

Suicide Assessment in Primary Care



Project ECHO
Melissa Butler, Ph.D., HSPP
12/12/2019



Suicide is the **2nd** Leading cause of death for pre-teens, teens, and young adults (ages 10-24)

Indiana Youth Risk Behavior Survey (2015) – surveyed almost 2000 9th-12th graders



- 19% stated that they seriously considered attempting suicide in the last year
- 17% Made a Suicide Plan
- 9.9% Attempted Suicide
- By this data, in an average class of 30, 3 students would have attempted suicide
- Indiana ranks 25th in overall suicide rates (all ages); and is above national rate



45% of individuals who die by suicide saw their primary care physician in the month prior to their death.

Misconceptions about Suicide

- Myth: Talking about suicide will give someone the idea to do it or try it
- Myth: Only certain types of teenagers become suicidal
- Myth: once the suicide attempt is over they are no longer at risk
- FACT – Talking about suicide helps. There is absolutely no data to support that talking about suicide increases suicide thoughts or attempts.
- FACT – Every teen has the potential for suicide.
- FACT – Teens are at most risk to die by suicide 3 months following an attempt

Screening for Suicide in Primary Care Settings

- Routine depression and suicide screening should occur during medical visits.
- Need to determine when will patients complete this screen/assessment (e.g., with intake paper work, in waiting room, etc.)?
- NOTE: Need to have a procedure of who will review the results and how will this information be flagged

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Commonly Used Screening Tool: PHQ-9

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 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 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 Score: 1-4 Minimal depression; 5-9 Mild depression; 10-14 Moderate depression; 15-19 Moderately severe depression; 20-27 Severe depression

Available free at :

<https://www.phqscreeners.com/>

A score of 10 or above is often viewed as a cut-off for intervention or further assessment needed. Score of 15 and above is a “red flag”

PHQ-9 – Pay Attention to Response to Item 9

- Question 9 - Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself?
- Follow-up and document that you did so!



Be on the lookout for common warning signs



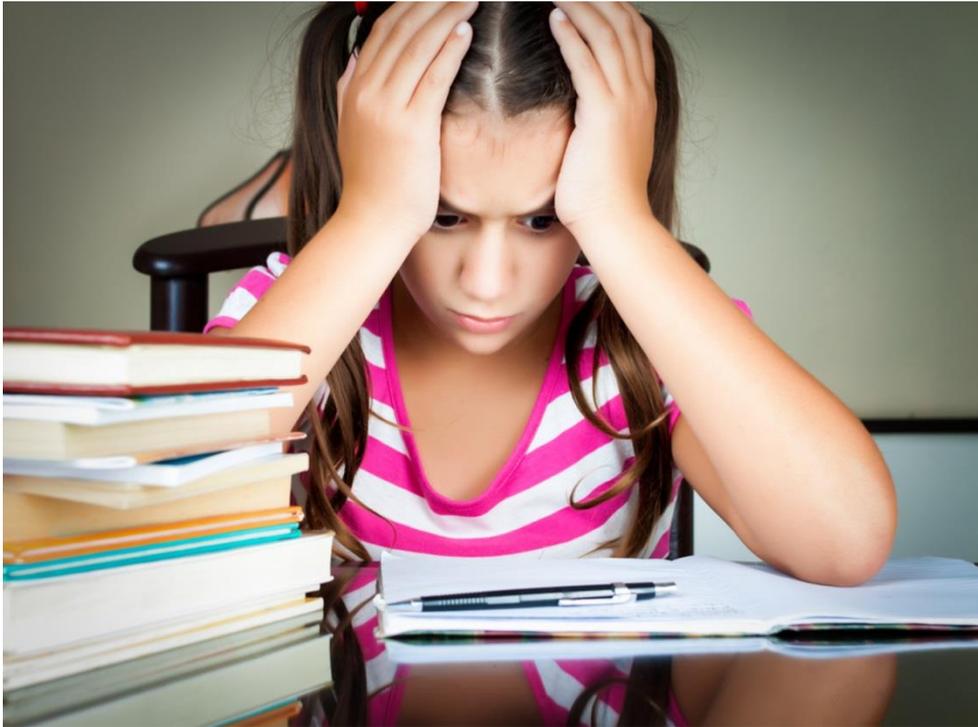
- Talking about suicide /death / killing themselves
- Making plans to kill themselves
- Reporting intent that they are going to kill themselves

Warning Signs: Passive Suicidal Ideation

- “My family would be better off without me”
- “I don’t want to be a burden”
- “Everyone would be better off without me.”
- “I wish I had never been born.”
- “If wish I could just go to sleep and never wake up.”
- “I’m just so tired of it all. I can’t do this anymore.”
- “If something were to kill me, it wouldn’t be the worst thing.”

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

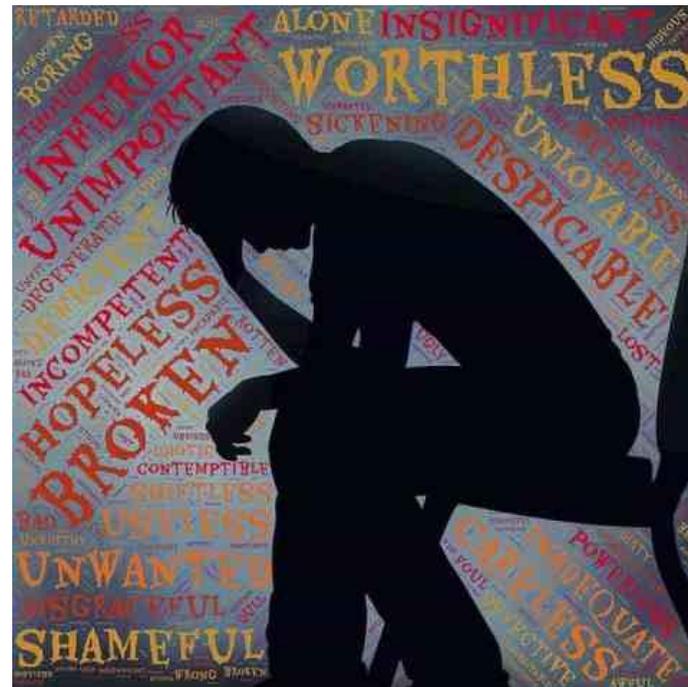
Warning Signs: Helplessness and Hopelessness



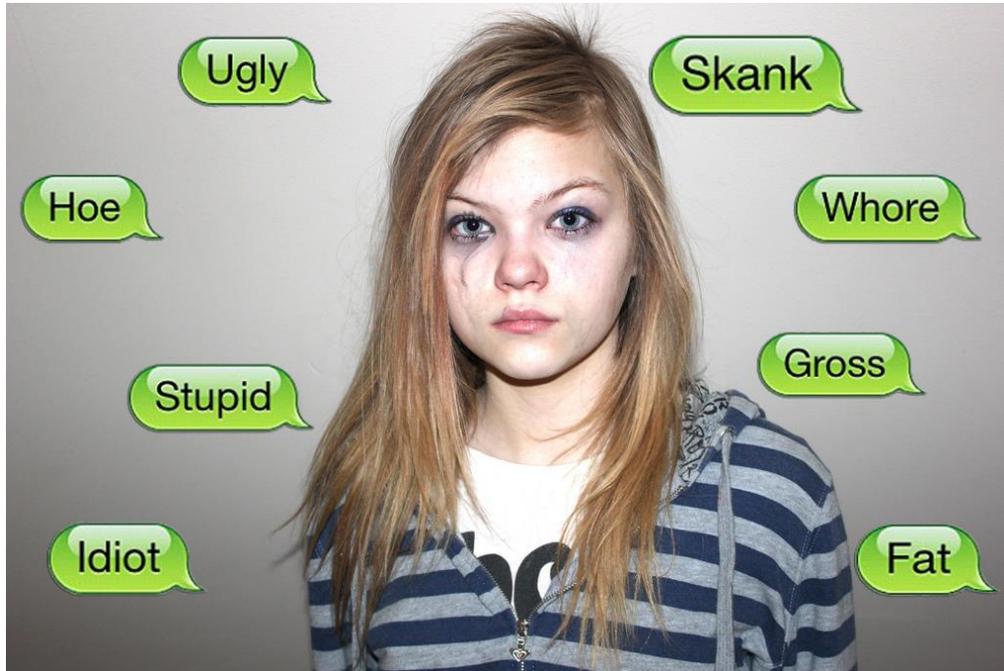
- “It will never get better.”
- “Nothing I do matters.”

Other Warning Signs:

- Displaying severe overwhelming emotional pain or distress
- Significant changes in mood (includes increased irritability)
- Significant changes in habits/behavior (sleeping too much or not sleeping enough)
- Withdrawal or isolating
- Not enjoying activities (i.e. going through motions)
- Increased substance use



Other Warning Signs Continued



- Watch for when there is an anticipated or actual painful event, loss, or change
- Teens experiencing prolonged stress (i.e. bullying)
- LGBTQ+ Teens - face a lot of adversity and are at greater risk.

How to ask about thoughts of suicide

- *“Are you doing okay,”*
- *“Do you ever have thoughts about death and dying?”*
- *“Sometimes, people in your situation (describe the situation) can lose hope; I’m wondering if you may have lost hope, too?”*
- *“Have you ever had the thought that things would be better if you were dead?”*
- *“Have you thought of hurting yourself?”*
- *“Have you ever wished you were dead or never been born?”*
- *“Have you ever thought about killing yourself?”*

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

WHAT NOT TO SAY:

- Never ask leading questions such as “You’re not thinking of hurting or killing yourself, are you?” or “*I hope that you aren’t thinking about hurting yourself.*”
- Don’t dismiss self-harm or suicidal comments as “attention-seeking.”

Note: Use a nonjudgmental, non-condescending, matter-of-fact approach.

Non-Suicidal Self-Injury



- Be sure to also ask about history of non-suicidal self-injury (aka self-harm behavior).
- “Have you ever cut or hurt yourself or felt the urge to do so?”
- “Do any of your friends struggle with self-harm?”

If they deny having suicidal thoughts but you have reason to **suspect** they are having suicidal thoughts...

- If there is other evidence of suicidal thoughts, such as reports from family or friends that suggests they are having suicidal thoughts even though they deny it you can ask: *“You seem very upset to me, and I’m still concerned about you, are you sure that you haven’t been thinking about hurting yourself or thinking that everyone would be better off without you?”*
- If they still deny, you can then share the information that was disclosed by family or others that leads you to think they are having suicidal thoughts. *“I hear that you are saying you’re not having these thoughts but I am concerned because”*

My patient is having suicidal thoughts ... Now What?



Need to assess further

- Frequency, Duration, and Intensity of the thoughts
- History of Prior Attempts
- Do they have a plan
- Do they have access to means to carry out their plans
- Do they have intent to kill themselves

How to Ask about frequency, duration, and intensity of suicidal thoughts

- *“When did you begin having suicidal thoughts?”*
- *“Did any event (stressor) precipitate the suicidal thoughts?”*
- *“How often do you have thoughts of suicide? How long do they last? How strong are they?”*
- *“What is the worst they have ever been?”*
- *“What do you do when you have suicidal thoughts? Do you find that you have them more frequently or more intensely at different times of the day or of the week?”*

Questions to assess prior attempt:

- *“Have you ever tried to kill yourself or attempt suicide?”*
- *“Have things ever been so bad for you in the past that you thought about killing yourself or actually tried to hurt yourself or kill yourself?”*
- *“What did you do? When did you do it? Did you try more than once?”*
- *“Does anyone know about your suicide attempt(s)?” [If yes, are there any attempts that people don’t know about?]*
- *“Did you require medical care?”*

Assessing if they have a PLAN:

- Ask whether the patient has a plan and, if so, get the specifics.
- “Have you ever thought about acting on your thoughts? Have you ever tried to act on your thoughts?”
- *“Do you have a plan or have you been planning to kill yourself? If so, how would you do it? “Where would you do it?”*
- *“Do you have the (drugs, gun, rope) that you would use? Where is it right now?”*

Assessing Suicide Intent

- “Do you have any intention of killing yourself?”
- *“Have you thought about when you might do it?”*
- *“Is there something (an event) that would trigger you to do it?”*



Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Assessing Suicidal Intent

- *“What would it accomplish if you were to end your life?”*
- *“How confident are you that this plan would actually end your life?”*
- *“What have you done to begin to carry out the plan?”*
- *“How likely do you think you are to carry out your plan?”*
- *“What stops you from killing yourself?”*

Treatment Considerations ...

- High Safety Risk – have patient transported to closest emergency department for assessment
- Inform parents/guardians and develop plan for increased supervision. Create safety plan.
- Assess need for medication treatment or referral to psychiatrist.
- If patient is in therapy, contact and inform therapist. If not in therapy, consider referral for outpatient therapy.
- Plan frequent follow-ups with patient





In-Home Safety Checklist

Adult supervision at all times

Your child will need to be under supervision, by an adult, at all times. If your child goes to other households, a trusted adult needs to be present who is also aware of the safety plan. Spending time unsupervised at friends houses is not recommended at this time. This means your child can not be left alone and should not be responsible for watching/babysitting others at this time.

Remove all weapons from the home. This includes, but is not limited to, knives, guns and ammunition.

If this is not possible, lock up these items in a secure location that your child does not have access to. Lock and store ammunition in a different location than the gun, to reduce risk of gaining access to both.

Bedroom/House Search

Search the house and your child's room for any objects that could be used to self-harm. This includes but is not limited to, razors, pencil sharpeners, scissors, make-up sharpeners, belts, ropes, cords, etc. Remove access/lock up these items to reduce risk of self-harm.

Lock up and/or remove all prescriptions and over the counter medications

Lock up these items in a secure location or in a lock box. Items include, but not limited to: Tylenol, aspirin, vitamins, supplements, antacids, allergy medications and all prescription medications

Remove/limit access to all chemicals in the home

Your child should not have access to chemicals including, but not limited to, alcohol, cleaning supplies, and tools/power tools. Keep in mind that these items must not be accessible to your child at all. It is possible that all these items may have to be removed from your home as "out of reach" is not limiting/removing access from your child.

Beware of items in the home that could limit airflow. Item include, but not limited to, plastic bags, balloons, belts, cords of any kind, scarves, ropes, bed sheets, etc.

While it is not realistic to remove all these items from the home, it is important to be aware of these items and what your child is doing with these items, or using these items for. These items (belts, scarves, plastic bags, balloons, cords from vacuums etc.) should not be used without the supervision of a trusted adult.

If your child drives, take away your child's keys, and do not allow access to driving a vehicle

Your child should not have access to a car and driving, until deemed safe to resume driving by their outpatient mental health provider

Resources:

You can purchase lock boxes at our Riley Hospital Safety Store, located in the Outpatient Center. You can also buy lock boxes/safety boxes at any local hardware store/retail store, or online.

Safety Plan Considerations

Reducing Access to MEANS

- Work with family members or guardians to restrict access to means of any kind, including access to firearms, potentially lethal prescription and over the counter (OTC) medications, alcohol, and even rope.



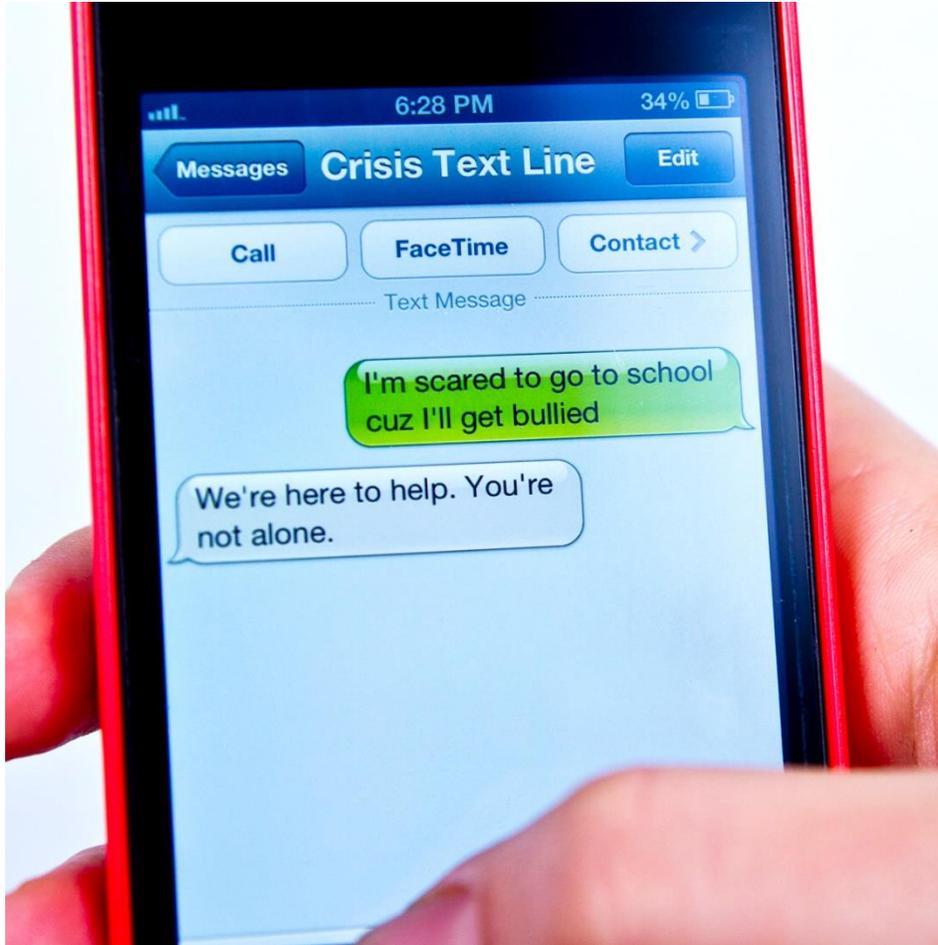
Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Reducing Access to MEANS

- Frequently adolescents and children know where the gun cabinet is and where the keys are kept when parents think they don't.
- Hiding items around the house Does not work !!!
- All medications should be in a locked box.
- Also, children and adolescents should not be managing their own medications and pill bottles. ASK ABOUT THIS during primary care visit.

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Provide Resources



Many teens will prefer to use texting rather than a traditional suicide hotline.

- ***Crisis Text Line***: Text IN to 741741 [Crisis Text Line is a free, 24/7, confidential text message service for people in crisis].
- **National Suicide Prevention Lifeline** at **1-800-273-TALK (8255)**. [Has an online CHAT feature]

Avoid No-Suicide Contracts / Promises

- “No-suicide contracts” have been found to be ineffective in preventing suicidal behavior and are often done solely to alleviate anxiety on the part of the provider.
- It is more effective to make a plan with your suicidal patients concerning what they will do in the event that they feel suicidal and are worried about their safety, rather than what they won't do.

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Document, Document, Document ...

- Thoroughly document suicide risk assessment (and rationale), management plan, actions that occurred (e.g., met with family) and any consultation (e.g., with psychiatrist).



Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

Follow-up Plans



- Close follow-up with a potentially suicidal patient is critical.
- Identify who will follow-up with patients who have expressed suicidal ideation and how follow-up will occur (e.g., office visit, phone call).

Source: Suicide Prevention Primer – SPRC WICHE Mental Health Program available at <http://www.sprc.org/settings/primary-care/toolkit?sid=508>

What Not to Do

- ***The absolute worse thing you can do is to NOT ask or assess about suicide.***
- Some providers are afraid to ask because it makes them uncomfortable and they don't know what to do if the answer is yes.
- Having a plan and clinic procedures in place will help increase physician comfort level

Any Questions or Comments????



Contact Information



Melissa A. Butler, Ph.D., HSP

Indiana University School of Medicine,
Department of Psychiatry

Email: mertl@iupui.edu