SUICIDE SCREENING: PRACTICAL APPROACH TO IDENTIFYING SUICIDE RISK AND NEXT STEPS FOR THE PEDIATRICIAN

Colby Tyson, MD

Assistant Professor of Psychiatry at The George Washington University School of Medicine and Health Sciences

Attending Physician Children's National Health System

Objectives

- At the end of this session, attendees will be able to…

1. Appreciate the importance of integrating suicide screening into primary care standard of care
2. Be familiar with evidence based screening tools used to screen for suicide
3. Determine action steps when there is concern for suicide risk
4. Identify resources that assist with managing patients identified as high risk for suicide

Why Screen for Suicide?

- Suicide is a serious and increasing public health problem in the U.S
- Second leading cause of death for youth aged 10–24 years.
- For adolescents, the lifetime prevalence of suicidal ideation is an estimated 12.1% and 4.1% of adolescents have attempted suicide.

10–14	15–24	25–34
Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984
Suicide 436	**Suicide 5,723**	**Suicide 7,366**
Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376
Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791
Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445
Heart Disease 111	Congenital Anomalies 388	Liver Disease 925
CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792
Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575
Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546
Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472

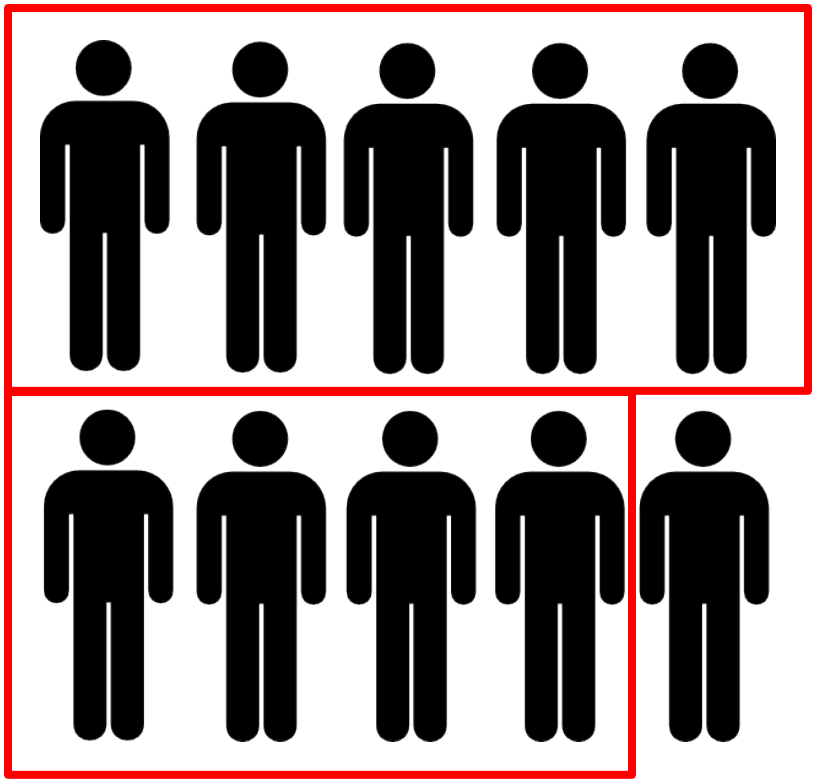
Why Screen for Suicide?

- From 2007 to 2015, the suicide rate among males aged 15 to 19 increased 31%, and among females, it doubled, reaching the highest rate recorded for the period 1975–2015

- 2013 Youth Risk Behavior Survey of students in grades 9 through 12 in the United States
  - 39.1% of girls and 20.8% of boys felt sad or hopeless almost every day for at least 2 weeks in a row
  - 16.9% of girls and 10.3% of boys had planned a suicide attempt
  - 10.6% of girls and 5.4% of boys had attempted suicide
  - 3.6% of girls and 1.8% of boys had made a suicide attempt that required medical attention

Why screen for suicide in Primary Care?

- More than 70% of adolescents see a physician at least once per year, and nearly 90% of adolescents who attempt suicide have seen their primary care provider (PCP) within the previous year
- 45% of adolescents who died by suicide visited their PCP within a month of their suicide
- The American Academy of Pediatrics and the American Medical Association recommend annual depression screening for adolescents in primary care…
  - Suicidal ideation can also come up outside of the context of depression



Case 1: Jessica

- Jessica is a 16 yo girl in 10th grade at a rigorous private school with no past medical history presenting for her annual physical accompanied by mother
- *Parent concerns:* grades dropping, increased panic attacks, increased irritability, recently found marijuana in room
- *Dev hx:* separation anxiety otherwise met all developmental milestones
- *Social hx:* very high achieving and academically focused, trouble with friend group, parents with contentious divorce
- *On today's exam:*
  - Appears more withdrawn then previous visits, well healed linear scars noted on right forearm, still on growth curve but has lost 5 lbs since last visit, vitals stable and recent lab work within normal limits

Case 1: Jessica

- What are your concerns at this point?
- How are you feeling about this patient?
- What are red flags that suicide screening is needed?

Case 1: Red flags for Jessica

- Substance use
- Parental discord
- Ongoing stress with school
- Clear change in functioning
- Possible Depressive symptoms
- Anxiety
- Hx of Cutting (unclear of intent)
- Isolation
- Not in current psychiatric care

Suicide risk factors

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, not isolated to depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Isolation
- Barriers to accessing mental health care
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma
- Being a sexual minority

Case 1: Jessica

- PHQ-9 results:
  - depressive symptoms are moderate
  - Positive for question 9 related to suicide.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 or staying asleep, or 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 are 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 figety 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	0	1	2	3

add columns 5 + 4 + 3

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: 12

10. If you checked off *any problems*, 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

Case 1: Jessica

- How do you structure the rest of the visit?
- How do you start the conversation with Jessica about your observations?

Engagement tips

- Open-ended questions
- Try to remain neutral when forming your questions
- Listen first, then ask follow up questions (avoid giving advice right away)
- Ask direct questions
- Explore patients thoughts about self harm and suicide. Be curious!
- Validate experience

Case 1: Jessica

- Further clinical assessment done
  - No plan, intent, desire, or history of previous attempt

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Various tools to screen for suicide

- Columbia Suicide Severity Rating Scale
- Ask Suicide-Screening Questions
- SAFE-T

Columbia Suicide Severity Rating Scale

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.	**Past 3 Months**	
If YES, ask: *Was this within the past 3 months?*		

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
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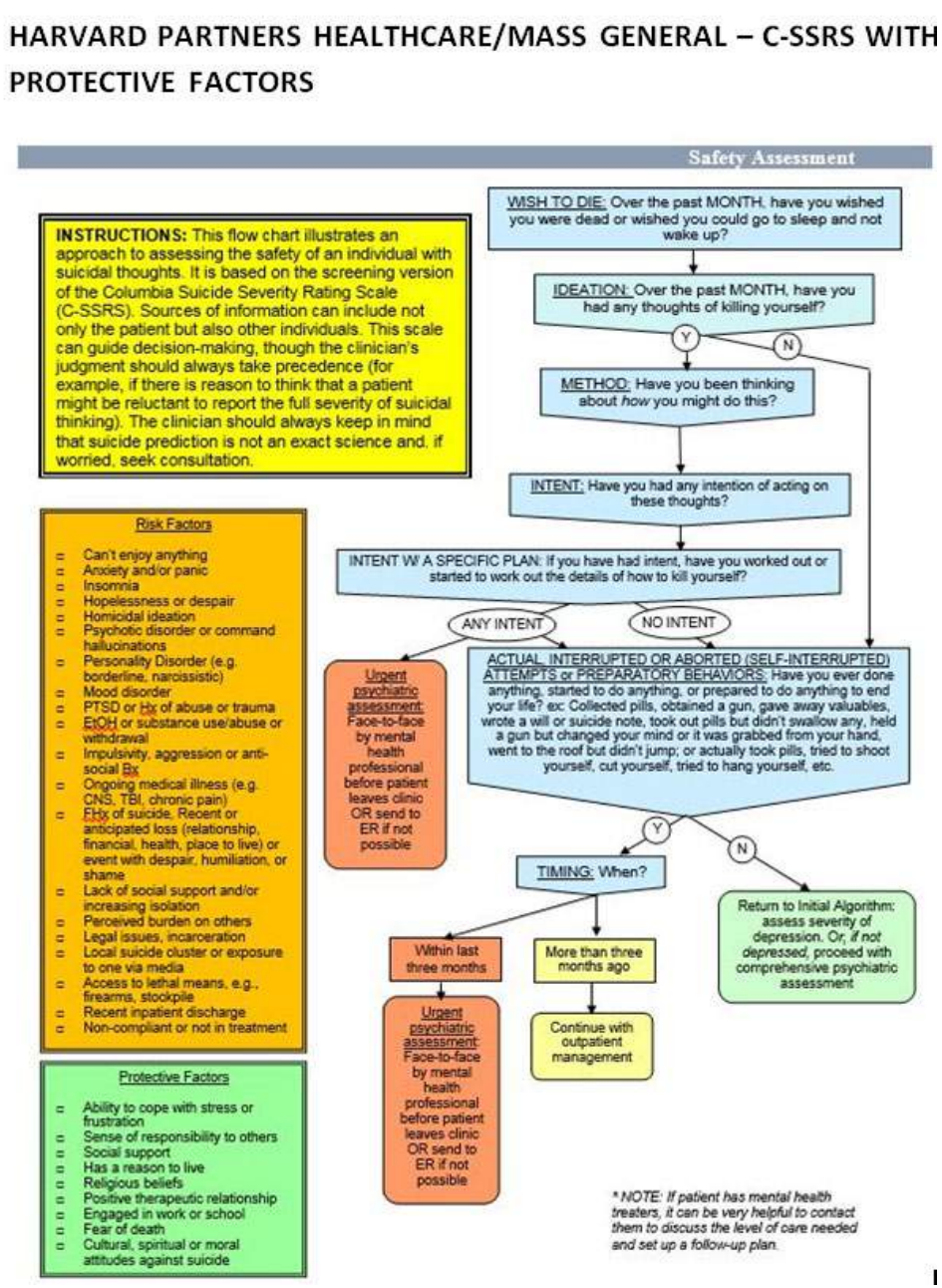
Columbia Suicide Severity Rating Scale



Jessica's C-SSRS

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2) ***Have you had any actual thoughts of killing yourself?***		X
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.*"		X
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.*"		X
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?***		X
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Positive screen: low risk (not acute)

Possible Next steps

- Safety planning
- Referral for mental health services
- Use of in-house psychological, Social work, or telepsych resources
- Close pediatric follow up at least until outpatient mental health services are established
- Consider alternative supports systems in child's life to engage

Case 1: Jessica

- Patient returns for follow up visit 2 weeks later while waiting for outpatient psychiatry appointment

COLUMBIA-SUICIDE SEVERITY RATING SCALE

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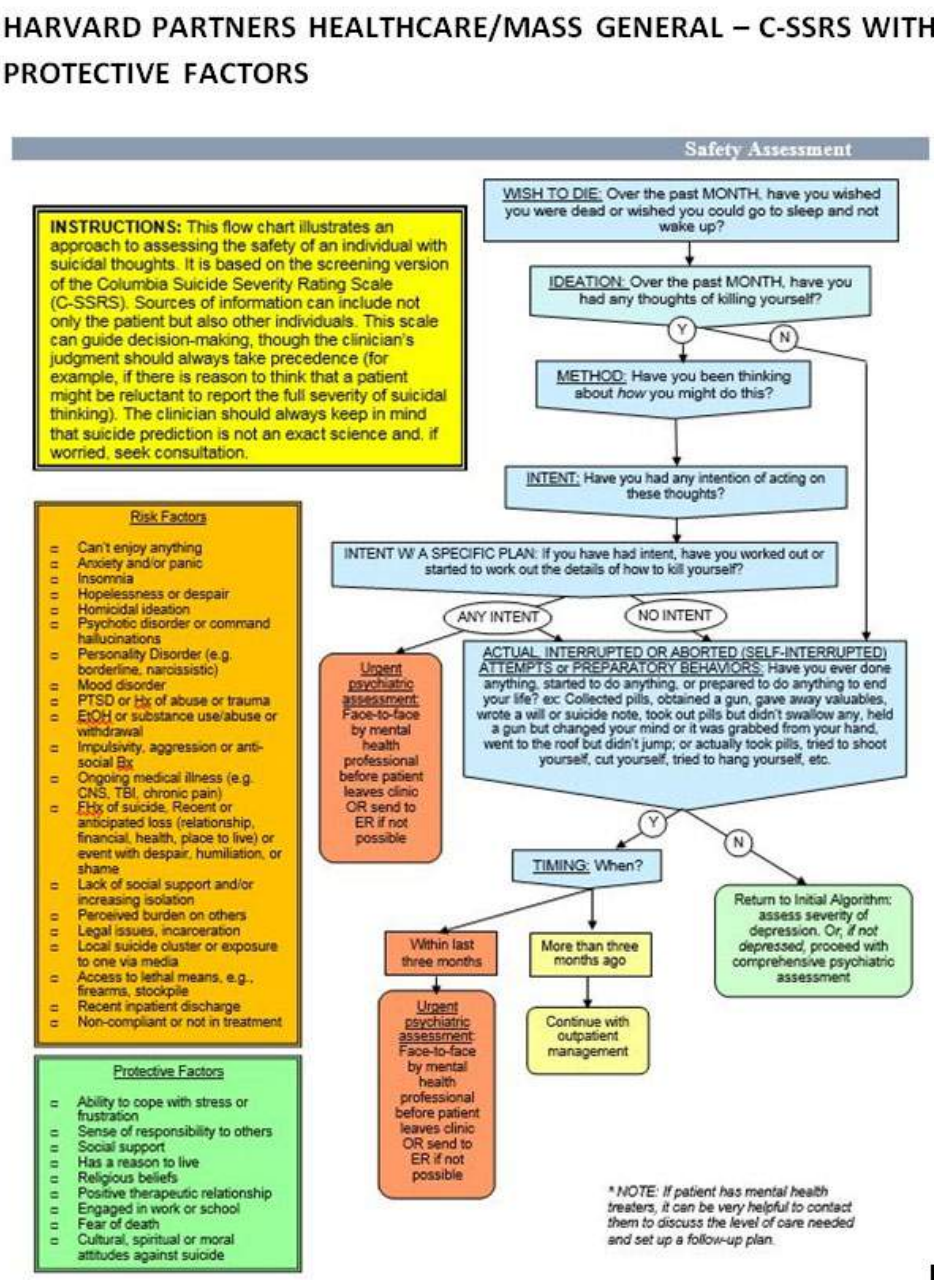
Positive Screen: high risk

- In house Safety precautions: do not leave patient alone and make sure environment is safe
- Use of in house psychological and Social work services
- Refer to nearest emergency room for further evaluation if no in house mental health services available
- Debrief with family on what to expect



Example of moderate risk

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Positive screen: moderate risk

- Safety Planning
- Can call:
  - Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) for advice
  - DC MAP (DC Mental Health Access in Pediatrics)
- Use of in house mental health service if available
- When applicable, reach out to patient's outpatient mental health team
- Possible referral to ED for further assessment

Creating an appropriate environment

- Promotion of mental health as integral to your practice (posters, educational materials, brochures, etc)
- Development of a contingency or crisis plan for urgent mental health problems
- Host educational sessions for clinicians/staff
- Monitoring and documenting adverse childhood events and anniversaries of significant losses or traumatic events
- Address stigma
- Routine consents to communicate with mental health providers
- Establish mental health referral base
- Consider integrated care model
- Use of validated evidence based screening tools

Online resources

- AAP Mental Health Initiatives:
  - https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/About.aspx
- AACAP Facts for Families
  - https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/FFF-Guide-Home.aspx

References:

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