Youth Suicide Prevention in Primary Care Settings

Presenting Problem:

A primary care provider (PCP) sought consultation from WI CPCP regarding a 16-year-old female patient currently being treated for depression with sertraline (75mg/day) and Cognitive Behavioral Therapy (CBT). The patient had been showing signs of improvement, with only mild lingering insomnia noted at her most recent appointment. However, her parent recently reported that the patient disclosed taking four Tylenol tablets two nights ago after experiencing emotional distress from a breakup via text message. The PCP has scheduled an appointment for this afternoon and is seeking guidance on how to proceed.

Consultant's Response:

1. Assessment of Safety:

- Risk Assessment: Utilize the Columbia Suicide Severity Rating Scale (C-SSRS) to evaluate the risk of suicide and determine the necessary level of care.
- Safety Planning: Develop a comprehensive safety plan in collaboration with the patient's current therapist.
- Crisis Information: Ensure the patient and family have contact information for crisis services and understand the importance of seeking emergency care (e.g., ER or 911) if an imminent risk arises. 988 Suicide & Crisis Lifeline
- **Home Safety Measures:**
    - Secure firearms outside the home, if possible, with ammunition stored separately.
    - Store potentially dangerous items, such as knives and medications, out of sight to reduce impulsive access.
    - Supervise the child closely, avoiding situations where they may be left alone, especially during emotional escalation.
    - Limit social media use to supervised times, as taking a break from social media can be beneficial.

2. Assessment of Current Treatment:

- Psychotherapy: CBT is an effective treatment for depression in adolescents. Consider increasing the frequency of sessions to weekly if the patient is currently attending only 1-2 sessions per month.
- **Medication:**
    - Acknowledge that some patients may make impulsive, reactive suicide attempts in response to psychosocial stressors, regardless of their depression management.
    - Focus on psychotherapy to address triggers of suicide and hopelessness, along with a robust safety plan.
    - If the patient feels her depression is well-managed otherwise, continuing the current medication regimen may be advisable. Consider the upward titration of sertraline if needed while closely monitoring for safety.

- If the patient and/or family is convinced that sertraline is causing increased suicidality, despite hearing reasoning to the contrary, it's best not to argue, as there can be potential liability and the negative placebo effect may be too strong to overcome! Consider switching to a different medication at that point.
- In the following few weeks, if suicidality increases while continuing sertraline, consider switching medications.

3. Additions to the Treatment Plan:

- Behavioral Activation: Introduce behavioral activation techniques to the treatment plan to help improve the patient's mood. Providing a behavioral activation worksheet can aid in initiating this process.

Teaching Points:

- The American Academy of Pediatrics (AAP) guidelines recommend annual screening for suicidality in all patients aged 12 and older.
  - The Patient Health Questionnaire (PHQ-9) includes a question on suicidality.
    - PHQ-9 Questionnaire for Depression Scoring and Interpretation Guide
  - The Ask Suicide Questions (ASQ) screener provides a more thorough assessment.
- Suicidality assessments, including interviews and using a rating scale like the C-SSRS, should be conducted for any patient presenting with suicidal symptoms or screening positive for suicidality on tools like the ASQ or PHQ-9.