Suicide Risk Assessment & Prevention/Intervention

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Disclosures

• Dr. Montenegro is a Partnership Access Line consultant.
• He has no financial conflicts of interest to report.
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><strong>Suicide Attempt</strong></td>
<td>Behavior with potential for harm &amp; intent to die</td>
</tr>
<tr>
<td><strong>Interrupted Attempt</strong></td>
<td>Person is interrupted from engaging in dangerous act by someone else</td>
</tr>
<tr>
<td><strong>Aborted Attempt</strong></td>
<td>Person takes steps to harm themselves and stops</td>
</tr>
<tr>
<td><strong>Non-Suicidal Self-Injury</strong></td>
<td>Injurious act without intent to die</td>
</tr>
<tr>
<td><strong>Suicidal ideation</strong></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

- Significantly lower than rates for all other age groups ($p < 0.05$).
- Significantly higher than rates for all other age groups except 75 and over ($p < 0.05$).

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 3 at: [Seattle Children's Hospital Research Foundation](http://www.seattlechildrens.org)
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>19.8</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](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%
GP Training: Screening
Brief Suicide Safety Screening

1. Consider measures (PHQ-9-A, SCARED, CRAFFT 2.0)
2. Interview patient alone & with caregiver(s)

SAFETY TRUMPS CONFIDENTIALITY
# PHQ-9A

**PHQ-9 modified for Adolescents (PHQ-A)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Clinician:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**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>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Little interest or pleasure in doing things?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Poor appetite, weight loss, or over-eating?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Feeling tired, or having little energy?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Trouble concentrating on things like school work, reading, or watching TV?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
</tr>
</tbody>
</table>

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes  [ ] No

If you are experiencing any of the problems on this form, 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  [ ] Very difficult  [ ] Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

[ ] Yes  [ ] No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes  [ ] No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.**

Office use only:  

Severity score: _______
GP Training:
Assessment– know the risk factors
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 is Associated with Mental Health Problems

• Psychological autopsy studies: 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--one of the most common triggers of suicidal behavior in adolescents
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
## 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</td>
<td>No</td>
</tr>
<tr>
<td>2. Have you had any thoughts about killing yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Have you thought about how you would kill yourself? What did you think about?</td>
<td>Yes</td>
<td>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</td>
<td>No</td>
</tr>
<tr>
<td>5. If so, have you ever decided how or when you would kill yourself? What was your plan? When you made this plan, was any part of you thinking about actually doing it?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- If YES, do you currently have a plan?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- What was going on?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Were you using substances?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How long did it last?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did you follow through on the plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have any other plans?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- How would you get what you need to carry out your plan or plans?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you done anything to prepare to carry out your plan or plans?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are there guns in the house?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Have you ever hurt yourself deliberately, but not with the intention to kill yourself (NSSI)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- What did you do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Where on your body?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How often have you done this?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- When was the last time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- What was going on or triggered it?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## VIOLENCE SCREEN: Have you ever had thoughts about hurting or killing someone other than yourself?

If yes, describe:

If current concern, please complete the "In Depth Violence Risk Assessment" on page 5.

Providers are ENCOURAGED to seek consultation as needed when completing risk evaluations.
Reducing Suicide Risk

Universal Strategies

Selective Strategies

Indicated Strategies

Estimated % of Suicide Attempts Prevented

Estimated % of Suicides Prevented

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Estimated % of Suicide Attempts Prevented</th>
<th>Estimated % of Suicides Prevented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Awareness</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>Media Guidelines</td>
<td>1.2</td>
<td>2</td>
</tr>
<tr>
<td>Means Restriction</td>
<td>0.9</td>
<td>4</td>
</tr>
<tr>
<td>School Based Programs</td>
<td>2.9</td>
<td>6</td>
</tr>
<tr>
<td>GP Training</td>
<td>6.3</td>
<td>8</td>
</tr>
<tr>
<td>Gatekeeper Training</td>
<td>4.9</td>
<td>10</td>
</tr>
<tr>
<td>Coordinated Aftercare</td>
<td>19.8</td>
<td>12</td>
</tr>
<tr>
<td>Psychosocial Treatment</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>
GP Training: Intervention - What next?
<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>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
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<td></td>
<td>-</td>
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</tr>
</tbody>
</table>

**DETERMINATION OF RISK**

Support
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.
- 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 consult team.

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
- Inform legal guardian
- Complete Coping Card & CPP in session.
- For new report of SI or NSSI, bring to MAP Consult Team.
- For new reports of self-harm or SI, bring to 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
- Patient should be referred for admission to a psychiatric inpatient hospital via the SCH ER:
  - Voluntary
  - Parent-Initiated Treatment
  - Involuntary Treatment
- For new report of SI or NSSI, bring to MAP Team.

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
- Patient should be referred for admission to a psychiatric inpatient hospital via the SCH ER:
  - Voluntary
  - Parent-Initiated Treatment
  - Involuntary Treatment
- For new report of SI or NSSI, bring to MAP Team.

6E. (4) - Moderate - Severe Risk
- Recent SI with intent AND/OR plan (NOT current)
- Recent or current life-threatening NSSI
- Patient should be referred for admission to a psychiatric inpatient hospital via the SCH ER:
  - Voluntary
  - Parent-Initiated Treatment
  - Involuntary Treatment
- For new report of SI or NSSI, bring to MAP Team.

6F. (5) - Severe Risk
- Current SI with intent AND/OR plan
- Current life-threatening NSSI
- Patient should be referred for admission to a psychiatric inpatient hospital via the SCH ER:
  - Voluntary
  - Parent-Initiated Treatment
  - Involuntary Treatment
- For new report of SI or NSSI, bring to MAP Team.
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?
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 job as a 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.
  - Sharp: 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.
- If dealing with destructive or aggressive behaviors lock up items that may be easily broken or used as a weapon.
- Hiding Locked Items: Ensure that your child does not have knowledge of the location of these items.

Home Life:
- In your home environment, maintain a “low-key” atmosphere while maintaining your regular routine.
  - Follow your typical house rules, and pick your battles appropriately.
    - Remember, safety is your foremost concern.
    - Encourage your child to attend school, unless otherwise directed by your providers.
  - Administer medications as directed by your child’s medical/psychiatric provider.
  - Provide appropriate supervision until the crisis is resolved.
  - Attend the next scheduled appointment with his or her provider.
    - At this appointment continue working on your Crisis Prevention Plan.

In the event of another crisis:
- If you believe that you, your child, or another person is unsafe, take your child to your closest Emergency Department.
- Please consider your child’s safety when transporting him or her in your own vehicle.
- If you are unable to safely transport your child call 911 to have them transported.

Resources Numbers by County:
- King County:
  - King County Crisis Line: 206-461-3222 or 866-4CRISIS (427-4747)
  - Children’s Crisis Outreach Response System (CCORS): 206-461-3222
  - King County Teen Line: 866-TEENLINK (833-6546)
    - Teen can talk directly to another teen who receives crisis management oversight
- Snohomish County:
  - Snohomish County Crisis Line: 425-258-4357 or 800-584-3578
- Pierce County:
  - Pierce County Crisis Line: 800-576-7764 or 253-396-5180
  - Other County and Crisis Line phone number:
- Statewide Resources:
  - Alcohol Drug Help Line: 206-722-3700 or 800-562-1240 (Washington only)
  - Alcohol Drug Teen Line: 206-722-4222 or 877-345-8336
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
CRISIS PREVENTION PLAN

PATIENT NAME:

CRISIS TRIGGERS, WARNING SIGNS, AND INTERVENTIONS

My triggers are:
1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

My early warning signs are:
1.
2.
3.
4.
5.

When my parents/caregivers notice my early warning signs, they can:
1.
2.
3.
4.
5.
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

GET HELP NOW
Call the National Suicide Prevention Lifeline

CALL 911

EMAIL SAFETY PLAN
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
Questions?