Suicide Prevention: Standard Operating Procedures for the Primary Care Office

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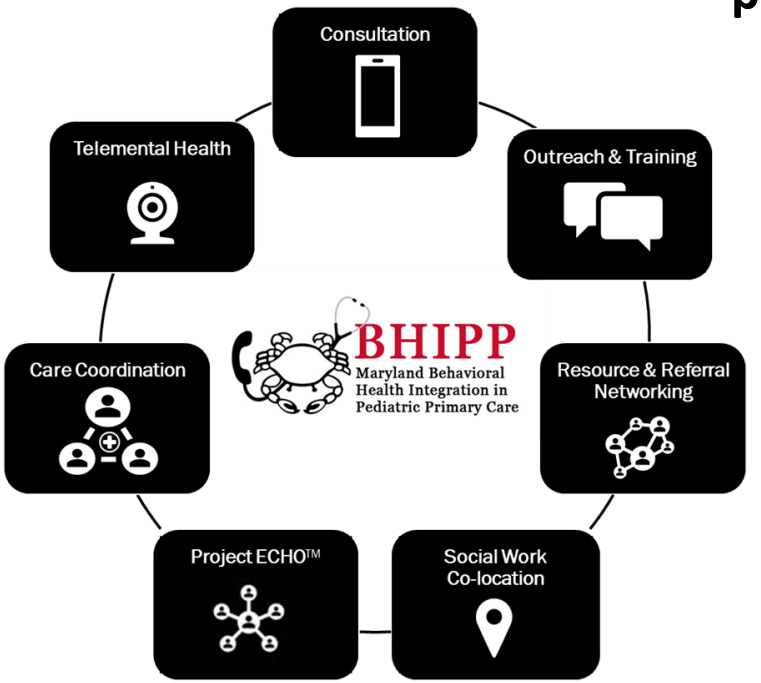
Who We Are – Maryland BHIPP



Offering support to pediatric primary care providers through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®
- Direct telemental health services:
  - Care coordination
  - Psychiatry
  - Psychology
  - Counseling

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Partners & Funding

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Disclosures

- None

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Learning Objectives

1) Describe the rationale for screening for suicide in pediatric care settings

2) Select appropriate screening tools for evaluating suicidal ideation in pediatric primary care

3) Create standard operating procedures for suicide prevention in a pediatric care setting

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Suicide in the United States

- Over 48,000 Americans die by suicide each year (CDC, 2021)
- 11th leading cause of death (CDC, 2021)
- Suicide surpassed motor vehicle accidents as leading cause of injury-related death (Rockett, 2012)
- Provisional data from CDC's National Center for Health Statistics indicate that both the number and the rate of suicides in the United States increased 4% from 2020 to 2021, after two consecutive years of decline in 2019 and 2020.
  - The largest increase in the rate of suicide occurred among males ages 15-24 – an 8% increase (CDC, Press release: September 30, 2022)

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Youth Suicide in the U.S.

- Serious public health threat
- **2nd leading cause of death for** youth ages 10-14 years
- **3rd leading cause of death** for ages 15-24
- 6,642 suicide deaths among U.S. youth in 2020

CDC WISQARS, 2020

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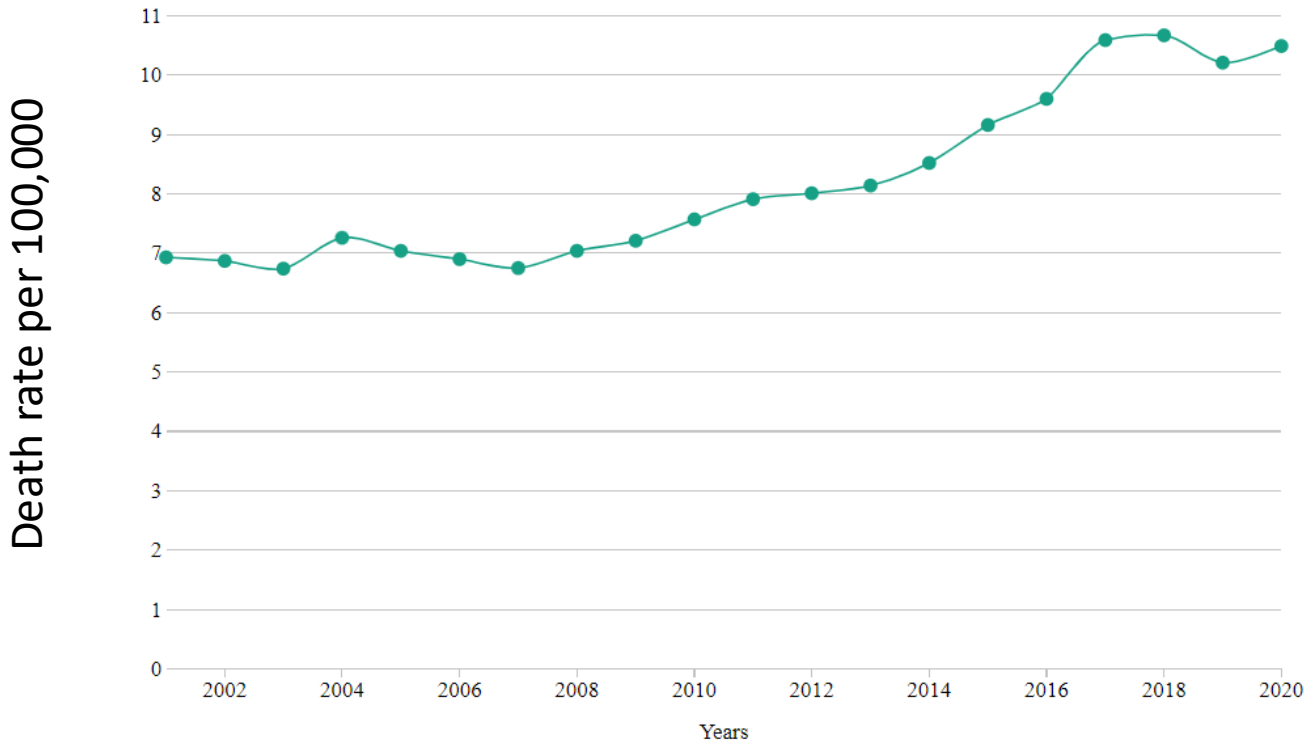
Youth Suicide in the US, trends over time



Crude rate
Ages 10-24

CDC WISQARS, 2020

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Younger Children and Suicidality

- Children under 12 yrs plan, attempt and die from suicide
  - 2nd leading cause of death for 12-year-olds
  - 6th leading cause of death for children 12 and under

- 2016 (underestimates)
  - 5-14 yr olds
    - 443 deaths
    - 121 were 12 and under

CDC 2012; Tishler, Reiss, & Rhodes, 2007; Natl Vital Stat Rep, 2006; CDC WISQARS, 2020

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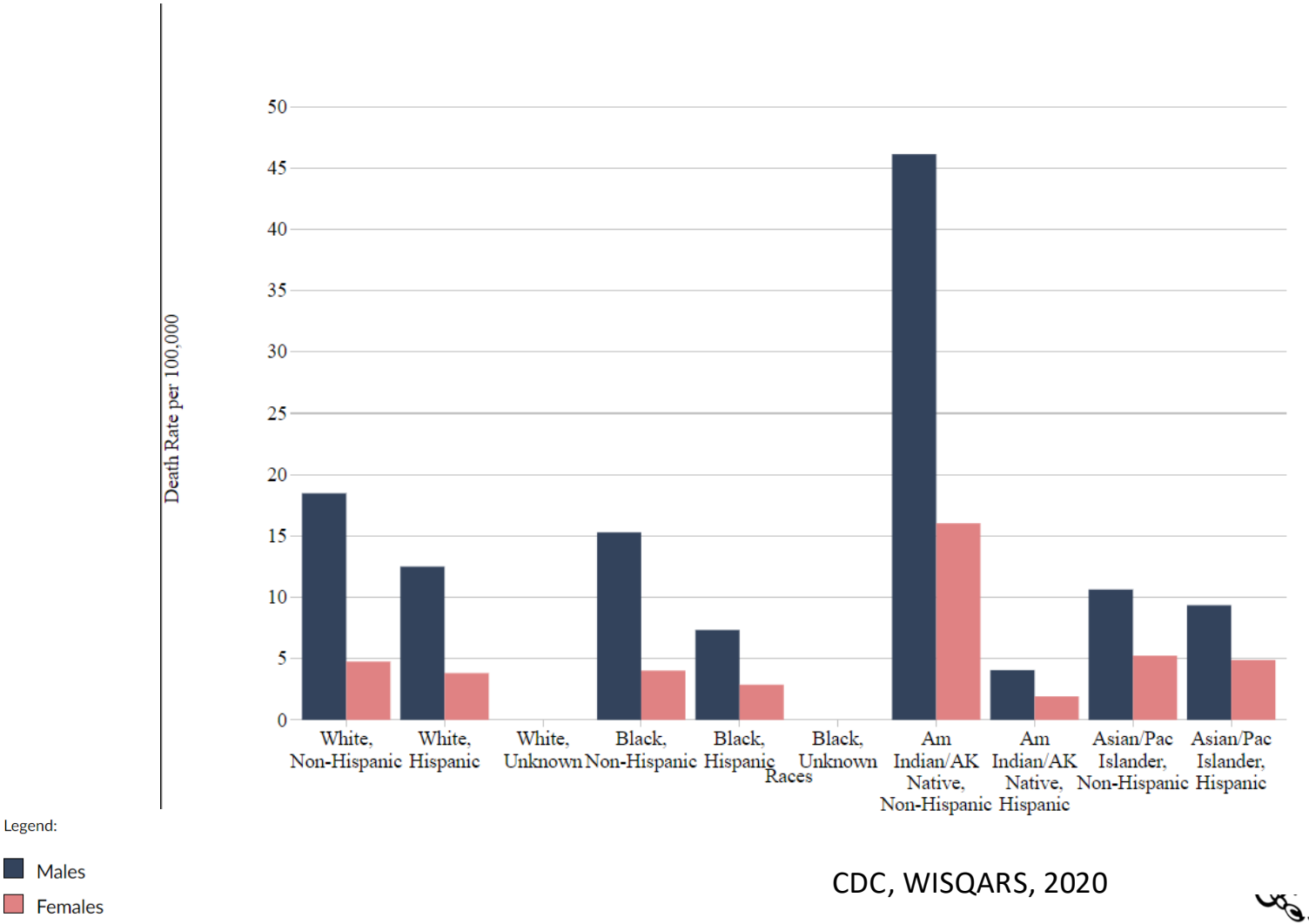
CDC: Suicide Rates, Ages 10–24 Years, by Race/Ethnicity and Sex, United States, 2020



CDC, WISQARS, 2020

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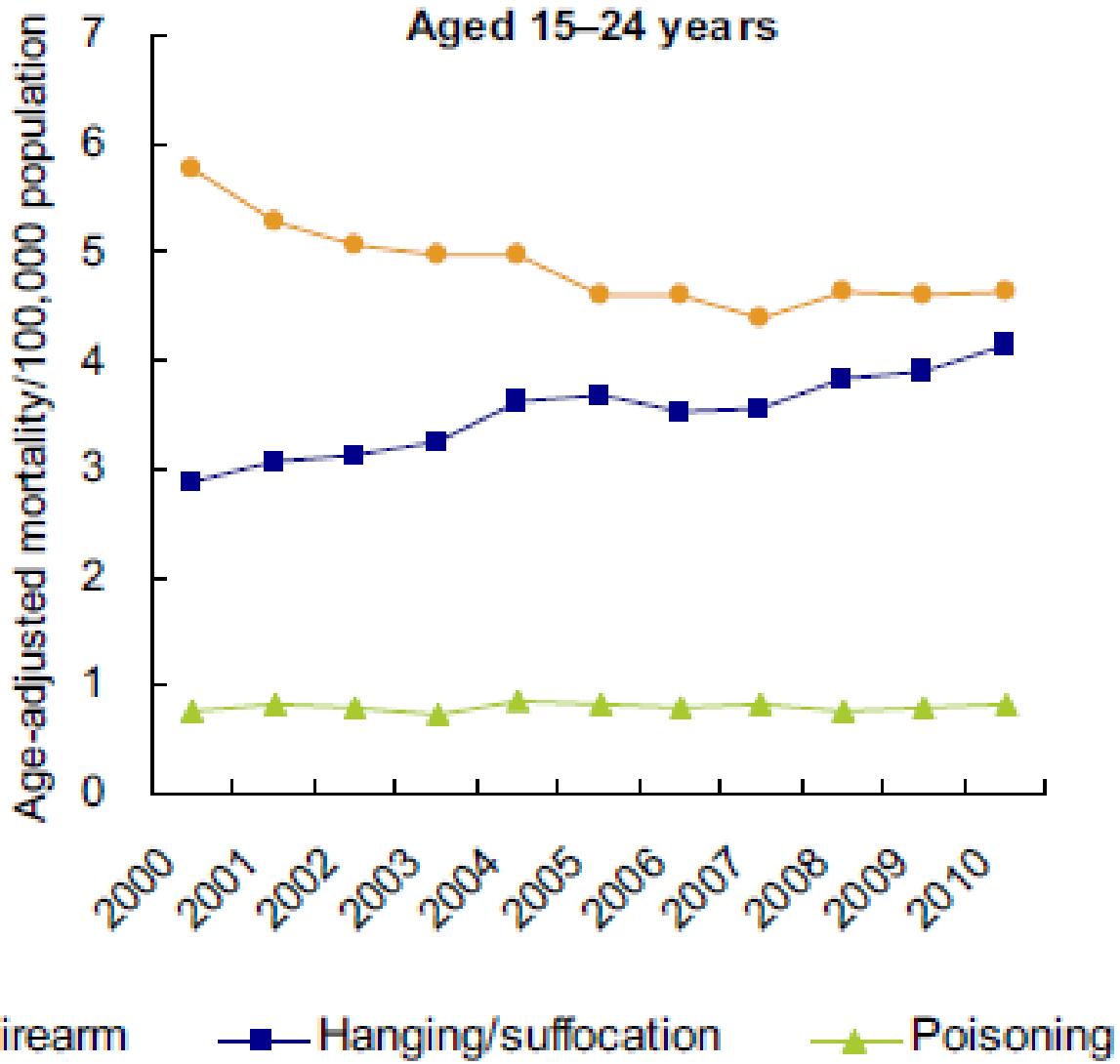
Increase in Hanging/Suffocation in the US, 2000-2010, Baker et al., 2013



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Suicidal Behavior

- **~2 million young people** attempt suicide annually
  - 8.5% of high school students made an attempt
    - Prevalence range: (5.5-14.3)
  - 3% made an attempt resulting in medical treatment
    - Prevalence range: (1.4 – 5.6)

- ED visits for attempted suicide in children <14 is same as adults >50

SAMHSA, 2012; CDC, 2014

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Suicidal Ideation

- **Youth**

  In 2013:

  - 2.5 million (17%) high school students reported "seriously considered suicide" in the past 12 months
    - Prevalence range: (12.0% – 19.2%)
  - 2 million (13.6%) high school students made a plan
    - Prevalence range: (9.8% – 17.4%)

- 12% of children ages 6 to 12 have suicidal thoughts

CDC, 2013, 2014; SAMHSA, 2012

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Suicide Prevention: Key Elements of Office SOPs

- **Screen**
- Assess risk level
- Safety plan

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Why screen in primary care?

- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves
  - 80% of adolescents contact within 3 months
  - 50% of youth had been to ED within 1 year
  - Frequently present with somatic complaints
- For those at risk for suicide, a visit with their PCP may be the best opportunity to access intervention.

- Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877.
- Suicide Prevention Resource Center

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Who should we screen for suicide risk?

- Several studies have refuted myths about iatrogenic risk of asking youth questions about suicide, such as the worry about "putting ideas into their heads." (Suicide Risk Screening Toolkit, NIMH)

- Universal screening for adolescents ages 12+ is recommended by:
  - USPSTF
  - American Academy of Pediatrics
  - American Academy of Child and Adolescent Psychiatry
  - American Foundation for Suicide Prevention
  - The Guidelines for Adolescent Depression in Primary Care (GLAD-PC)

- Indicated screening for 8-11 yo (NIMH, Blueprint for Youth Suicide Prevention)
  - When there are other significant risk factors

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Risk Factors: Key Symptoms

- **Ideation** (Threatening to hurt or kill self)
- **Substance Abuse** (Increased or excessive substance use)
- **Purposelessness** (No reason for living)
- **Anxiety** (Anxiety, agitation, unable to sleep)
- **Trapped** (Feeling trapped - like there's no way out;)
- **Hopelessness** (Hopelessness about the future)

- **Withdrawal** (Withdrawing from friends, family and society)
- **Anger** (Rage, uncontrolled anger, seeking revenge)
- **Recklessness** (Acting reckless or engaging in risky activities)
- **Mood Changes** (Dramatic mood changes)

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American Association of Suicidology

PHQ-A

- Ages 11-17
- Self-report, past two weeks
- Modified version of Patient Health Questionnaire-9
- Nine item adult depression screening and severity measure, closely related to DSM-IV criteria , (Kroenke, 2001)
- Item 9: “Thoughts that you would be better off dead or of hurting yourself in some way.”

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PHQ-9 Modified for Adolescents (PHQ-A)

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.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. 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?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

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:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

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Scoring the PHQ-A

Interpreting the scores:

	Total score	Recommended Next Steps
None or Minimal depressive symptoms	0-4	• PCP reviews with patient • Confirms negatives • Option to discuss additional issues • Considers other diagnosis (ADHD, etc) and treats accordingly, if applicable
Mild to Moderate depressive symptoms	5-14	• Watchful waiting • Supportive counseling • Educate member to call if symptoms deteriorate • Repeat PHQ-A at PCP follow-up • Consider referral if PHQ-A scores fall in high risk areas
Moderate to severe depressive symptoms	15-19	• Consider anti-depressant medication management through PCP (w/ consultation if needed) • Consider referral/linkage to community-based organizations, school-based counseling, etc • Consider referral to psychiatrist for medication and/or to therapist for therapy services
Severe depressive symptoms	20-27	• Immediate referral to **CalOptima Behavioral Health Line** at **1-855-877-3885**

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Risks outside of Depression

Table 1. Risk Factors for Suicide.

Risk Factor	Strength of Association with Suicide	Quality of Evidence*
Precipitating factors		
Drug and alcohol misuse[12]	Strong	High
Access to lethal means[15]	Moderate	High
Life events[16]	Moderate	High
New diagnosis of terminal or chronic physical illness[17]	Moderate	Moderate
Media effects[18]	Weak	Moderate
Predisposing factors		
Neuropsychiatric disorders[12]	Strong	High
Family history of suicidal behavior[19]	Strong	High
Previous suicide attempt[20]	Moderate	High
Adverse childhood experiences[21]	Moderate	Moderate
Socioeconomic deprivation[22]	Weak	Low

* Low quality indicates reported associations alone, moderate quality indicates reported associations that have been replicated in different settings, and high quality indicates associations that are supported by evidence from quasi-experimental studies or clinical trials.

Fazel & Runeson, 2020, NEJM

- Other psychiatric conditions at greater risk:
  - Substance use disorders
  - Schizophrenia & psychotic disorders
  - OCD
  - PTSD & trauma disorders
  - Anxiety disorders

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Suicide Prevention: Key Elements of Office SOPs

- Screen
- **Assess risk level**
- Safety plan

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The Big Question

- Do the patient and their parent/guardian(s) feel that they can keep from seriously harming themselves with appropriate supervision and do the parents/caregivers feel that they can provide adequate supervision to keep their child safe?
  - If yes – proceed to safety planning
    - After safety planning, reconsider the above question to ensure that all parties feel the safety plan can be realistically followed
  - If no – further evaluation is needed immediately
    - Consider ED (or alternate setting) referral

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Columbia Suicide Severity Rating Scale (C-SSRS)

- Provides framework for asking questions to help determine risk
- Addresses full spectrum of suicidality in one instrument
- Tracks frequency and severity of suicidal thoughts and behaviors over time (*both rated on a 0-5*)
- Classifies types of ideation and behavior
- Ideation: From "No ideation" to "Active Suicidal Ideation with Specific Plan and Intent"
  - frequency, duration, controllability, deterrents, and reasons for ideation, likelihood of attempt
- Behavior: From "Absence of Suicidal Behavior" to "Multiple Attempts"

Dr. Kelly Posner

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More on C-SSRS

- Severity of Ideation Subscale
  - A positive answer to question 4 or 5 indicated presence of ideation with at least some intent to die in the past one month
    - Indicates severe risk and clear need for further evaluation and clinical management
- Suicidal Behavior Subscale
  - Presence of ANY suicidal behavior in past three months indicates a severe risk and clear need for further evaluation and clinical management
- Full C-SSRS with additional sections available
- "Since last contact" version available
- Additional training available through website http://www.cssrs.columbia.edu/

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Columbia Suicide Severity Rating Scale (C-SSRS)

	In the Past Month	
Answer 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 actually had any thoughts about killing yourself?		
If YES to 2, answer questions 3, 4, 5 and 6 If NO to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on 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?		
Always Ask Question 6	In the Past 3 Months	
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.
If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for care.

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

DON'T LEAVE THE PERSON ALONE.

STAY ENGAGED UNTIL YOU MAKE A WARM HAND OFF TO SOMEONE WHO CAN HELP.

The Columbia LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

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Suicide Prevention: Key Elements of Office SOPs

- Screen
- Assess risk level
- **Safety plan**

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Safety Planning

- **Not** a no-suicide contract
- Developed in a collaborative manner with child/teen
- Step-wise increase in level of intervention from "within self" strategies up to ED
- Hierarchically-arranged coping strategy list
- Can be used as a stand-alone intervention or part of longer, more comprehensive treatment
- Written document
  - Brief, easy-to-read format

Greg Brown & Barbara Stanley

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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

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SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name _____ Phone _____
   Clinician Pager or Emergency Contact # _____
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. _____

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Safety Planning: Making the Environment Safe

Counseling on Access to Lethal Means (CALM)

- Involve family
- May be temporary
- Examples:
  - Firearms
    - Ideally remove from home, lock up
  - Medications
    - Limit quantity, remove unneeded, consider less lethal alternatives, lock and parents administer
  - Alcohol
    - Ideally remove from home, lock up

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Safety Planning: Additional Considerations for Youth

- Plan for increased level of supervision at home
  - Limiting time left alone, increased time spent with family, social media monitoring, etc.
  - Parents should make this explicit
- Devise a “check-in system” for parents and kids
  - There should be limits on both ends
    - Supportive concern =/= nagging
    - The goal is to assess safety and not (primarily) to manage parent anxiety
  - Fine to adopt means of checking in beyond explicit verbal statements as long as it’s predetermined
    - Can use codes (“red zone”) or a chart if needed

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Comprehensive Approach to Suicide Prevention in Primary Care Office (SPRC)

- Establish clear, written standardized protocols for managing when a patient presents with active suicidal ideation
- Train all staff (this includes front desk, medical assistants, etc.) in the established standard protocols
- Implement a “dry run” with a mock patient to ensure that the protocol can be followed seamlessly
- Consider having all staff participate in an evidence-based suicide prevention training
  - Many available for free through your local health department
- Create referral relationships with behavioral health practices that will take on pediatric patients with suicidal ideation
- Keep paper and/or electronic copies of screening/assessment tools handy
- Maintain up-to-date list of crisis resources
  - 988
  - Local crisis services including mobile crisis teams and walk-in clinics
  - Emergency departments

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Considerations when drafting your SOPs

- Who
  - Who on your staff will call mobile crisis/911 if necessary?
  - Who on your staff will be responsible for the patient until they leave the office?
    - It is helpful if one member of the team who knows the patient and family can stay with them until they leave the office.
    - Ensure all staff understand that a patient with active suicidal ideation should not be left alone
    - Other patients may need to be rescheduled
  - Does anyone else need to be contacted?
    - Example: Medical Director
    - Parents/guardians of patient
      - Ensure you keep up to date emergency contact information on all patients.
- What
  - What will the parent/guardian say when they arrive at the hospital?
    - Provide them with a print-out of your most recent encounter to take with them to the hospital.
      - Ideally this will detail your assessment and include a copy of any screening tools/assessments.
      - Have parents sign a release so you can speak to hospital staff before they leave.
  - What will happen after the patient leaves the office?
    - Example: Will the patient's provider call the hospital to ensure they arrived?

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Considerations when drafting your SOPs cont.

- When
  - When can parents expect a check-in call from the provider to check on the patient?
- Where
  - Keep an up-to-date list of local walk-in clinics and hospitals
  - Call ahead to alert them your patient is en route and establish contact if consultation is necessary
- How
  - How will the patient be transported to the hospital?

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If patient cannot stay safe

- If based upon your risk assessment you feel a higher level of care is necessary to keep the youth from attempting suicide:
- Share your determination with the family
- Determine where patient will go
  - Walk-in clinic
  - Emergency Department
- Determine how patient will be transported:
  - Can the parent/guardian transport them safely?
  - Is a mobile crisis team available to transport?
  - If no, call 911
    - Be aware that if you call 911 the youth may be transported in the back of a police car

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Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions ...

- _____ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
- _____ should be called/paged to assist with collaborative safety planning.
- Identify and call patient's support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization ...

- Our nearest Emergency Department or psychiatric emergency center is _____
- Phone # _____
- _____ will call _____ to arrange transport.
  (Name of individual or job title) (Means of transport [ambulance, police, etc.] and phone #)

Backup transportation plan: Call _____

- _____ will wait with patient for transport.

Documentation and follow-up ...

- _____ will call ED to provide patient information.
- _____ will document incident in _____
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms/instructions/chart-flagging materials are located _____
- _____ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- _____ will follow-up with patient within _____
  (Name of individual or job title) (Time frame)

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Documentation

- Screening/assessment results
- Risk level and rationale
- Treatment plan to address/reduce current risk
- Firearm instructions, if relevant
- Follow up plan
- For youth, treatment plan should include roles for parent/guardian

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Questions?

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Thank You!

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