Opening the Door: Approaching Suicidality in Primary Care

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Virginia Mental Health Access Program

Presenters have no financial disclosures

Objectives

- Learn the prevalence of suicidality.
- Define risk groups
- Recognize SI using screening tools
- Respond to SI using a safety plan
- Referral sources you can access: WHEN and TO WHO

We Recognize:

- Suicidality is a very scary topic
- We were NOT taught how to approach suicidality in our training
- Our **CONFIDENCE** in approaching suicidality is very low
- Addressing suicidality can be time consuming
- Become comfortable with the uncomfortable

The Pendulum of Care

Challenges

- TIME
- Education
- Discomfort

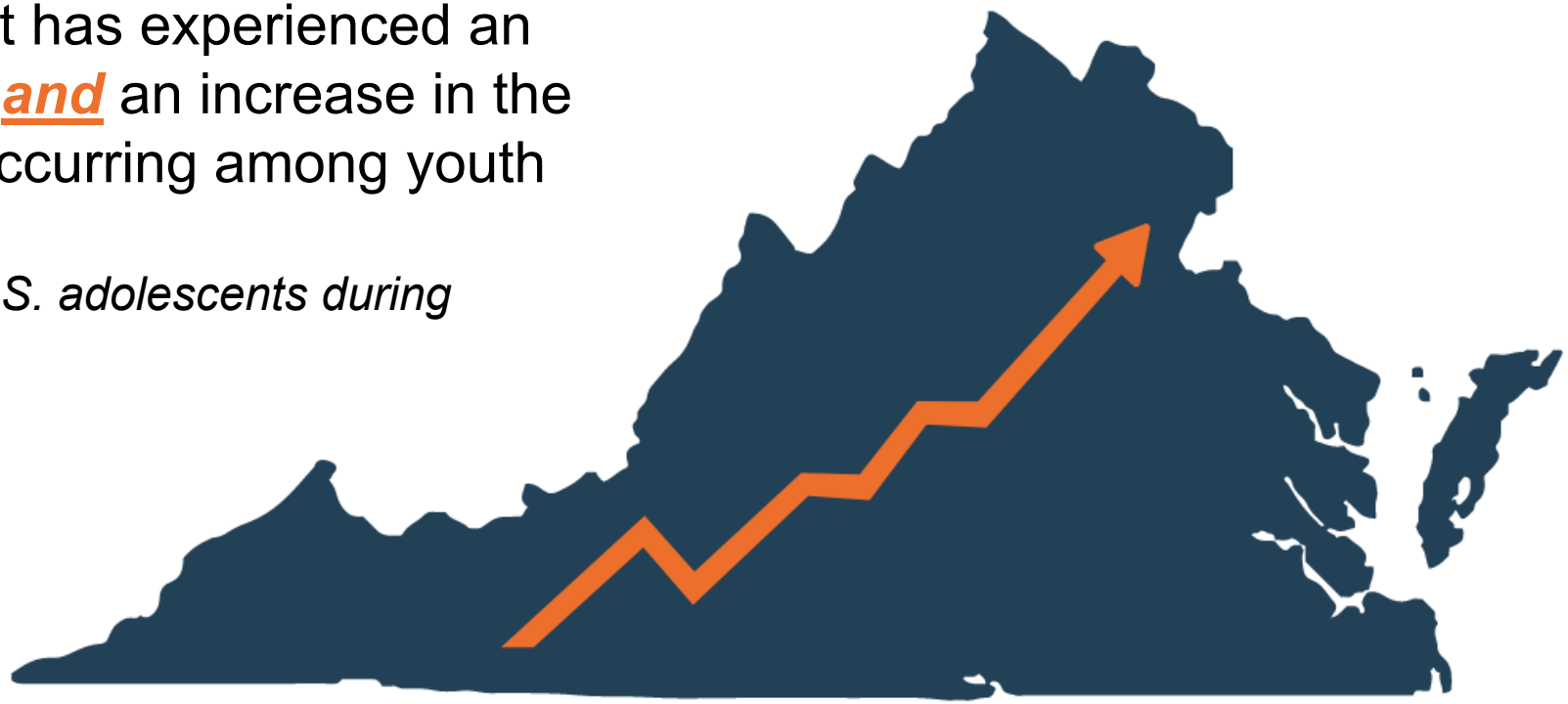
Strengths

- Familiarity with family
- Trust
- Knowledge of strengths and family challenges

Scope of the Problem in Virginia

- Suicide is the **2nd leading cause of death** for ages 10-24
  - (*National Institute of Mental Health, 2021)*

- Virginia is 1 of 5 states that has experienced an increase in youth suicides ***and*** an increase in the proportion of all suicides occurring among youth since the pandemic
  - (*Evaluation of suicides in U.S. adolescents during COVID, 2022)*



Scope of the Problem in Virginia

According to the *2022 Virginia School Survey of Climate and Working Conditions:*

- **40**% of Virginia high **schoolers felt sad or hopeless almost daily** for more than two weeks in a row
- **10%** of middle school and **13%** of high school students said that they had **seriously considered attempting suicide** in the past 12 months
- Of those, 56% said **they made a plan** for how they would attempt suicide

Scope of the Problem in Southwest Virginia

According to the 2024 EO report on Youth Mental Health in SWVA:

- There is approximately 1 mental health provider per more than 1,000 individuals.
- Almost 200 middle and high school students surveyed reported attempting suicide in 2024.
- 26.9% of deaths amongst 10-19 year olds were due to suicide.

What This Looks Like in Practice

- 2019 AAP Periodic Survey of Fellows indicate:
  - **92%** of pediatricians have had a patient disclose suicidal ideation
  - **80%** of pediatricians have had a patient attempt or die by suicide
  - **48%** of pediatricians have had a patient attempt or die by suicide in the past year
- **Suicide is complex but often preventable!**

Blueprint for Youth Suicide Prevention

American Academy of Pediatrics

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

American Foundation for Suicide Prevention

How Can We Address The Problem?

Audience Poll

- Are you currently using any mental health screening tool?
  - Yes
  - No

https://www.menti.com/al1meydygrdd

- Are you currently using any of the following screeners? Check all that apply:
  - Bright Futures
  - PSC 17
  - PHQ 9 / PHQ-A
  - GAD-7
  - SCARED
  - Vanderbilt
  - Other

https://www.menti.com/alzfbrq1hzz1

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  - Bright Futures
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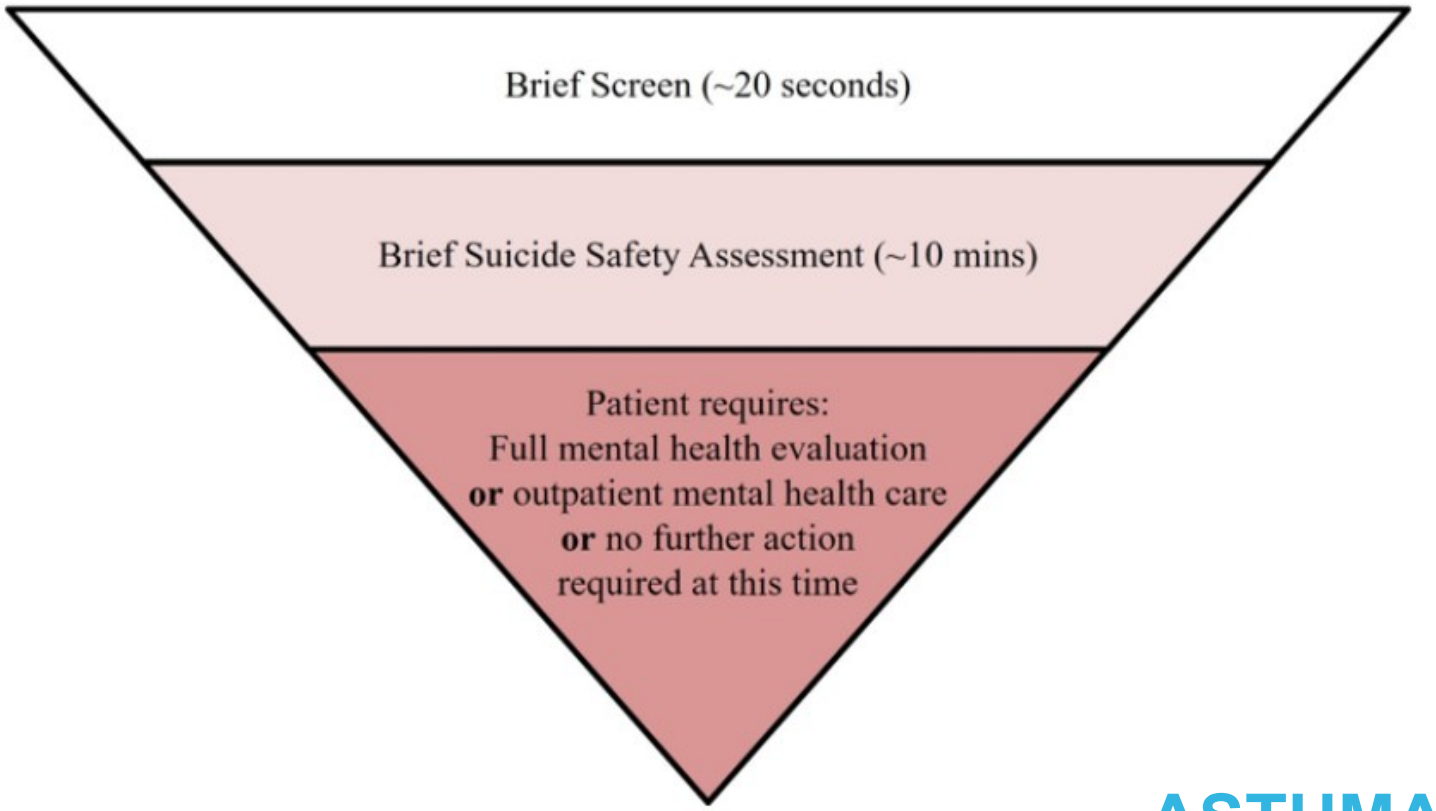
  - GAD-7
  - SCARED
  - Vanderbilt
  - Other

AAP Screening Recommendations for Suicidality

- Youth ages 12+: **Universal screening**
- Youth ages 8-11: Screen when clinically indicated
- Youth under age 8: Screening not indicated; assess for suicidal thoughts/behaviors if warning signs are present

"Blueprint for Youth Suicide Prevention" (2022), AAP and American Foundation for Suicide Prevention

The Difference Between Screening and Assessment



Source: NIMH ASQ Toolkit

ASTHMA ANALOGY

Screening Tools for Suicidality

PATIENT HEALTH QUESTIONNAIRE AND GENERAL ANXIETY DISORDER (PHQ-9 AND GAD-7)

Date: _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	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
Add the score for each column				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one) **Not difficult at all** **Somewhat difficult** **Very difficult** **Extremely difficult**

Ruth,14-Year-Old Comes in for Well Check

- You gave a PHQ-9 as a screen tool before you get into the exam room
- Her answers score a 14, and she answers “2" on question 9
- What do you do now?

Factors = Increased Suicide Risk

- Previous suicide attempts
- Family history of suicide
- LGBTQ+ identification
- Adverse childhood experiences/trauma
- Family/peer conflict

- Poor social supports
- Unwillingness to connect with help
- Substance use
- Access to lethal means
- Chronic medical illness
- Male gender

Factors = Decreased Suicide Risk

- Access to care
- Connection to others
  - family, friends, community
- Self regulation skills

- Relationship skills
- Cultural and religious beliefs for self preservation
- Supportive relationships with care givers
- Limited access to lethal means

Warning Signs
Youth May Be Considering Suicide

Talking about or making plans for suicide

Expressing hopelessness about the future

Showing worrisome behavioral cues or marked changes in behavior, especially:

- *Withdrawal from or changing social connections*
- *Changes in sleep (increased or decreased)*
- *Anger or hostility that seems out of character or out of context*
- *Recent increased agitation or irritability*

Displaying severe/overwhelming emotion pain or distress

Giving personal possessions away, or finding new homes for their pets

Stratifying Suicide Risk

Low

- Self harm, no SI, hopeful, social support

→ Therapy, active monitoring, validation, psychoeducation of family/parent

High

- Previous attempt, high intent and lethal plans, bleak future, hopelessness, agitated/impulsive states, regret for life
- NO SOCIAL SUPPORT

→ Safety planning, ER crisis planning, crisis lines, hospitalization

↑ Agitation, impulsivity, stressful life event, access, intoxication

PAL Conference 2016, Hilt

Ruth, our 14-Year-Old Well Check

- She denies any specific plans for killing herself
- She does say she often thinks about just not being here anymore
- How much better everyone else would be if she were gone
- She is not sleeping well
- She is still going to school, but grades are dropping

Ruth, our 14-Year-Old Well Check

Risk

- Quit volleyball
- Withdrawing from friends
- Not sleeping

Resilience

- Supportive family
- Strong faith
- Limited access to lethal means

Intervention

Safety Planning

- HOW??

Referral

- WHERE??

Recognizing Suicidality & Deciding on Referral

- Ask directly, using non-clinical language – use their terms after clarifying they mean suicide.
- **Use an open ended question based on the screener:**
  - "Tell me more about your answer on this questionnaire."
  - "What were you thinking about when you wanted to die?"
- **Start broad if you don't have a screener:**
  - "Ever wish that you weren't around?"
  - "Ever thought about killing yourself?"
- **Be specific, get details (Ideation, Method, Intent, Access):**
  - "In the past month, have you thought about killing yourself?"
  - "Have you made any plans for how you would kill yourself? What would you do?"
  - "What have you done to prepare to die?" "What has kept you from dying?"

- **Asking does not worsen the suicidal ideation or risk**

PAL Conference, Hilt; AAP

NIMH TOOLKIT

asQ: Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No

2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No

3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No

4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe:

Refer: Follow up Apt or Therapist Today?

- **Ideation, Plan and Intent** are all present
- = Refer to Same Day Crisis Assessment

✓ Confirm arrival to the facility

✓ Provide clinical information to assessing clinician

✓ Be prepared to insist on assessment

- **Ideation present without Intent or Plan**
- = Could Refer to Same Day Crisis Assessment **or** Could make Safety Plan and send home

✓ Create Safety Plan with Patient and Parent

✓ Make a follow up plan you're comfortable with ("return tomorrow or next week")

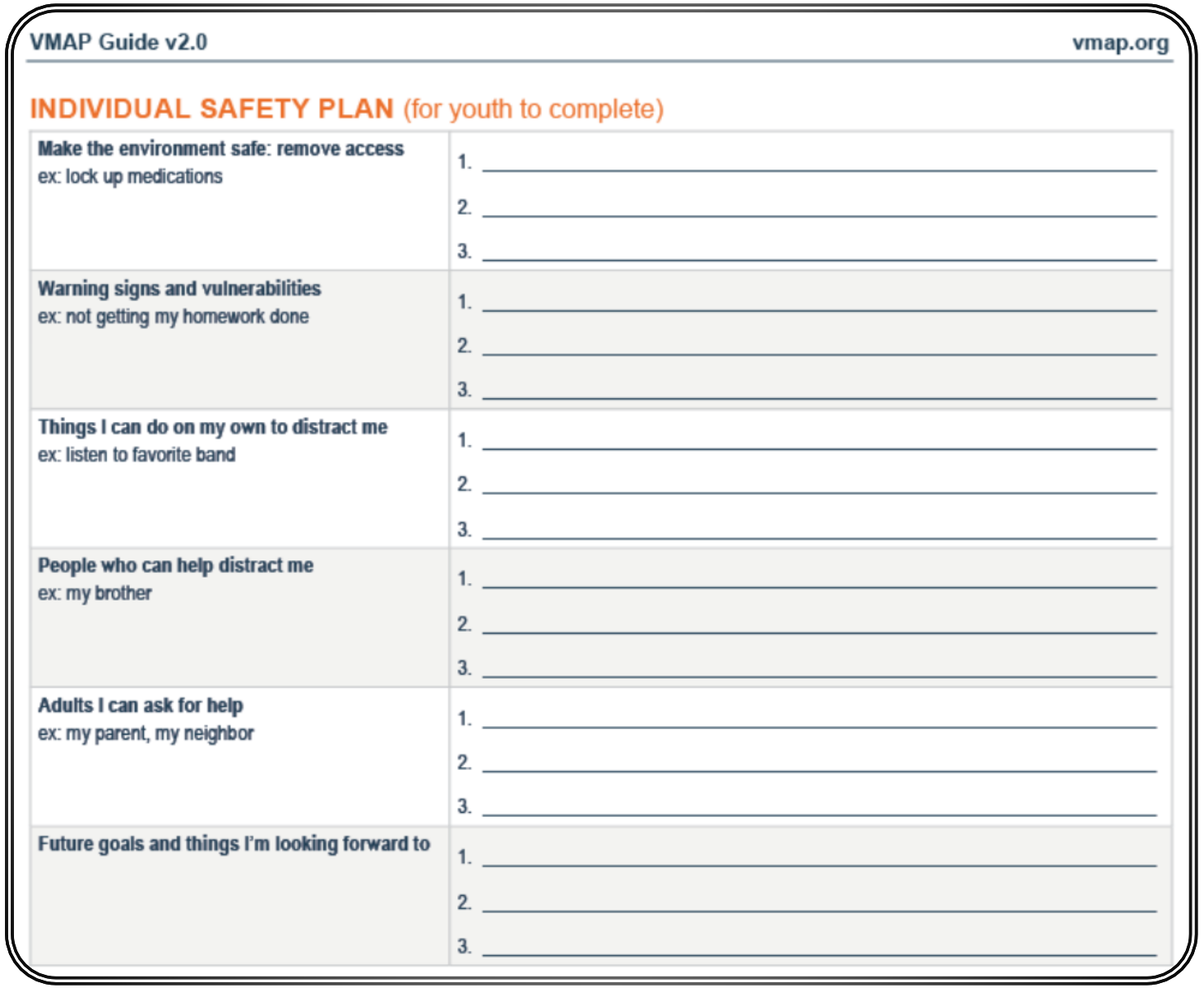
✓ Refer to outpatient mental health providers

Evidence-Based Interventions

- **Safety Planning for Suicidal Ideation**
  - **Metanalysis on Safety Planning with Youth,** Abbott-Smith, S., Ring, N., Dougall, N.,& Davey, J. (2023). Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people? – A systematic scoping review. *Journal of Psychiatric and Mental Health Nursing*, 30, 899–910. https://doi.org/10.1111/jpm.12928
- **Dialectical Behavior Therapy – Adolescent (DBT-A)**
  - Suicide attempts and suicidal ideation
  - Individual, family, and parent training sessions

Evidence-Based Interventions

- **Cognitive-Behavioral Therapy**
  - Suicide attempts (shows similar reductions to typical community care for suicidal ideation)
  - Individual, family, and parent training sessions
- **Interpersonal Therapy - Adolescent (IPT-A)**
  - Suicidal Ideation
  - Individual sessions
- **Research in Evidence-Based Interventions:** https://doi.org/10.1080/15374416.2019.1591281
  - Catherine R. Glenn, Erika C. Esposito, Andrew C. Porter & Devin J. Robinson (2019). Evidence Base Update of Psychosocial Treatments for Self-Injurious Thoughts and Behaviors in Youth, Journal of Clinical Child & Adolescent Psychology, 48:3, 357-392, DOI:10.1080/15374416.2019.1591281



VMAP Guide v2.0 vmap.org

INDIVIDUAL SAFETY PLAN (for youth to complete)

Make the environment safe: remove access ex: lock up medications	1. _____ 2. _____ 3. _____
Warning signs and vulnerabilities ex: not getting my homework done	1. _____ 2. _____ 3. _____
Things I can do on my own to distract me ex: listen to favorite band	1. _____ 2. _____ 3. _____
People who can help distract me ex: my brother	1. _____ 2. _____ 3. _____
Adults I can ask for help ex: my parent, my neighbor	1. _____ 2. _____ 3. _____
Future goals and things I'm looking forward to	1. _____ 2. _____ 3. _____

Safety Plan Demystified

- Access to means (firearms, substances, medications, sharp objects)
- Warning signs
- Coping strategies
- People who help
- Numbers to call

Step One: Safety Planning

Introduce your agenda <u>after</u> listening:

- “I care about you and how you’ve been feeling. I don’t want you to die. Let’s make a plan together to keep you safe when you have suicidal thoughts.”

Step Two: Safety Planning

Show them your plan:

- “This is a Safety Plan, where we write what you can do when you have thoughts about wanting to die. Here is where we can write the people who will support you.”

Step Three: Safety Planning

Complete it with them, using their words:

- Write down triggers for SI
- Ask what they are already doing that helps reduce SI, including eliciting unhealthy coping (self-injury, substance use, eating, social conflicts)
- Consider their unhealthy coping in a risk assessment: for example, alcohol use increases risk of attempts
- Write down and emphasize any healthy coping that they are doing (talking to someone, taking a shower, watching TV, exercising, listening to music, praying, playing video games)

Step Four: Safety Planning

Ask them if the coping plan is realistic for the situations where they had SI in the past (in school, at night etc.):

- Ask their caregiver if they can help the patient follow it
- Also consider their reaction to the patient's SI
- Review a Safe Homes handout with them and see if they can secure their home environment from means of attempting suicide (weapons, sharps, medications/supplements)

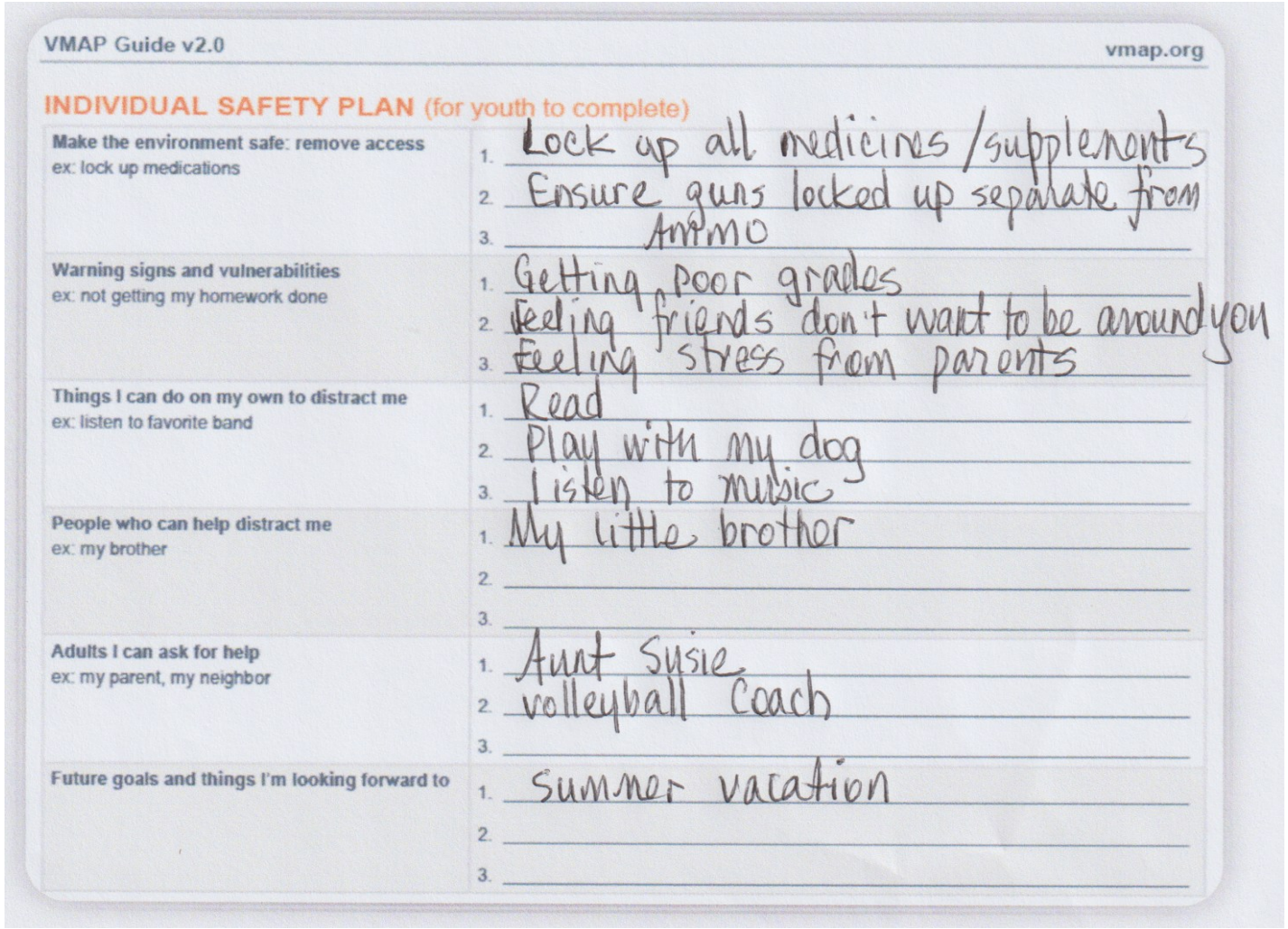
Step Five: Safety Planning

Review next steps:

- Referrals, medication interventions, follow up appointments
- Write down this part of the plan!
- Put copies of all written information in the patient's medical record
- **Note:** Making the plan may reveal that they need further evaluation/ assessment; be prepared to say that you're not feeling confident in this plan and want them to be assessed by a mental heath professional

Meet Ruth

Ruth's Completed Safety Plan



VMAP Guide v2.0 vmap.org

INDIVIDUAL SAFETY PLAN (for youth to complete)

Make the environment safe: remove access ex: lock up medications	1. Lock up all medicines / supplements 2. Ensure guns locked up separate from ammo 3.
Warning signs and vulnerabilities ex: not getting my homework done	1. Getting poor grades 2. Feeling friends don't want to be around you 3. Feeling stress from parents
Things I can do on my own to distract me ex: listen to favorite band	1. Read 2. Play with my dog 3. Listen to music
People who can help distract me ex: my brother	1. My little brother 2. 3.
Adults I can ask for help ex: my parent, my neighbor	1. Aunt Susie 2. volleyball Coach 3.
Future goals and things I'm looking forward to	1. Summer vacation 2. 3.

POLL: What Areas Would You Like Support to Increase Your Clinical Confidence?

Check all that apply.

- Verbal assessment of SI risk
- Addressing suicidality directly with individual
- Addressing suicidality with parent/family
- Safety planning
- Referral to community services
- Referral for emergency assessment

https://www.menti.com/alrip4irfmgr

Sandy's Story

Virginia Mental Health Access Program

Provider Education

Several education opportunities for primary care providers on screening, diagnosis, management, and treatment of pediatric mental health conditions.

- REACH PPP
- Pearls & Pitfalls
- ECHO
- Guidebook

The VMAP Line

Connects primary care providers to regional and/or specialist hubs that offer mental health consultation and care navigation for their patients 21 and under.

- **Specialized Physicians** (child psychiatrists and/or developmental pediatricians)
- **Licensed Mental Health Professionals** (psychologists and/or social workers)
- **Care Navigators**

Referral & Local Resources

Refer to Correct Levels of Care!

- **Outpatient Therapy –** For patient with no current suicidal ideation (SI), may have a history of SI in the past without plans, and need therapy for mood and/ or behavior. One to two times per week, one-hour sessions.
- **Intensive In-Home/Wrap-Around Services/Mobile Crisis Team –** For a patient with some safety concerns, low risk, self-injury, or SI without plan or intent.
- **PATH CSU (Positive Alternatives To Hospitalization) –** For a patient with moderate to high risk, SI with plan but no intent and can commit to safety. Operated by Mount Rogers Community Services. PATH provides an alternative to hospitalization for children experiencing a mental health crisis. PATH utilizes both residential and mobile services.
- **Inpatient Treatment –** For a patient with a plan and intent, any access to means, recent attempt, has high risk factors, isn't articulate or making contradictory statements, cannot make a safety plan, **or if parent isn't supportive and reliable.**

Referral & Local Resources

Recommend Emergency Assessment When Not Sure!

Send patient and caregiver directly to the Emergency Dept or CSB. Call police for assistance if patient is unwilling to go safely or parent isn't agreeing.

Community Service Board 24 Hour Emergency Numbers:

- Cumberland Mountain Community Services Board: 276-964-6702 (800-286-0586 after hours)
- Dickinson County Behavioral Health Services: 276-926-1680 (1650 after hours)
- Highlands Community Services: 800-500-7019
- Mount Rogers Community Services: 866-589-0265
- New River Valley Community Services: 540-961-8400
- Piedmont Community Services: 888-819-1331
- Planning District One (PD1) Behavioral Health Services: 877-928-9062

988 Suicide & Crisis Lifeline/ 988lifeline.org

Confidence

- Back to the Asthma Analogy
- What are your resources?
- Recognize > Respond > Refer
- How can you increase your confidence in severe depression and suicidality?
- What resources do you have? What do you need?
- Workshop
- Talk to your team
- Call the VMAP line
- Crisis Referral Resources
- Safety Plan and screeners printed out

Key Takeaway Points

- Suicidality is prevalent.
- Awareness of risk groups helps determine next steps of care.
- Use routine screening tools for SI.
- Safety plans can be developed in your office.
- You have access to a variety of local resources including VMAP!

VMAP Line: 888-371-8627

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