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

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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.
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 than 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.
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

### Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns: 5 - 4 - 3 - 3 = TOTAL 12

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

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?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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*

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
<th>Lifetime</th>
<th>Past 3 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Have you been thinking about how you might do this?</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Have you had these thoughts and some intention of acting on them?</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES, ask: Was this within the past 3 months?</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
- Item 5 Behavioral Health Consultation and Patient Safety Precautions
- Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 6 3 months ago or less; Behavioral Health Consultation and Patient Safety Precautions
Columbia Suicide Severity Rating Scale

HARVARD PARTNERS HEALTHCARE/MASS GENERAL – C-SSRS WITH PROTECTIVE FACTORS

INSTRUCTIONS: This flow chart illustrates an approach to assessing the safety of an individual with suicidal thoughts. It is based on the screening version of the Columbia Suicide Severity Rating Scale (C-SSRS). Sources of information can include not only the patient but also other individuals. This scale can guide decision-making, though the clinician’s judgment should always take precedence (for example, if there is reason to think that a patient might be reluctant to report the full severity of suicidal thinking). The clinician should always keep in mind that suicide prediction is not an exact science and, if worried, seek consultation.

Risk Factors
- Can’t enjoy anything
- Anxiety and/or panic
- Insomnia
- Hopelessness or despair
- Homosexuality
- Psychotic disorder or command hallucinations
- Personality Disorder (e.g., borderline, narcissistic)
- Mood disorder
- PTSD or Up of abuse or trauma
- Suicide
- Substance use/abuse or withdrawal
- Impulsivity, aggression or antisocial behavior
- Ongoing medical illness (e.g., CHF, TB, CNS disease)
- Risk of suicide: recent or anticipated loss (relationship, financial, health, place to live) or event with despair, humiliation, or shame
- Lack of social support and/or increasing isolation
- Perceived burden on others
- Legal issues, incarceration
- Local suicide cluster or exposure to one via media
- Access to lethal means, e.g., firearms, prescription
- Recent inpatient discharge
- Non-compliant or not in treatment

Protective Factors
- Ability to cope with stress or frustration
- Sense of responsibility to others
- Social support
- Health
- Religious beliefs
- Positive therapeutic relationship
- Engaged in work or school
- Fear of death
- Cultural, spiritual or moral attitudes against suicide

Safety Assessment

WISH TO DIE: Over the past MONTH, have you wished you were dead or wished you could go to sleep and not wake up?

IDEATION: Over the past MONTH, have you had any thoughts of killing yourself?

METHOD: Have you been thinking about how you might do this?

INTENT: Have you had any intention of acting on these thoughts?

INTENT IN A SPECIFIC PLAN: If you have had intent, have you worked out or started to work out the details of how to kill yourself?

ANY INTENT

ACTUAL, INTERRUPTED OR ABORTED (SELF-INTERRUPTED) ATTEMPTS OR PREPARATORY BEHAVIOR: Have you ever done anything, started to do anything, or prepared to do anything to end your life? (e.g., 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.)

ANY INTENT

RETURN TO INITIAL ALGORITHM: Assess severity of depression. Or, if not depressed, proceed with comprehensive psychiatric assessment.

Urgent psychiatric assessment: Face-to-face by mental health professional before patient leaves clinic OR send to ER if not possible

Within last three months ago

Return to Initial Algorithm: Assess severity of depression. Or, if not depressed, proceed with comprehensive psychiatric assessment.

Continues with outpatient management

Within last three months ago

*NOTE: If patient has mental health issues, it can be very helpful to contact them to discuss the level of care needed and set up a follow-up plan.
Jessica’s C-SSRS

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Primary Care

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<tr>
<td>Ask questions that are in bold and underlined.</td>
<td>YES  NO</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>x</td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>x</td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) Have you been thinking about how you might do this?</td>
<td>x</td>
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<td>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.”</td>
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- Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
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.
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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<td>YES NO</td>
</tr>
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<td>X</td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>X</td>
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If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

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<th>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 or how I would actually do it...and I would never go through with it.”</th>
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<td></td>
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If YES, ask: Was this within the past 3 months?

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- Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 6.3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
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
References:

• Lisa M. Horowitz, Jeffrey A. Bridge, Maryland Pao, Edwin D. Boudreaux, Screening Youth for Suicide Risk in Medical Settings: Time to Ask Questions, American Journal of Preventive Medicine, Volume 47, Issue 3, Supplement 2, 2014, Pages S170-S175.

• Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice, Jane Meschan Foy, Kelly J. Kelleher, Danielle Laraque, for the American Academy of Pediatrics Task Force on Mental Health, Pediatrics Jun 2010, 125 (Supplement 3) S87-S108.


• Guy S. Diamond, Joanna L. Herres, E. Stephanie Krauthamer Ewing, Tita O. Atte, Syreeta W. Scott, Matt B. Wintersteen, Robert J. Gallop, Comprehensive Screening for Suicide Risk in Primary Care, American Journal of Preventive Medicine, Volume 53, Issue 1, 2017, Pages 48-54