Adolescent & Young Adult Behavioral Health Collaborative Innovation & Improvement Network (AYA-BH CoIIN)

ADDRESSING ADOLESCENT & YOUNG ADULT DEPRESSION IN PRIMARY CARE

Addressing Self-Harm and Suicide Prevention

April 7, 2022

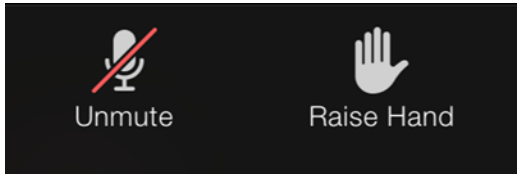
Charlotte McCorkel, LICSW

Adolescent & Young Adult Health National Resource Center

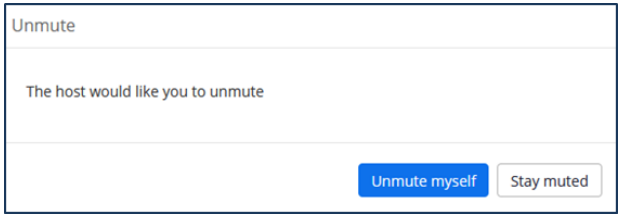
Notes on Technology

Mute/Unmute

Upon joining this webinar, you will automatically be put on mute. During the Q&A session, you will be able to unmute yourself by pressing the “unmute” button at the bottom of your left-hand screen.



NOTE: The “unmute” notification will give you the choice to unmute yourself or stay muted.



VoIP (computer only)

If using VoIP you MUST have a microphone to speak.

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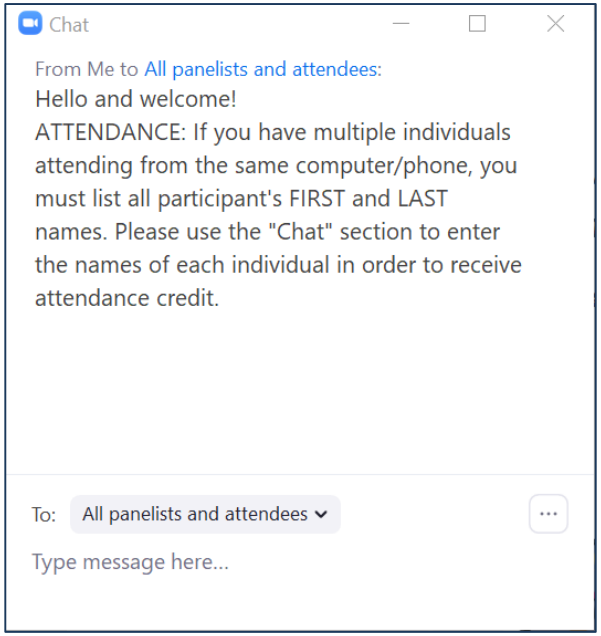
Attendance

- Type your name and state in the “Chat”
- If you are not registered for the QI collaborative, also include your affiliation in the “Chat”
- If you have multiple individuals attending from the same computer/phone, enter **all** participant names in the “Chat” section.
- If attending by phone only, please e-mail Christy Fay at Christina.Fay@med.uvm.edu



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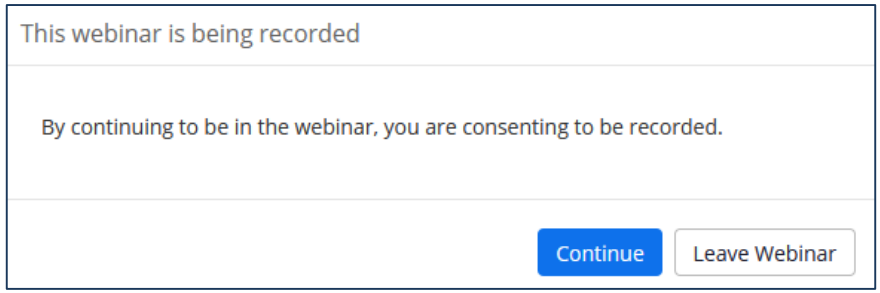
Recordings & Handouts



- Handouts and materials to today's learning session along with the link to the recording will be sent out via Listserv and posted on the AYA-BH CoIIN website: https://med.uvm.edu/nipn/aya-bh_coiin/c2home

NOTE: If you have missed a webinar and not yet viewed the recording, contact Christy Fay, Christina.Fay@med.uvm.edu to discuss your plan to catch up.

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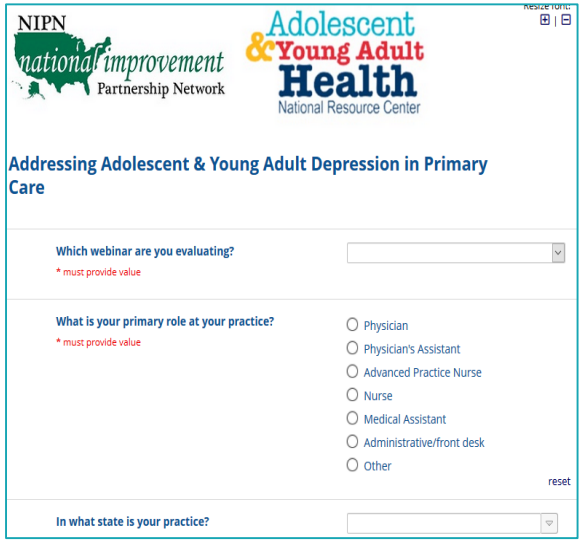
Evaluation

Provide feedback on the learning session via short 6 question survey at

https://go.uvm.edu/ayabhcoiinwebinareval



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Acknowledgements

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- **Grant Period:** September 1, 2018 – August 31, 2023 (5 years)
- **Project Officer:** Pamela Vodicka, MS, RD
- **Name:** Adolescent and Young Adult Health National Capacity Building Program (AYAH-NCBP)
- **Lead Organization:** National Adolescent Health Information Center (NAHIC), at the University of California at San Francisco (UCSF)
- More information at **nahic.ucsf.edu/resource-center/**
- The contents of this presentation are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

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Agenda

- **Peer Learning** – State-specific break out groups
- **Addressing Self-Harm and Suicide Prevention**– Charlotte McCorkel, LICSW

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Photo by AllGo - An App For Plus Size People on Unsplash

Through shared learning we can rapidly test and implement changes that lead to improvement.

PEER LEARNING

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Breakout group topic

Clinical PDSA Cycles: Lessons Learned

- What changes have you tested at your site?
- What have your learned through those tests?

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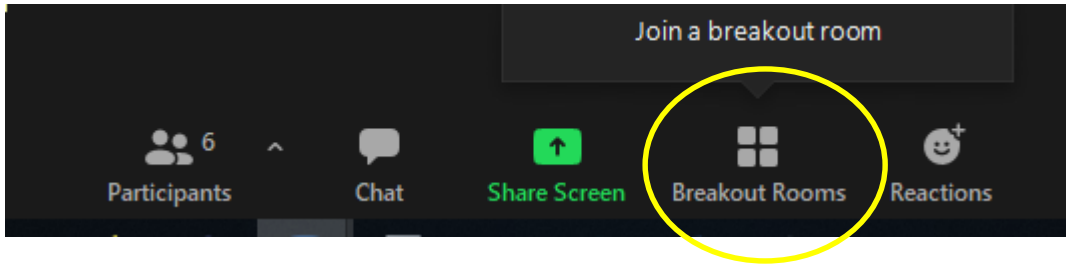
Process

- Select “Breakout Rooms”



- Select your state to join breakout

- Turn on video, use your voice

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Addressing Self-Harm and Suicide Prevention

Charlotte McCorkel, LICSW
Howard Center

With credit to Thomas Delaney, PhD
Vermont Child Health Improvement Program

Objectives

- Increase understanding of suicide and self-harm data and trends
- Increase awareness of screening and risk assessment
- Increase knowledge of risk management practices

Language

- Definitions – self harm; suicide
- Using preferred language reduces stigma
- Terms to use: took their own life; died by suicide
  Self-harming behavior, self-injurious behavior
- Terms to avoid: successful, committed, completed;
  Self-mutilation, attention-seeking

Theory – Self-Harm

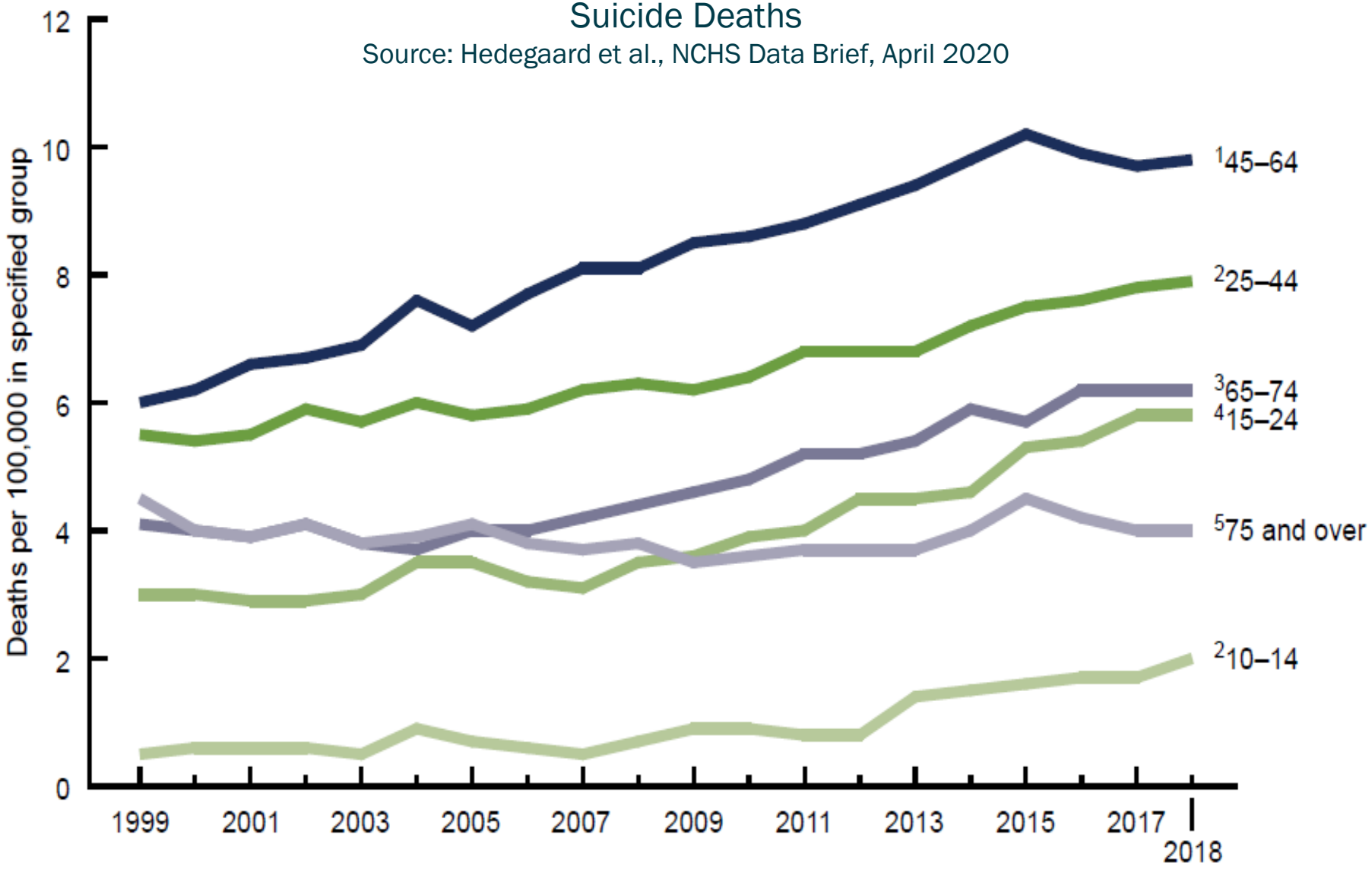
- Brain releases endorphins which decrease emotional distress
- Dramatic, visible, immediate results – it (temporarily works)
- Powerful communication, control
- Maladaptive coping/inadequate self-soothing
- Influence of peers, influence of media

Theory – Suicide

- Thomas Joiner – thwarted belonging, perceived burdensomeness, acquired ability to act violently
- David Jobes – psychological pain, stress, agitation, hopelessness, self-hate
- Schneidman – ambivalence about existence

Suicide Deaths

Source: Hedegaard et al., NCHS Data Brief, April 2020



[1]Significant increasing trend from 1999 to 2015; stable trend from 2015 through 2018, $p < 0.05$.
[2]Significant increasing trend from 1999 through 2018, with different rates of change over time, $p < 0.05$.
[3]Stable trend from 1999 to 2004; significant increasing trend from 2004 to 2016; stable trend from 2016 through 2018, $p < 0.05$.
[4]Stable trend from 1999 to 2007; significant increasing trend from 2007 through 2018, $p < 0.05$.
[5]Significant decreasing trend from 1999 to 2012; stable trend from 2012 through 2018, $p < 0.05$.

Overview of Suicide in Young People

Suicide is the **second leading cause of death** for young people aged 10-18 in the US. The data below reflect the method used in young peoples' suicide deaths, based on ICD-10.

Lethal means differences based on **sex**:

Firearms: **6.52**/100,000 males, **1.02**/100,000 females
Suffocation: **5.15**/100,000 males, **2.40**/100,000 females
Poisoning: **0.45**/100,000 males, **0.58**/100,000 females

Lethal means differences based on **age range** (12-15 versus 16-19):

Firearms: **1.98**/100,000 younger, **5.64**/100,000 older
Suffocation: **2.9**/100,000 younger, **4.69**/100,000 older
Poisoning: **0.25**/100,000 younger, **0.77**/100,000 older

Suicide and Self-harming Behaviors: LGBTQ+

YRBS item	% Heterosexual	% LGB
Seriously considered attempting suicide.	**14.5** (13.4 – 15.7)	**46.8** (43.1 – 50.6)
Made a suicide plan.	**12.1** (11.1 – 13.1)	**40.2** (36.6 – 44.0)
Attempted suicide.	**6.4** (5.6 – 7.4)	**23.4** (20.0 – 27.1)
Made a suicide attempt that required medical attention.	**1.7** (1.4 – 2.2)	**6.3** (4.8 – 8.3)

Ivey-Stephenson et al, 2019 YRBS data for ages 14-18, 2020

Suicide and Self-harming Behaviors: Screening Considerations

- Since there is limited evidence for the effectiveness of suicide specific screenings for adolescents, the United States Preventative Services Task Force recommends screening for depression for this age range.

- Depression screening is also a recommended part of well visits for ages 12-18 per Bright Futures. The Patient Health Questionnaire – Adolescent version is commonly used for this. **However, depression screenings may not be good indicators of suicide risk.**

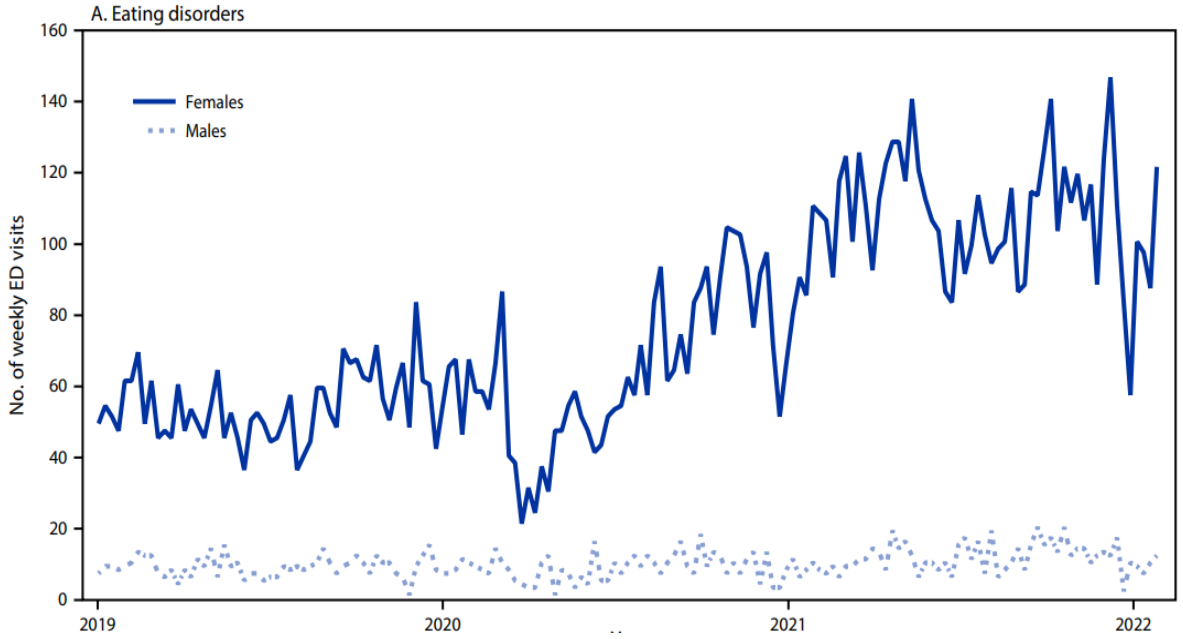
- Reasons to adopt a suicide-specific screening approach in primacy care include:
  - Most adolescents participating in health care visits
  - ~80% of youth who dies by suicide had contact with an outpatient health care provider in the year prior to death
  - Vast majority (>70%) of adolescents who died by suicide were not in mental health treatment at the time of their death

- Commonly used tools: Columbia-Suicide Severity Rating Scale (C-SSRS), Ask Suicide-Screening Questions (ASQ) and the Beck Depression Inventory (BDI)

Possible Impacts of COVID-19

Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022

Lakshmi Radhakrishnan, MPH[1]; Rebecca T. Leeb, PhD[2]; Rebecca H. Bitsko, PhD[2]; Kelly Carey, MPH[1]; Abigail Gates, MSPH[1];



Changes from Jan 19 to Jan 22:

Trauma and stress-related Symptoms

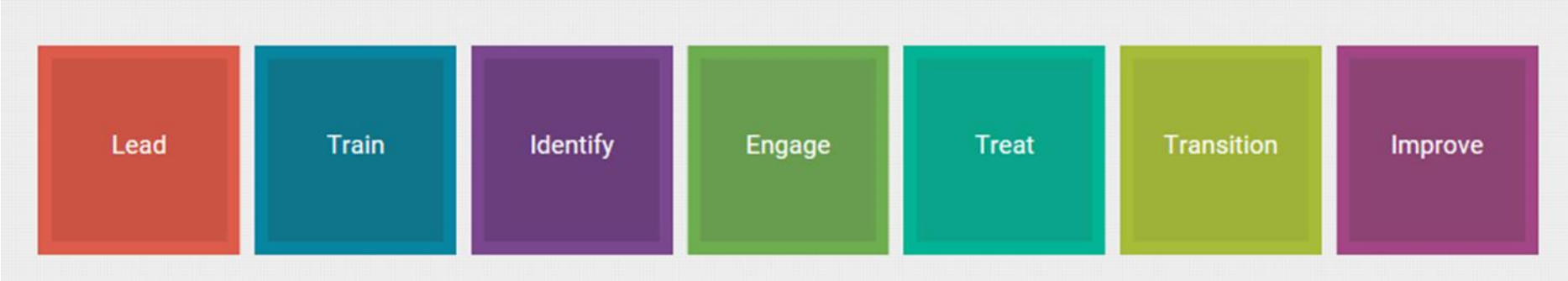
OCD and tic disorders

Anxiety

Eating disorders

Screening & Assessment: Zero Suicide Model

- Tools and framework
- Best care = outpatient plan with safety plan
- Hospitalization “is not the panacea for despair”
- Suicide care pathway



Suicide Care Pathway

- Screening
- Assessment and Risk Formulation
- Risk Management and Safety Planning
- Treatment
- Follow Up Care

Screening

Suicide Risk Screening group
Suicide Risk Screening on admission
PHQ-2 "How often during the past 2 weeks have you been bothered by:"
Little interest or pleasure in doing things?
Feeling down, depressed, or hopeless?
Columbia Suicide Severity Rating Scale
1. Have you ever wished you were dead or wished you could go to sleep and not wake up?
2. Have you actually had thoughts of killing yourself?
3.Have you been thinking about how you might kill yourself?
4. Suicidal Intent Without Specific Plan
5. Suicide Intent with Specific Plan
6. Have you ever done anything, started to do anything or prepared to do anything to end your life?
How long ago did you do any of these?

Screening

- Best practice = universal screening
- Your response matters!
- “Non-judgmental compassion” and “respectful curiosity”
- Be direct and specific in questions
- Ask about friends and peers - show you care

Screening

- "Have you ever hurt yourself on purpose?"
- "Have you ever thought about hurting yourself on purpose?"
- "Do you have any thoughts about ending your life?"
- "Do you think about suicide?"
- "If you were thinking about hurting yourself or ending your life, who would you tell?"

Screening to Assessment

- When there is any concern (by anyone) about self-harm or suicide, an assessment is recommended
- Who can provide an assessment in house?
- Is there any ongoing provider? (therapist, clinician through community mental health center. Etc.)
- Mobile crisis service?
- Emergency Department if truly emergent

Best Practices – Assessment

- Balance risk and protective factors
- Understand ideation (including duration and frequency), intent and plan
- Explore attempts, rehearsals, acquiring means
- Identify deterrents and future orientation
- Importance of collateral interview – parents/guardians, therapist, crisis team

Risk Factors

- Conditions, stressful events or situations that MAY increase the likelihood of a suicide attempt or death
- Chronic or acute
- Not predictive
- Family, personal/behavioral, environmental/social

Protective Factors

- Positive resources and conditions that promote resilience and reduce the potential for suicide
- Family protective factors
- Personal/behavioral protective factors
- Environmental/social protective factors

Safety Planning

- Means restriction
- Supervision
- Toolkit – Virtual Hope Box
- Crisis planning
- No contracts!

Treatment

- Outpatient treatment with safety plan
- Emergency bed program
- Inpatient hospitalization
- Remember hospitalization is short term
  - Risks and benefits
- Intensive treatment, residential – system of care

Treatment

- Family-centered care
- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Medication?
- Follow up care

Take Action!

- Implement universal screening
- Establish/review practice protocols and your own suicide care pathway
- Obtain and recommend use of gun locks, lock boxes, medication boxes
- Shift your language
- Increase awareness of local resources

Further Information

- Suicide Prevention Resource Center www.sprc.org
- Umatter www.umatterucangethelp.com
- VT Suicide Prevention Center www.vtspc.org
- Crisis Text Line www.crisistextline.org

New AAP Resources: Blueprint for Youth Suicide Prevention

Background

Public Health Framework

Risk Factors, Protective Factors, Warning Signs

Strategies for Clinical Settings

Strategies for Community and School Settings

Acknowledgments and Endorsements

Additional Resources for Suicide Prevention

Available at: www.aap.org/suicideprevention

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VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Questions?

Thank You

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What's Next

- March chart review and PDSA Log due April 18, 2022
  - Reports will be delayed until last week of April
- Final Learning Session May 5, 2022: ADHD Management- Amanda Downey, MD

Evaluation

- Provide feedback on the learning session via short 6 question survey at https://go.uvm.edu/ayabhcoiinwebinareval

Learning Session Recordings

- Recordings and other project materials can be found at our website: https://med.uvm.edu/nipn/aya-bh_coiin/c2home

Thank you from the NIPN Team

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