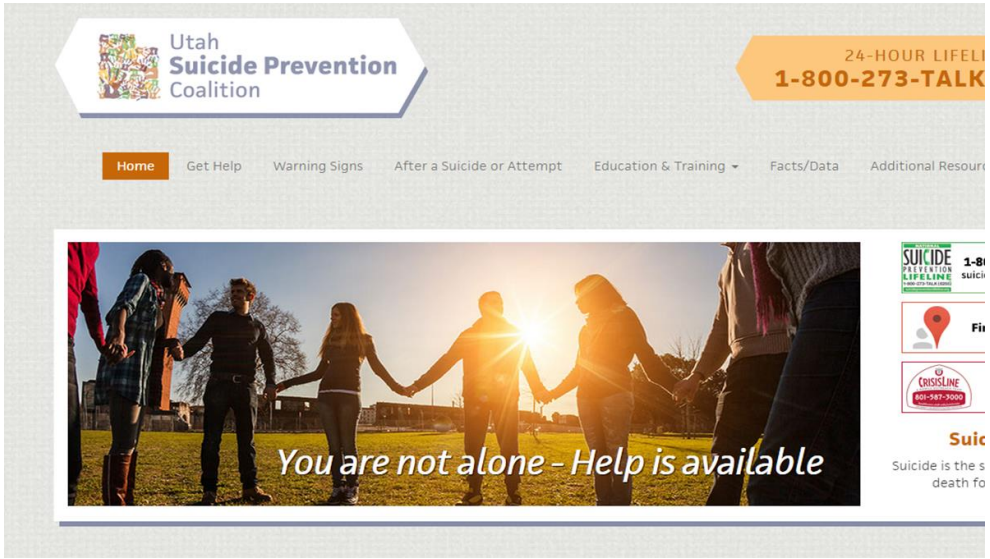
1. Warning signs/ coping skills
2. External supports - family/support system education
3. Ensure safe environment - counsel on access to lethal means
4. Very close follow-up

Sample Safety Plan with Low Risk Assessment

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



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

CRISISLINE
& MOBILE OUTREACH TEAM
801-587-3000
healthcare.utah.edu/uni/crisis
UNIVERSITY NEUROPSYCHIATRIC INSTITUTE