Suicide Risk Assessment & Prevention/Intervention

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WY PAL | June 6, 2020
Objectives

1. Participants will learn the epidemiology of suicidality in youth.

2. Participants will learn how to employ youth suicidality screening and assessment techniques and tools.

3. Participants will review the risk categorization and initial intervention for youth with suicidality in primary care.
Disclosures

• Dr. Montenegro is a Partnership Access Line consultant.

• He has no financial conflicts of interest to report.

Arabel
Epidemiology

Suicidal Ideation and Suicidality
# Continuum of Suicide-Specific Risk Indicators

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Attempt</td>
<td>Behavior with potential for harm &amp; intent to die</td>
</tr>
<tr>
<td>Interrupted Attempt</td>
<td>Person is interrupted from engaging in dangerous act by someone else</td>
</tr>
<tr>
<td>Aborted Attempt</td>
<td>Person takes steps to harm themselves and stops</td>
</tr>
<tr>
<td>Non-Suicidal Self-Injury</td>
<td>Injurious act without intent to die</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Thinking about killing self; ranges from passive (wish to be dead) to active and persistent</td>
</tr>
</tbody>
</table>
Suicide is a Public Health Problem

Suicide Rates from National Vital Statistics System, 1999-2014 (Curtin et al, 2016)

Figure 3. Suicide rates for males, by age: United States, 1999 and 2014

NOTES: For all age groups, the difference in rates between 1999 and 2014 is significant (p < 0.05). Suicides are identified with codes U03, X60–X84, and Y87.0 from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Access data for Figure 3 at:
Suicide is a Public Health Problem

Suicide Rates from National Vital Statistics System, 1999-2014 (Curtin et al, 2016)

Figure 2. Suicide rates for females, by age: United States, 1999 and 2014

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>1999</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>10–14</td>
<td>0.5</td>
<td>1.5</td>
</tr>
<tr>
<td>15–24</td>
<td>3.0</td>
<td>4.6</td>
</tr>
<tr>
<td>25–44</td>
<td>5.5</td>
<td>7.2</td>
</tr>
<tr>
<td>45–64</td>
<td>16.0</td>
<td>19.8</td>
</tr>
<tr>
<td>65–74</td>
<td>4.1</td>
<td>5.9</td>
</tr>
<tr>
<td>75 and over</td>
<td>4.5</td>
<td>4.0</td>
</tr>
</tbody>
</table>

*Significantly higher than rates for all other age groups (p < 0.05).
NOTES: For all age groups, the difference in rates between 1999 and 2014 is significant (p < 0.05). Suicides are identified with codes U03, X60–X84, and Y87.0 from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Access data for Figure 2 at: http://www.cdc.gov/nchs/data/databriefs/db241_table.pdf#2.
Epidemiology of Adolescent Suicide
Suicide Completion Rates

- Ages 5 to 11: 1 per 1 million
- Ages 10-14: 1 per 100,000
- Ages 15-19: 7-8 per 100,000
Means of Completed Suicide

• Hanging and Firearms >90%
• Overdose ~7%
• Other Means (Cutting) <3%
Reducing Suicide Risk

![Bar Chart]

- **Estimated % of Suicide Attempts Prevented**
- **Estimated % of Suicides Prevented**

### Categories
- Public Awareness
- Media Guidelines
- Means Restriction
- School Based Programs
- GP Training
- Gatekeeper Training
- Coordinated Aftercare
- Psychosocial Treatment

### Strategies
- **Universal Strategies**
- **Indicated Strategies**
- **Selective Strategies**
GP Training: Screening
1. Consider measures (PHQ-9-A, SCARED, CRAFFT 2.0)
2. Interview patient alone & with caregiver(s)

*Safety trumps confidentiality*
## PHQ-9 modified for Adolescents (PHQ-A)

**Name:** ____________________________  **Clinician:** ____________________________  **Date:** ____________

### Instructions:
How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>(0) Not at all</th>
<th>(1) Several days</th>
<th>(2) More than half the days</th>
<th>(3) Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>Poor appetite, weight loss, or overeating?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Feeling tired, or having little energy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself – or feeling that you are a</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)*
GP Training:
Assessment—know the risk factors
Conceptual Model

Population risk factors

Lack of social cohesion
- Rapid changes in social structure/values
- Economic turmoil
- Social isolation

Individual risk factors

Distal or predisposing
- Family history
- Early-life adversity
- Epigenetic changes
- Genetics
- Stable changes in gene function

Developmental or mediating
- Cognitive deficits: impaired memory specificity and problem-solving
- Development of personality traits
- Genetic and epigenetic factors
- Chronic substance use

Proximal or precipitating
- High anxiety
- High impulsive aggression
- Behavioural disinhibition
- Acute substance use
- Biological, genetic and epigenetic factors
- Life events

Suicide
- Suicidal behaviour
- Suicidal ideation

Environmental factors
- Media reports
- Access to lethal means
- Poor access to mental health care

*Psychopathology* refers to any single mental illness associated with suicide risk, as described in the text, or a combination of mental illnesses, including major depressive disorder, bipolar disorder, schizophrenia, and personality disorders; the presence of a depressive episode is often a sign of increased suicide risk.

From Tureki & Brent (2016). The Lancet. V.387
Predisposing Risk Factors for Suicide

- Substance use disorders
- Previous suicide attempt or self-harm
- Family history of suicide attempts (5x) and completion
- History of physical or sexual abuse
- Impulsivity
- Social isolation
- Male
- White or Native American
- Psychiatric disorders
Precipitating Factors

- Interpersonal problems: breakups and family fights
- Disciplinary problems
- Bullying
- Profound loss
- Access to means
- Alcohol and drug use
- Exposure to suicide
Suicidal Behavior & Mental Health Problems

- 90% of youth who commit suicide have a mental health disorder
- Associated mental health problems include:
  - Mood and impulsive behavior disorders
  - Borderline personality disorder features
- Associated psychosocial problems include:
  - Difficulties regulating negative emotions
  - History of abuse
  - Poor attachment
  - Exposure to high levels of family discord
  - Family conflict
Assessment Acronym: Is Path Warm

- Ideation
- Substance abuse
- Purposelessness
- Anxiety
- Trapped
- Hopelessness
- Withdrawal
- Anger
- Recklessness
- Mood changes
GP Training: Assessment - Use an assessment tool
Areas of Assessment: Suicide Specific Inquiry

Ask About:

• Suicidal ideation
• Suicide plans

Give Added Consideration to:

• Suicide attempts (actual and aborted)
• First episode of suicidality (Kessler 1999)
• Hopelessness
• Ambivalence: a chance to intervene
• Psychological pain history
## SCH Psychiatry Safety Assessment (V11.9.16)

### SELF-HARM THOUGHTS AND BEHAVIORS

<table>
<thead>
<tr>
<th>Question</th>
<th>Lifetime: Most Suicidal</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you ever wish you weren’t alive anymore?</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>2. Have you had any thoughts about killing yourself?</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>3. Have you thought about how you would kill yourself? What did you think about?</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>4. If so, when you thought about killing yourself, did you think that this was something you might actually do (i.e., did you have some intention of acting on them?)</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>5. If not, have you ever decided how you would kill yourself? What did you think about?</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
</tbody>
</table>
Reducing Suicide Risk

- Estimated % of Suicide Attempts Prevented
- Estimated % of Suicides Prevented

Universal Strategies
- Selective Strategies
- Indicated Strategies
GP Training: Intervention - What next?
## Assessment

### ASSESSMENT

<table>
<thead>
<tr>
<th>RISK</th>
<th>PROTECTIVE</th>
<th>SUICIDE SPECIFIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent loss/humiliating event</td>
<td>-</td>
<td>-</td>
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</table>

### DETERMINATION OF RISK

Support
Assessment

**SUICIDAL IDEATION INTERVENTION PLAN:**
(Please consider risk and protective factors when selecting level of risk)
Providers are ENCOURAGED to seek consultation as needed when completing risk evaluations.

6A. (0) - No Current Safety Concerns
- □ No history of active suicidal ideation or NSSI.
  *(There can be presence of passive thoughts of death, history of thoughts that you would rather be dead or what life would be like if you weren’t here)*

6B. (1) - Mild risk
- Patient reports:
  - □ Past but not recent or current suicidal ideation
  - □ Past but not recent or current NSSI
  - □ No lifetime history of life threatening behavior

□ No further questions required.

□ Home Safety Planning Handout provided to parent/caregiver

□ Provide CPP homework to patient/family to complete before next session.
□ Home Safety Planning Handout provided to parent/caregiver
□ If current or recent SI:
  - □ Consider informing legal guardian
  - □ Complete Coping Card & CPP in session with patient.
□ For new reports of self-harm or SI, bring to MAP
Mild Risk: Next Steps

- Validation, letting them know that you’ll help
- Inform appropriate people
- Brainstorming on coping skills, replacement behaviors
- Help family identify precipitants, begin problem solving, implement appropriate supervision
- Means reduction
- Safety planning
- Close follow-up
- Medications?
Mild Risk: Next Steps

Standard Home Safety Interventions and County Crisis Numbers

As you leave the Emergency Department at Seattle Children’s Hospital, here are some important recommendations. Once the current crisis has passed and you have met with your child’s outpatient mental health provider, the recommendations below should be discussed with that provider. Until that time, your role as parent/caregiver is to prevent another escalation/crisis to the best of your ability. The ongoing safety/security of your whole family is of utmost importance.

Please consider following the pre-emptive safety steps below:

Safety Proofing the Home:

- Secure and lock up objects your child could use to hurt him/herself or others, such as:
  - Medications: All medication, including all over-the-counter medicines.
  - Sharps: Such as knives and razors.
  - Strangulation: Such as belts, cords, ropes, and sheets.
  - Firearms and ammunition: Should be locked and kept in different locations from each other.
Moderate Risk: Crisis Prevention Plan?

- Written list of warning signs, coping strategies and resources developed collaboratively with the youth
- Includes contact information for social supports and professional supports
- Often includes reasons for living
- Many templates on-line
- “MY3” App
- NOT A NO HARM CONTRACT
Moderate Risk: Crisis Prevention Plan?

Department of Psychiatry & Behavioral Medicine

CRISIS PREVENTION PLAN

PATIENT NAME:

CRISIS TRIGGERS, WARNING SIGNS, AND INTERVENTIONS

My triggers are:

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
YOUR SAFETY PLAN
Fill out your safety plan and reference it when you are having thoughts of suicide

- 1. MY WARNING SIGNS
- 2. MY COPING STRATEGIES
- 3. MY DISTRACTIONS
- 4. MY NETWORK
- 5. KEEPING MYSELF SAFE
- 6. MY REASON TO LIVE

EMAIL SAFETY PLAN

GET HELP NOW
Call the National Suicide Prevention Lifeline

CALL 911
SUICIDAL IDEATION INTERVENTION PLAN:
(Please consider risk and protective factors when selecting level of risk)
Providers are ENCOURAGED to seek consultation as needed when completing risk evaluations.

6A. (0) - No Current Safety Concerns
☐ No history of active suicidal ideation or NSSI. 
   (There can be presence of passive thoughts of death, history of thoughts that you would rather be dead or what life would be like if you weren’t here)
   □ No further questions required.
   □ Home Safety Planning Handout provided to parent/caregiver

6B (1) - Mild risk
Patient reports:
☐ Past but not recent or current suicidal ideation
   AND/OR
☐ Past but not recent or current NSSI
   AND
☐ No lifetime history of life threatening behavior
   □ Provide CPP homework to patient/family to complete before next session.
   □ Home Safety Planning Handout provided to parent/caregiver
   □ If current or recent SI:
     o Consider informing legal guardian
     o Complete Coping Card & CPP in session with patient.
     o Review Home Safety Planning Handout in session with patient.
     □ For new reports of self-harm or SI, bring to MAP consult team.

6C. (2) - Mild - Moderate Risk
☐ Recent or current suicidal ideation with no plan or intent to kill self
   AND/OR
☐ Recent or current non-life threatening NSSI

6D (3) - Moderate Risk
☐ Current suicidal ideation with ambivalence about living but no clear intent OR Plan, WITH or WITHOUT recent or current non-life threatening NSSI

6E (4) - Moderate - Severe Risk
☐ Recent SI with intent AND/OR plan
   (NOT current)
   OR
☐ Recent or current life-threatening NSSI
   □ Inform legal guardian
   □ Complete Coping Card & CPP in session.
   □ Review Home Safety Planning Handout in session with patient and family.
   □ For new report of SI or NSSI, bring to MAP Consult Team
   □ For new reports of self-harm or SI, bring to team.

6F (5) - Severe Risk
☐ Current SI with intent AND/OR plan
   OR
☐ Current life-threatening NSSI
   □ Patient should be referred for admission to a psychiatric inpatient hospital via the SCH ER:
     o Voluntary
     o Parent-Initiated Treatment
     o Involuntary Treatment
   □ For new report of SI or NSSI, bring to MAP Team
High Risk: to ED

- Planned or recent attempt with a lethal method
- Attempt that included steps to avoid detection
- Inability to openly and honestly discuss suicide attempt and what precipitated it
- Inability to discuss safety planning
- Lack of alternatives for adequate monitoring and treatment
- Severe psychiatric disorders underlying suicidal ideation and behavior
- Agitation
- Impulsivity
- Severe hopelessness
- Poor social support
Three Ongoing Essential Tasks

• Screen
• Assess
• Intervene

Washington PAL

HOURS
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

TELEPHONE
866-599-7257 (toll-free)

FAX
206-985-3266

EMAIL
paladmin@seattlechildrens.org
Resources

• ASQ
  ➢ Search: Ask Suicide Screening Questions
• AAP Guidance on Suicide and Suicide Attempts in Adolescents
  ➢ Search: Suicide and Suicide Attempts in Adolescence
• National Suicide Prevention Lifeline: 800.273.TALK(8255)
• Safety Plan Template and Instructions:
  ➢ Search: Developing Effective Safety Plans for Suicidal Youth
• 24/7 Crisis Text Line: Text “HOME” to 741-741
• County Crisis Line
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Hope. Care. Cure.™